# HOW TO DE-STRESS A DISTRESSED SENIOR LIVING COMPANY

**Bruce Buchanan,** Healthcare Management Partners, PLLC
bbuchanan@hcmpllc.com


**Jeffery D. Parrish,** Waller Lansden Dortch & Davis, LLP
jeff.parrish@wallerlaw.com

**John C. Tishler,** Waller Lansden Dortch & Davis, LLP
john.tishler@wallerlaw.com



**Long Term Care and the Law**

February 22-24, 2017 | Manchester Grand Hyatt | San Diego, CA

## Executive Summary

External pressures, such as lower reimbursement rates and an overall shift in policy by the Centers for Medicare and Medicaid Services (CMS) and state Medicaid agencies have put significant financial and operational pressure on skilled nursing and other senior living operators in the United States. Internal pressures, such as poor operational decision-making and a difficult, competitive environment for patients and employees, have combined to put some skilled nursing facility (SNF) owners and operators against the proverbial financial and operational wall. However, our recent experiences in the skilled nursing business indicate that all is not lost for owners and operators of SNFs and, in fact, with some fairly basic operational and financial improvements, these operators can not only recover but thrive in the current environment.

## Pressures

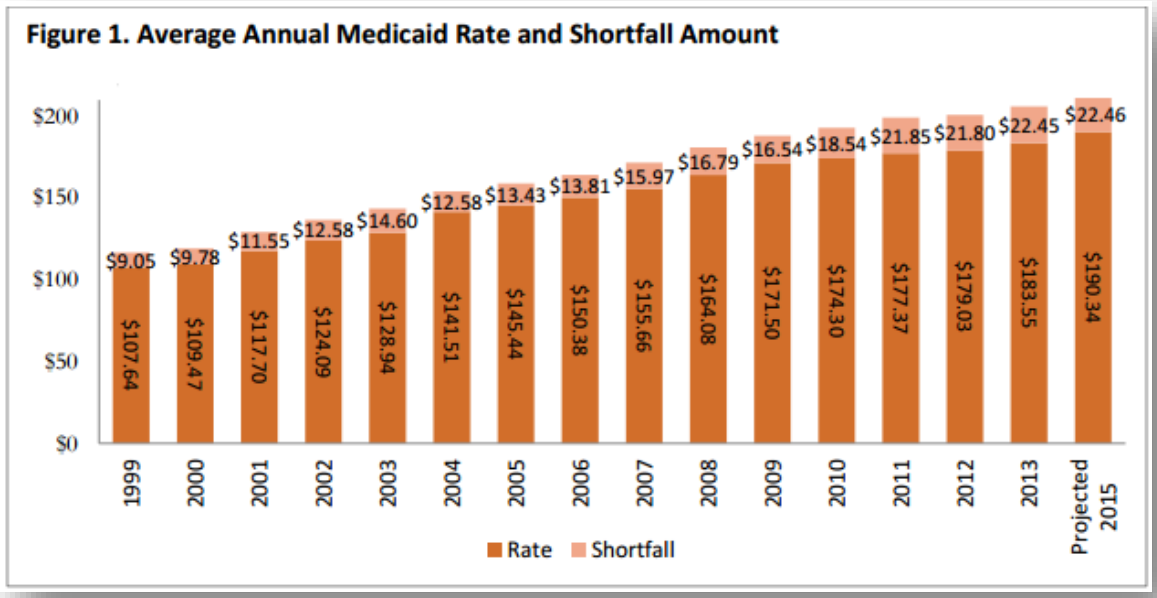
Increasingly, there are two primary types of owners of SNFs: (i) large, multi-state owners with revenues ranging from $500,000,000 and up, and (ii) smaller, family-owned operators or closely held companies owned by with revenues ranging up to $500,000,000. Obviously, the smaller companies are at greater risk simply because they tend to have less capital and less market dominance. Notwithstanding that, our suggestions work equally well for the larger or smaller owners or operators.

Among the most notable external pressures being applied to SNFs are:

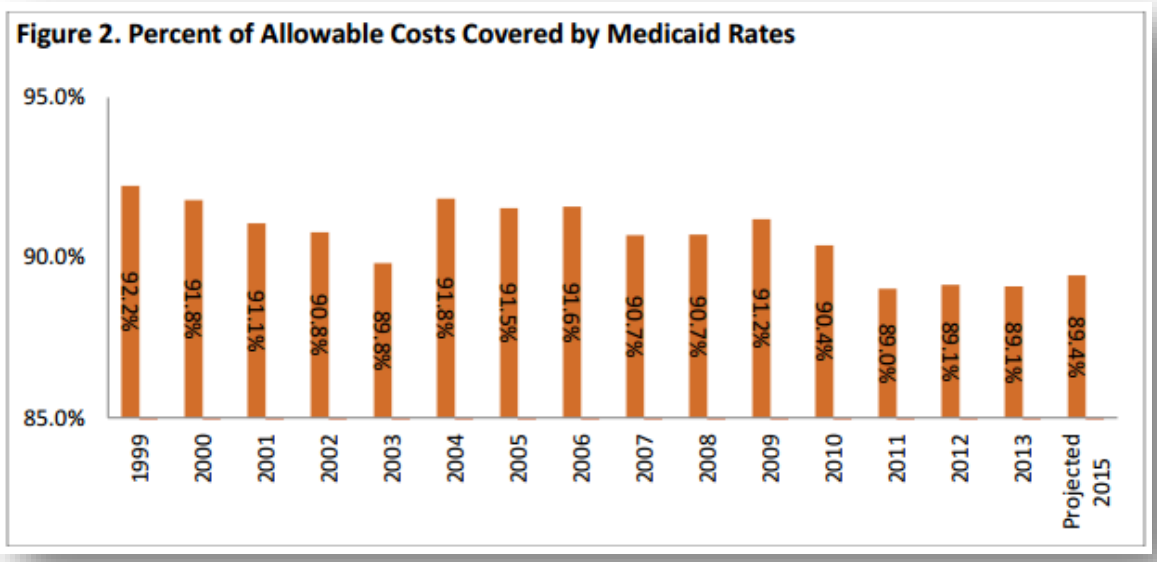
### *Medicaid Rates*

Although Medicaid rates have increased by more than 50% over time (from approximately $107.64 per patient day in 1999 to an estimated $190.34 per patient day in 2015), they have not kept pace with costs. The average annual Medicaid Rate shortfall, as shown in Figure 1 on the following page, has grown from less than $10 per day ($9.05 in 1999) to more than $22 per day ($22.46 in 2015). When considered with the historically thin profit margins on which most SNFs operate, this has had a crushing effect on the profitability of SNF owners and operators, especially smaller ones that do not have the operational scale with which to absorb these losses.

Likewise, allowable costs under Medicaid have also decreased since the late 1990s. In 1999, 92.2% of costs were allowable under Medicaid. As recently as 2009, Medicaid allowed 91.2% of all costs. Since 2009, however, the figure has dropped into the upper 80% range, as shown in Figure 2 on the following page.




Source: Eljay, LLC & Hansen Hunter & Company, PC (for the AHCA), April 2016




Source: Eljay, LLC & Hansen Hunter & Company, PC (for the AHCA), April 2016

Today, in most states, costs outstrip what Medicaid reimburses. In some states (typically where costs are affected by higher costs of goods or an abundance of unionized employees), SNF operators are losing large amounts of money because Medicaid reimbursement has not kept pace with costs. For example, Medicaid reimbursement lags behind costs by an average of approximately $52 per patient day in Wisconsin, an average of approximately $48 per patient day in New York, an average of approximately $35 per patient day in New Jersey, and an average of approximately $34 per patient day in Minnesota. Even at the other end of the spectrum, North Dakota operators' reimbursement rates only exceed their costs at an average of $2.42 per patient day, while Virginia operators essentially "break even" at an average of 32 cents per patient day. Operators in the next best states for Medicaid reimbursement rates versus costs do not even come close to breaking even, including a loss of an average of $1.65 per patient day in Delaware, a loss of an average of $6.67 per patient day in Florida, and a loss of an average of $7.79 per patient day in Georgia. Figure 3 below shows the cost challenges in several of the states based on projected 2015 costs.

**Figure 3. State-by-State Comparison of 2015 Rates to Projected 2015 Costs**

| State | 2015 Rate | Projected 2015 Cost | Projected Difference |
|---|---|---|---|
| Arizona | $208.12 | $217.10 | ($8.99) |
| California | $191.33 | $205.50 | ($14.17) |
| Colorado | $225.23 | $232.05 | ($6.82) |
| Connecticut | $230.06 | $255.04 | ($24.98) |
| Delaware | $256.69 | $258.34 | ($1.65) |
| Florida | $225.14 | $231.81 | ($6.67) |
| Georgia[11] | $164.02 | $171.81 | ($7.79) |
| Hawaii[12] | $260.77 | $281.85 | ($21.08) |
| Illinois | $145.99 | $171.08 | ($25.09) |
| Iowa | $165.39 | $177.64 | ($12.25) |
| Kansas | $158.70 | $169.14 | ($10.45) |
| Maine | $200.58 | $213.50 | ($12.92) |
| Maryland | $239.37 | $257.99 | ($18.62) |
| Massachusetts | $201.44 | $236.70 | ($35.26) |
| Minnesota | $179.96 | $214.00 | ($34.04) |
| Missouri | $152.66 | $167.57 | ($14.90) |
| Montana | $183.34 | $200.48 | ($17.14) |
| Nebraska | $161.87 | $186.93 | ($25.06) |
| Nevada | $201.41 | $224.12 | ($22.71) |
| New Jersey | $207.35 | $242.67 | ($35.32) |
| New Mexico | $168.00 | $192.73 | ($24.73) |
| New York | $234.16 | $282.59 | ($48.43) |
| North Dakota | $250.51 | $248.08 | $2.42 |
| Ohio | $175.10 | $196.79 | ($21.69) |
| Oklahoma | $144.08 | $158.89 | ($14.81) |
| Pennsylvania | $216.75 | $242.18 | ($25.43) |
| Texas | $141.64 | $154.18 | ($12.55) |
| Utah[11] | $188.70 | $205.21 | ($16.51) |
| Vermont | $217.23 | $234.98 | ($17.76) |
| Virginia[11] | $173.81 | $173.49 | $0.32 |
| Washington | $197.32 | $225.15 | ($27.83) |
| Wisconsin | $167.85 | $220.68 | ($52.84) |
| Wyoming | $224.12 | $249.04 | ($24.92) |

Source: Eljay, LLC & Hansen Hunter & Company, PC (for the AHCA), April 2016

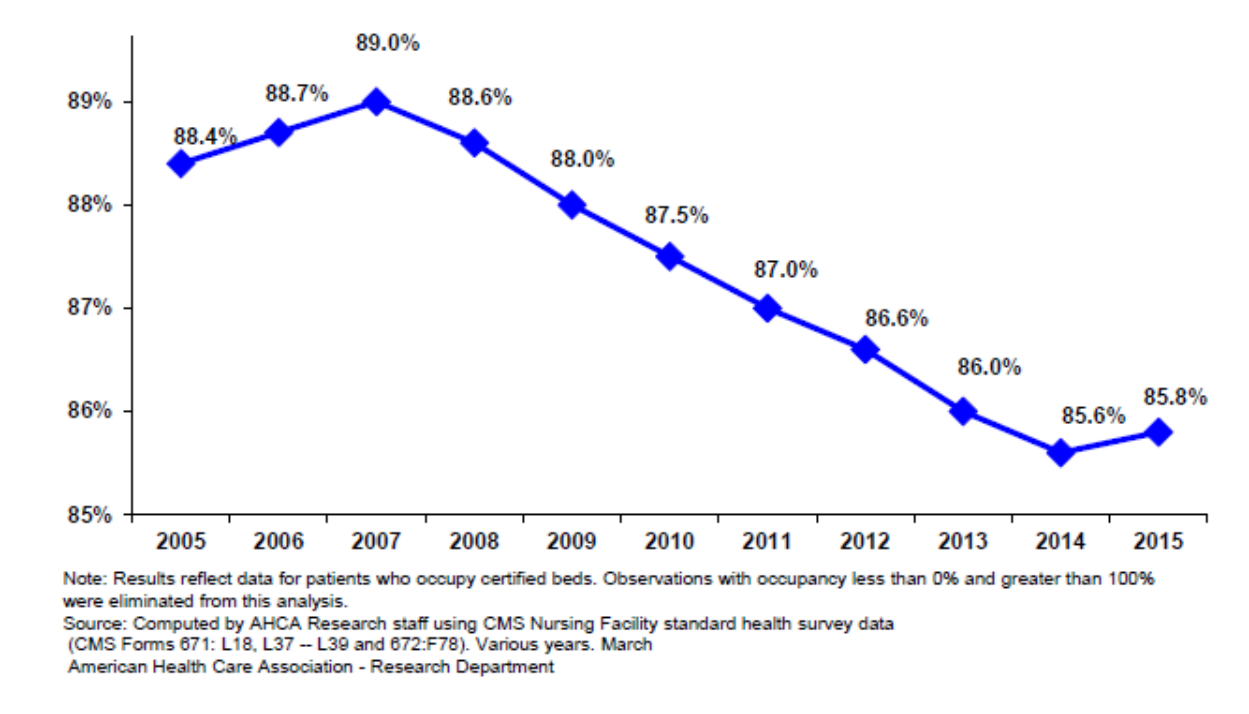
While these are averages, it means that those operating below the 50th percentile on average are losing money on Medicaid rates. As a result, increasingly, Medicaid-only or Medicaid-predominant SNFs are going out of business or filing for bankruptcy. Between 2010 and 2014, bankruptcy filings in the skilled nursing sector increased by more than a third according to Frost Brown Todd LLC.

In 2012, the Medicare Payment Advisory Commission estimated that overall United States SNFs' operating margin was 1.8% (including Medicaid, Medicare, and private pay operators).

***Declining Census/Increased Complexity***

In addition to negative rate pressures, census likewise continues to decrease. The highest census in the last 10 years was 91.48% in 2006. The lowest, tellingly, was in 2014 (the most recent year for which we have data). We anticipate 2016 will likewise show continued declining census. As illustrated in Figure X below, from 2005 to 2015, there was an overall decrease in census of 2.6%.

**Figure 4. Median Nursing Facility Occupancy Rate for Certified Beds**




Source: American Health Care Association

What is behind this? Much of it is policy driven at the federal level. *Modern Healthcare* reported in August 2016 that CMS is "urg[ing] states to use Medicaid to care for disabled at home." In addition, CMS recently released guidance that encouraged states to use Medicaid funds to keep beneficiaries at home and in community-based settings rather than skilled nursing settings. This policy is already being implemented based on the data. In 2014, 53% of total Medicaid long-term services and supports expenditures were spent on home- and community-based services, while such services accounted for only 45% of total Medicaid long-term services and supports expenditures in 2009. CMS' guidance further suggests that states establish an "open registry" of home care workers to make it easier for beneficiaries to find home care workers, develop "outlines" of qualifications for such workers, and pay adequate rates for home care services.

Medicare Advantage has gained significant market penetration already. Medicare Advantage essentially sets insurance rates for certain services. Insurance companies increasingly want to sign up providers to managed care contracts that set the prices at which certain costs will be paid. It is estimated that approximately 30-45% of all skilled nursing facilities operate under managed care contracts. Just as Medicaid is not keeping up with the actual costs of providing services, managed care rates are, anecdotally, covering only 70-80% of the actual costs of the services being provided. Managed care contracts further put pressure on SNFs by requiring administrative oversight and that skilled negotiators be hired or retained. Since these contracts come up for renewal every 12-24 months in many instances, keeping up with trends regarding what insurance will reimburse is an important skill operators need to have.

Managed care is also coming for Medicaid rates. Currently 27 states have it, and 13 others are phasing it in. One detrimental aspect of managed care is that case managers are determining patient qualifications for skilled nursing, with a predisposition to turn patients away from SNFs and more toward home health or community-based care. Thus, not only is managed care setting lower rates, but it is also cutting census for SNFs.

Finally, patients being treated in SNFs are increasingly more sick than they were 5-10 years ago. Of the five assisted daily living standards (bathing, bed mobility, transfer, toilet use, and eating) 95% of Medicare patients in SNFs are reported to have deficiencies in four of the five. Many patients present with some form of dementia as well.

***Increased Regulatory Scrutiny***

For at least the past 10 years, CMS has been preaching the need to measure facilities and care by quality metrics. In the past five years, enforcement of this approach has been through increased scrutiny on the care being provided. The Five Star program has been effective in differentiating the "best" from the "worst" operators to the public, giving considerable power to the consumer. Recently, CMS added six new quality measures to its Five Star program. The Department of Health and Human Services' Office of the Inspector General (OIG) has said that its top management and performance challenges include "ensuring quality in nursing home

care." Bills have been introduced in Congress that, among other things, would require CMS to establish "performance standards and scores," instruct CMS to "calculate the value-based incentive payments," and provide for judicial and administrative review of such value-based payments.

Increasingly, large settlements with the Department of Justice (DOJ) and OIG have become the norm. In October 2016, it was announced that Life Care Centers of America would pay a $145 million penalty to settle false claim allegations. A Kindred subsidiary, RehabCare, agreed to pay $125 million to settle false claim actions against it. Others have been hit with settlements ranging from $3.9 million (Wingate in Massachusetts and New York) to $2.2 million (THI in Pennsylvania and Texas) and $1.375 million (Essex in Massachusetts).

A new and troubling trend to the management of SNFs is that enforcement actions are not only being taken against corporate operators, but individual managers as well. Notably, the Chairman and Senior VP of Reimbursement were individually named and settled with the government for $1 million and $500,000, respectively in an action against North America Health Care in California. (The company itself settled claims against it for $28.5 million.) The Director of Operations of Vanguard in Tennessee has been accused of liability in a case in which the government made the accusation that poor care is the equivalent of a false claim. In 2009, the Department of Justice established its "HEAT" team, which stands for Health Care Fraud Prevention and Enforcement Action Team. The HEAT team's charge is to focus solely on false claims and fraud being perpetrated by healthcare companies. This was the first time that the DOJ set aside considerable resources just to investigate healthcare fraud.

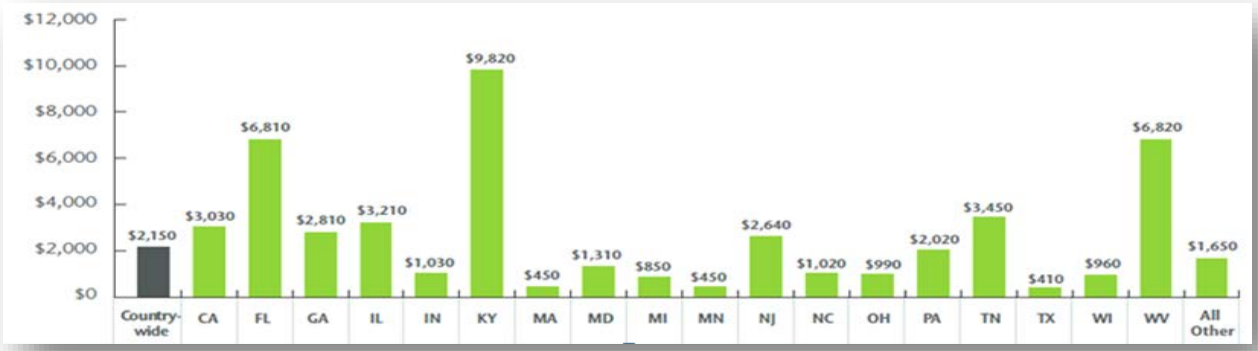
Penalties have also increased. Maximum daily civil monetary penalties for failure to meet certification have increased from $10,000 per day to $20,628 per day, while minimum daily civil monetary penalties also have increased from $3,050 to $6,291.

"Ground zero" for much of this scrutiny and issuing of increased penalties appears to be in the southeastern United States. Seven of the most penalized ten states are located in CMS' Region IV. The penalties amassed by Region IV (approximately $18.6 million) almost equal all other regions combined (approximately $20 million) and quadruple the penalties assessed against Regions I, II, III, VII, VIII, IX, and X combined ($4.3 million).

***Litigation***

While tort reform has taken the wind out of the sails of some plaintiffs' attorneys, not all states have implemented it. In states without tort reform, verdicts are setting records. In 2010, a 92-year-old patient's family was awarded $42.75 million against a SNF. In 2015, a 94-year old patient's family was awarded $18 million in a wrongful death suit in Kentucky. A World War II veteran and former general surgeon was awarded $8 million for a broken leg. A comparison of legal losses incurred by SNFs in various states in shown in Figure 5 on the following page.

**Figure 5. Comparison of Projected 2016 Loss Rates**



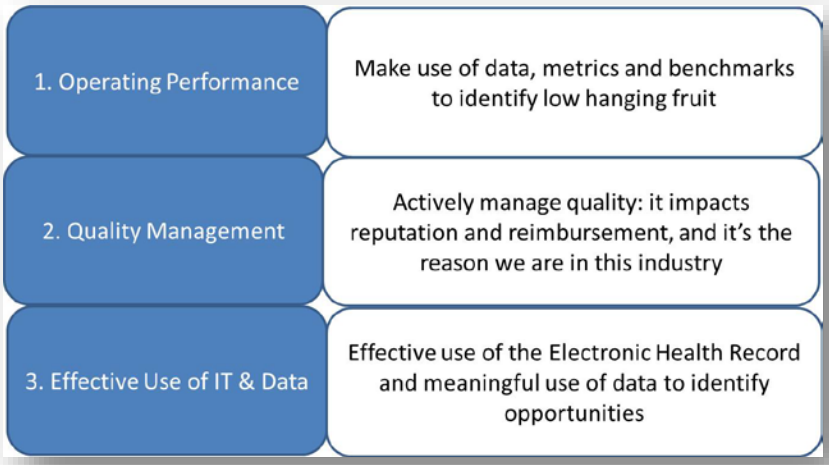

Source: AON LTC General Liability and Professional Liability Actuarial Analysis, Nov. 2015

One recent tool that SNFs have used to fight this type of litigation is mandatory arbitration clauses. CMS, however, has determined that it will not support such provisions in patient contracts, and it is a condition of participation in the CMS programs that SNFs not have such provisions in their contracts, effective November 28, 2016. A federal district court, however, has issued an injunction against implementation of this CMS determination. Its future is presently uncertain.

## Solutions and Counter Measures

Not all is lost, however. As a friend recently noted, "Stressed" is just "Desserts" spelled backwards. Accordingly, there is something that can be done to turn a distressed situation into a positive situation Below, we'll explore a few of these measures. Foremost in these solutions is that when investigating options for improvements, data is your friend. Data, metrics and benchmarking can lead to significantly improved results that will more than offset some of the difficult pressures being applied to SNFs today. A sampling of some of the areas you should be inquiring are shown in Figure 6 below.

**Figure 6. Internal Opportunities for Reducing Operational & Financial Distress**




### *Corporate Structure & Management Structure*

Are you bloated? Do you look fat? Not you—your business? If your overhead spend is more than 5% of net patient revenue, then you have some work to do in cutting expenses. The vast majority of your expenses should be at the patient bedside, not in the corporate office. Many SNF owners and operators believe that in this age of trying to manage a multitude of rules and regulations, it is advisable to simply add personnel. The opposite is true in this day of available data, especially as provided by that new electronic medical records (EMR) system you bought.

### *Monitor your Cash Flow, not just your P&L*

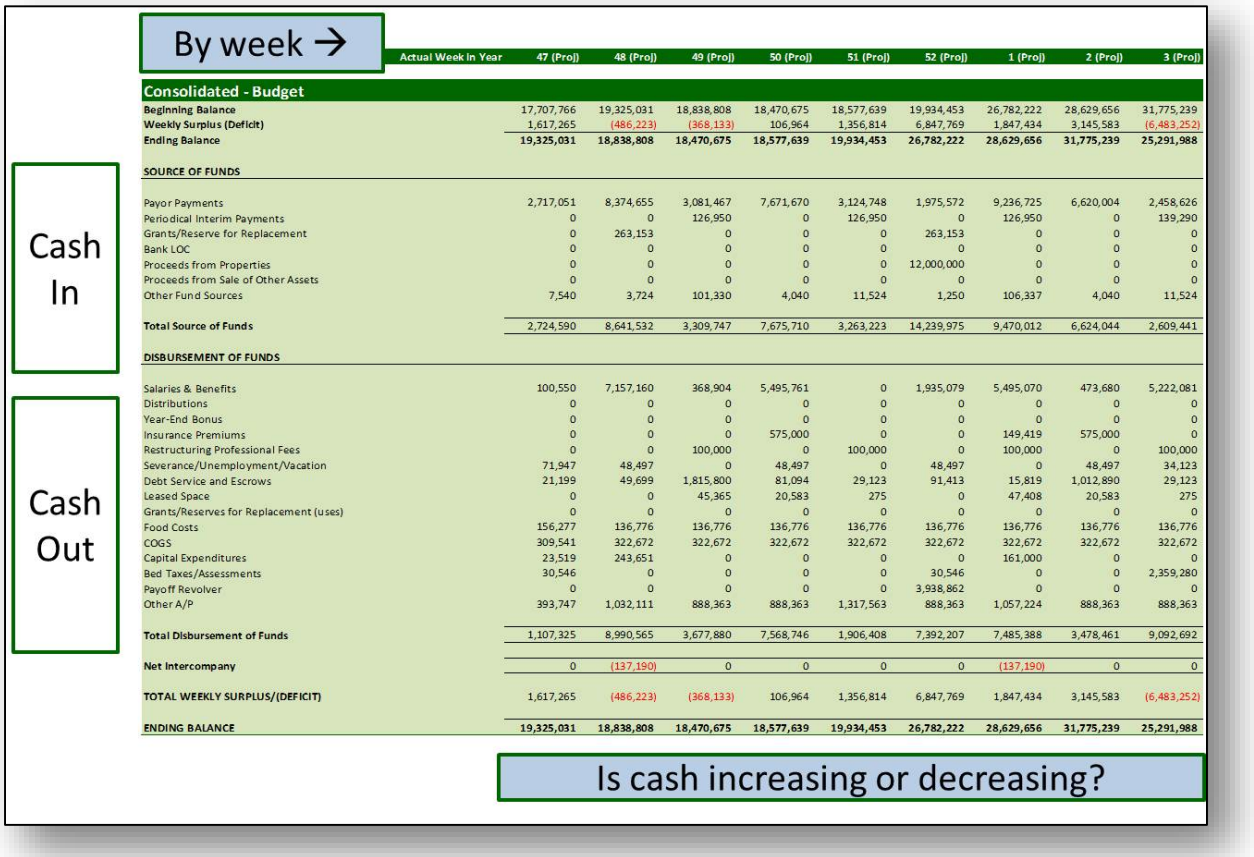
Most business rely upon a profit and loss statement for knowing where things stand financially. SNF owners and operators, however, really need to know what their cash flow picture looks like. First, revenues and accounts payable may come in at unpredictable times, at any one time your P&L may look great or not look so hot, depending on a day or two of timing. Cash flow allows you to look at a bigger picture. Ideally, you should have 13-week cash flow forecast which will allow you more options for planning on capital expenditure or that unexpected maintenance item that needs to be paid. Once you develop a 13-week cash flow forecast, go

ahead and engage in the process of developing a 12-month forecast. Then track whether your actual performance is keeping pace with your forecast.

Second, you should look at your "cash on hand." Do you have sufficient reserves to get you through the next 30 days? How about 60? You should have a minimum of 60 days cash on hand. Ideally, you will have 90 days cash on hand. Do not feel defeated if you do not have this level of cash on hand currently, but you should develop a game plan to obtain an ideal amount of cash on hand.

Figure 7 below illustrates a form of a Cash Flow statement that you can use. As you can see, the chart simply follows the cash coming in (revenues) and the cash going out (expenses). Ask yourself if your cash over the 13-week or 12-month period is increasing or decreasing. If it is not increasing, you should strongly consider taking steps to reduce your expenses and/or increase your revenues.

**Figure 7. Sample Cash Flow Statement**




| Actual Week in Year | 47 (Proj) | 48 (Proj) | 49 (Proj) | 50 (Proj) | 51 (Proj) | 52 (Proj) | 1 (Proj) | 2 (Proj) | 3 (Proj) |
|---|---|---|---|---|---|---|---|---|---|
| **Consolidated - Budget** | | | | | | | | | |
| **Beginning Balance** | 17,707,766 | 19,325,031 | 18,838,808 | 18,470,675 | 18,577,639 | 19,934,453 | 26,782,222 | 28,629,656 | 31,775,239 |
| **Weekly Surplus (Deficit)** | 1,617,265 | (486,223) | (368,133) | 106,964 | 1,356,814 | 6,847,769 | 1,847,434 | 3,145,583 | (6,483,252) |
| **Ending Balance** | **19,325,031** | **18,838,808** | **18,470,675** | **18,577,639** | **19,934,453** | **26,782,222** | **28,629,656** | **31,775,239** | **25,291,988** |
| **SOURCE OF FUNDS** | | | | | | | | | |
| Payor Payments | 2,717,051 | 8,374,655 | 3,081,467 | 7,671,670 | 3,124,748 | 1,975,572 | 9,236,725 | 6,620,004 | 2,458,626 |
| Periodical Interim Payments | 0 | 0 | 126,950 | 0 | 126,950 | 0 | 126,950 | 0 | 139,290 |
| Grants/Reserve for Replacement | 0 | 263,153 | 0 | 0 | 0 | 263,153 | 0 | 0 | 0 |
| Bank LOC | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Proceeds from Properties | 0 | 0 | 0 | 0 | 0 | 12,000,000 | 0 | 0 | 0 |
| Proceeds from Sale of Other Assets | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other Fund Sources | 7,540 | 3,724 | 101,330 | 4,040 | 11,524 | 1,250 | 106,337 | 4,040 | 11,524 |
| **Total Source of Funds** | 2,724,590 | 8,641,532 | 3,309,747 | 7,675,710 | 3,263,223 | 14,239,975 | 9,470,012 | 6,624,044 | 2,609,441 |
| **DISBURSEMENT OF FUNDS** | | | | | | | | | |
| Salaries & Benefits | 100,550 | 7,157,160 | 368,904 | 5,495,761 | 0 | 1,935,079 | 5,495,070 | 473,680 | 5,222,081 |
| Distributions | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Year-End Bonus | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Insurance Premiums | 0 | 0 | 0 | 575,000 | 0 | 0 | 149,419 | 575,000 | 0 |
| Restructuring Professional Fees | 0 | 0 | 100,000 | 0 | 100,000 | 0 | 100,000 | 0 | 100,000 |
| Severance/Unemployment/Vacation | 71,947 | 48,497 | 0 | 48,497 | 0 | 48,497 | 0 | 48,497 | 34,123 |
| Debt Service and Escrows | 21,199 | 49,699 | 1,815,800 | 81,094 | 29,123 | 91,413 | 15,819 | 1,012,890 | 29,123 |
| Leased Space | 0 | 0 | 45,365 | 20,583 | 275 | 0 | 47,408 | 20,583 | 275 |
| Grants/Reserves for Replacement (uses) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Food Costs | 156,277 | 136,776 | 136,776 | 136,776 | 136,776 | 136,776 | 136,776 | 136,776 | 136,776 |
| COGS | 309,541 | 322,672 | 322,672 | 322,672 | 322,672 | 322,672 | 322,672 | 322,672 | 322,672 |
| Capital Expenditures | 23,519 | 243,651 | 0 | 0 | 0 | 0 | 161,000 | 0 | 0 |
| Bed Taxes/Assessments | 30,546 | 0 | 0 | 0 | 0 | 30,546 | 0 | 0 | 2,359,280 |
| Payoff Revolver | 0 | 0 | 0 | 0 | 0 | 3,938,862 | 0 | 0 | 0 |
| Other A/P | 393,747 | 1,032,111 | 888,363 | 888,363 | 1,317,563 | 888,363 | 1,057,224 | 888,363 | 888,363 |
| **Total Disbursement of Funds** | 1,107,325 | 8,990,565 | 3,677,880 | 7,568,746 | 1,906,408 | 7,392,207 | 7,485,388 | 3,478,461 | 9,092,692 |
| **Net Intercompany** | 0 | (137,190) | 0 | 0 | 0 | 0 | (137,190) | 0 | 0 |
| **TOTAL WEEKLY SURPLUS/(DEFICIT)** | 1,617,265 | (486,223) | (368,133) | 106,964 | 1,356,814 | 6,847,769 | 1,847,434 | 3,145,583 | (6,483,252) |
| **ENDING BALANCE** | **19,325,031** | **18,838,808** | **18,470,675** | **18,577,639** | **19,934,453** | **26,782,222** | **28,629,656** | **31,775,239** | **25,291,988** |

***Revenue Cycle Performance***

You should be tracking your accounts receivable and collections along with your accounts payable. Ideally, you should collect your accounts receivable within 35 to 40 days of sending invoices. If you are not, you should focus resources on cutting your collection times. On accounts payable, you should be striving for a happy medium where you are receiving cash, on average, at least as fast as you are paying cash out. This may require, for a short time, that you "stretch" some of your payables. Be careful about stretching payables as it can anger a vendor or lead a vendor to demand that you pay in cash upon delivery.

***Staffing Ratios***

You should monitor whether you have the right skills for the acuity of your patient mix. For instance, if many of your patients tend to be in rehabilitation, you will want to be sure that your rehabilitation team is enhanced while your nursing team may be reduced. Alternatively, if you are treating many very sick patients, rehabilitation may be of secondary concern, and your nursing staff should be enhanced. By tracking staffing needs, you will have the right mix from a patient care and quality perspective and will be able to bill efficiently and effectively for the care that is being provided.

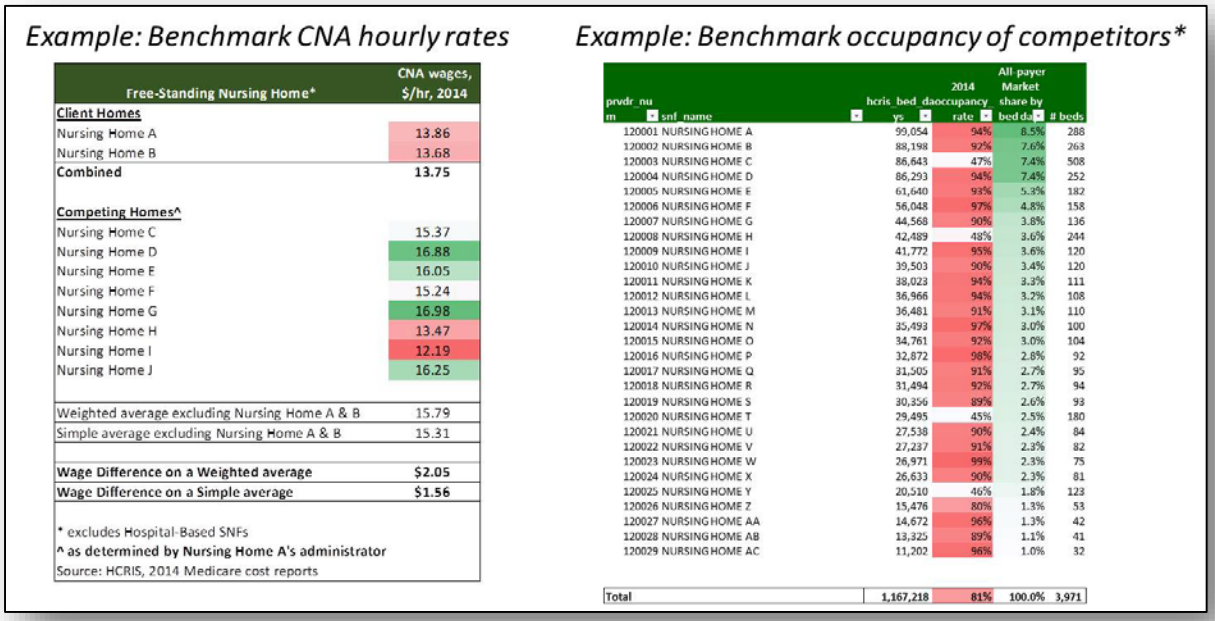
***Labor Costs/Turnover***

Do you have trouble keeping good staff? Relax, you are not alone. Some SNFs have turnover rates of close to 100% over a 12-month period because of competition in their markets. If this is happening to you, it is costing you money. Your employee costs are probably the single largest line item in your budget. Constantly losing people and having to re-train people or having gaps in your staffing will cost you money. You should consider whether you bite the bullet and pay at or, in some highly competitive markets, above the market rate so that you can retain good staff while not incurring the expense of turnover.

A side benefit of this consistency is that patients are likely to be more content, care will be better, and you may move up in the Five Star program. Use benchmarking data to identify where your labor costs are highest, and where payment rates are out of kilter with the market. There are many sources, but a good one is from HMP Metrics, provided by one of our authors.[1] Figure 8 on the following page shows that you can get activity and financial information and all-payer data, by provider, which is beneficial when thinking about managed care contracts, benchmarking on cost and revenue data. It also helps you understand how your competitors are actually performing and you can determine how well your referral sources are performing. Obtaining this information at least annually can give you a real competitive advantage.

[1] Please contact Clare Moylan at cmoylan@hcmpllc.com for more information on HMP Metrics.

**Figure 8. HMP Provider-Level Data Reports**



*Example: Benchmark CNA hourly rates*

| Free-Standing Nursing Home* | CNA wages, $/hr, 2014 |
|---|---|
| Client Homes | |
| Nursing Home A | 13.86 |
| Nursing Home B | 13.68 |
| Combined | 13.75 |
| | |
| Competing Homes^ | |
| Nursing Home C | 15.37 |
| Nursing Home D | 16.88 |
| Nursing Home E | 16.05 |
| Nursing Home F | 15.24 |
| Nursing Home G | 16.98 |
| Nursing Home H | 13.47 |
| Nursing Home I | 12.19 |
| Nursing Home J | 16.25 |
| | |
| Weighted average excluding Nursing Home A & B | 15.79 |
| Simple average excluding Nursing Home A & B | 15.31 |
| | |
| Wage Difference on a Weighted average | $2.05 |
| Wage Difference on a Simple average | $1.56 |

* excludes Hospital-Based SNFs
^ as determined by Nursing Home A's administrator
Source: HCRIS, 2014 Medicare cost reports

*Example: Benchmark occupancy of competitors**

| prvdr_num | snf_name | hcris_bed_days | 2014 occupancy rate | All-payer Market share by bed days | # beds |
|---|---|---|---|---|---|
| 120001 | NURSING HOME A | 99,054 | 94% | 8.5% | 288 |
| 120002 | NURSING HOME B | 88,198 | 92% | 7.6% | 263 |
| 120003 | NURSING HOME C | 86,643 | 47% | 7.4% | 508 |
| 120004 | NURSING HOME D | 86,293 | 94% | 7.4% | 252 |
| 120005 | NURSING HOME E | 61,640 | 93% | 5.3% | 182 |
| 120006 | NURSING HOME F | 56,048 | 97% | 4.8% | 158 |
| 120007 | NURSING HOME G | 44,568 | 90% | 3.8% | 136 |
| 120008 | NURSING HOME H | 42,489 | 48% | 3.6% | 244 |
| 120009 | NURSING HOME I | 41,772 | 95% | 3.6% | 120 |
| 120010 | NURSING HOME J | 39,503 | 90% | 3.4% | 120 |
| 120011 | NURSING HOME K | 38,023 | 94% | 3.3% | 111 |
| 120012 | NURSING HOME L | 36,966 | 94% | 3.2% | 108 |
| 120013 | NURSING HOME M | 36,481 | 91% | 3.1% | 110 |
| 120014 | NURSING HOME N | 35,493 | 97% | 3.0% | 100 |
| 120015 | NURSING HOME O | 34,761 | 92% | 3.0% | 104 |
| 120016 | NURSING HOME P | 32,872 | 98% | 2.8% | 92 |
| 120017 | NURSING HOME Q | 31,505 | 91% | 2.7% | 95 |
| 120018 | NURSING HOME R | 31,494 | 92% | 2.7% | 94 |
| 120019 | NURSING HOME S | 30,356 | 89% | 2.6% | 93 |
| 120020 | NURSING HOME T | 29,495 | 45% | 2.5% | 180 |
| 120021 | NURSING HOME U | 27,538 | 90% | 2.4% | 84 |
| 120022 | NURSING HOME V | 27,237 | 91% | 2.3% | 82 |
| 120023 | NURSING HOME W | 26,971 | 99% | 2.3% | 75 |
| 120024 | NURSING HOME X | 26,633 | 90% | 2.3% | 81 |
| 120025 | NURSING HOME Y | 20,510 | 46% | 1.8% | 123 |
| 120026 | NURSING HOME Z | 15,476 | 80% | 1.3% | 53 |
| 120027 | NURSING HOME AA | 14,672 | 96% | 1.3% | 42 |
| 120028 | NURSING HOME AB | 13,325 | 89% | 1.1% | 41 |
| 120029 | NURSING HOME AC | 11,202 | 96% | 1.0% | 32 |
| Total | | 1,167,218 | 81% | 100.0% | 3,971 |

Source: HMP Metrics™, www.hcmpllc.com

### *Employee Benefits*

With employee costs representing a significant portion of your expenses, keeping an eye on benefits is good business. Do your healthcare premiums keep rising? Do employees compare your benefits with others in the market? Renegotiating your health plan coverage on an annual basis may make a difference in employee satisfaction and retention.

### *Actively Manage Quality*

Of all the tools available to turn around a distressed SNF, improving the quality of care and the patient experience may be the most important in your toolbox. Quality impacts reputation and reimbursement, and it is the reason we are in this industry in the first place. There is a myth that quality eats into profits or costs a lot of money. Most studies show that the most cost-effective organizations have the best quality. Obtaining high quality, however, requires tenacity and vigilance.

Not only is CMS rewarding quality (and discouraging poor service), but customers are increasingly aware of which facilities provide quality service and which do not. The Five Star Rating System was explicitly put in place for the purpose of alerting consumers to where to go, and Nursing Home Compare on www.medicare.gov gives consumers many of the tools necessary to differentiate between facilities that focus on quality and those that have quality control issues.

The best owners and operators have a quality-focused culture in their facilities. Starting with a SNF clinical expert, you can implement a Quality Management Program (QMP) in your facilities. These experts can help tailor a QMP to your facilities that will move you from the middle of the pack to the top of the pack. Ultimately, a quality-based culture comes from the top down and includes training, reinforcement, and a reward-based system for achievement. Owners, operators, and top managers must be committed to the idea of improving quality. Once they are dedicated to improving quality, the next most important aspect of quality control is training the staff, which is your front line on quality, and using that training as a tool for quality control and reinforcement of concepts and ideas.

Minimum Data Set, or MDS, training to properly code for reimbursement will save you time and a lot of regulatory headaches. Failing to properly code for reimbursement risks audits, professional, and legal expense, and, ultimately, could result in a false claims allegation. Thus, constantly training those who are coding is a key ingredient to quality control. Further, regularly updating training on that EMR system is necessary. The EMR system that you have in place can be a key driver to improvements, but only if the people using it are well-trained and know how to get the most out of it.

***Effective Use of IT and Data***

As mentioned above, the issues with your EMR system can have a huge negative impact on quality as well as your financial bottom line. Merely declaring your first installation of an EMR system a failure and attempting workarounds is a scenario likely to lead to a loss of money. The impact on revenue cycle, reimbursement, and staff morale should not be underestimated.

When EMR systems were first introduced, there were a number of companies providing EMR services. Over time, the wheat has been separated from the chaff, and there are now a handful of EMR companies that comprise the better systems in the business. Do your research. If the company providing your EMR system was not among the best, you should either insist on a full re-install with new training from the company or move to another provider.

There have been several large judgments against EMR companies which had ineffective systems that cost providers significant money, all of which was recouped through litigation. Investigation of all of these options should be a top priority if you are experiencing trouble with your EMR. Among other things, you should be certain that your EMR system can connect internally with your pharmacy, rehabilitation, and nurse practitioners. Your EMR system also needs to have connectivity to the external resources such as acute and other post-acute providers, especially as you move toward population health management. By effectively using your data, and that of other providers, you will be able to inform your strategy, your quality, and, ultimately, your business development initiatives.

## Financial and Legal Considerations

### *Lending Considerations*

The market and the government are not making it easier for SNFs when it comes to borrowing and revenues. Typically, entering into transactions with real estate investment trusts (REITs) has been an option for some operators. In REIT transactions, the underlying ownership of the land and buildings is sold to the REIT, which then leases the property back to the operator. However, large REITs have been announcing their retreat from providing this option for SNFs. See "Health-Care REITs Back Off Nursing," Oct. 11, 2016, *Wall Street Journal.*

As a whole, for many of the reasons outlined in this article, lenders do not see the senior living business as an attractive sector. In the past, Medicaid would allow for you to obtain some reimbursement for your interest costs. That option, however, is no longer available to borrowers. Thus, where, in the past, leverage might be a strategic option for some operators, leverage is now a dirty word that puts tremendous pressure on SNFs to not only deal with all the challenges of operating in the current environment but also keep current on its debt payments. Ideally, one significant consideration owners should be investigating is a reduction in overall debt.

### *Analyzing your Debt*

One place to start is to look at the types of debt you have on your books and investigate whether there may be a more cost-effective form of debt. SNFs typically have either a revolving credit facility or a term loan or both.

A revolving credit facility is simply a loan against your receivables. This type of loan allows borrowers to avoid the "lumpiness" of collections from Medicare and Medicaid by having a line of credit that allows them to borrow against it to be able to pay vendors and other debts as they come due. Lenders of revolving credit facilities typically do not loan the full amount of your "eligible receivables." Instead, lenders have a borrowing base formula that allows you to draw down 80-90% of your Medicare, Medicaid, and private pay receivables. Once you pledge your receivables, receivables will come into your account and then be "swept" daily by the lender into an account the lender controls. Lenders will then account for your collections and, along with collections from prior days, advise you how much you may borrow. A term loan is usually a mortgage loan against your owned real estate or equipment. Repayment terms on term loans are typically around 15-30 years.

### *Consolidating your Debt*

If you have several different lenders, it may be wise to consolidate all of your debt with a single lender in exchange for a lower interest rate or longer terms. For instance, many SNFs have a mixture of Department of Housing and Urban Development (HUD) loans, conventional term loans, and a revolving credit facility. Borrowers should shop around for the best overall lending arrangements.

HUD lenders often has 30-year terms on mortgages with relatively few covenants (or reporting requirements). Similarly, the United States Department of Agriculture has a mortgage program for SNFs that are in rural and agricultural areas. These loans frequently have lower interest rates and few covenants but are not available to refinance existing mortgage loans. Be sure to consider all your options if you are highly leveraged.

### *Consider the Organizational Structure of your Business*

In years past, often to hedge against tort claims, SNFs created complex organizational structures that may no longer be necessary but which still cost you money to maintain. These complicated structures involve filing annual reports, tax returns, and keeping up with the financial reportings on numerous subsidiaries that no longer serve a purpose, not to mention the fees owed to the Secretary of State for each entity. If your state has enacted tort reform, consider whether you need separate entities for each nursing home you operate.

### *Other Money-Saving Techniques*

In a pinch, there are ways to immediately enhance cash flow. If you are paying your payables on a 30-day lag, merely extending the timing of those payments to a 45- or 60-day lag can lead to a significant one-time pick up in cash flow. Obviously, you need to do this carefully so as not to disrupt services or create ill-will with your important vendors. Additionally, take a hard look at your overhead. If a job is not having at least a significant indirect impact on bedside care, eliminate it. Also, eliminate the use of company planes and cars. Finally, consider hiring a turnaround consultant. These consultants are both skilled and experienced in implementing many of the options outlined in this article in order to accomplish a SNF operator's objectives quickly and efficiently.

### *Bankruptcy Considerations*

Sometimes, notwithstanding all of your efforts to the contrary, you just need a fresh start. Fortunately, bankruptcy is an option. It can allow you breathing room to rearrange your financial affairs and allow you to restructure your debt. It can also set up a favorable environment for selling your business and may allow you to shed unprofitable facilities. The downside of bankruptcy is that it may have an impact on your operations. If not appropriately communicated, and if it is not a fairly quick process, you can lose some of your personnel, who will be concerned about the future of the company. Referral sources may also shy away from sending patients to your SNFs. Working with turnaround professionals to formulate a plan before you file bankruptcy and communicating that plan with your employees and referral sources is always best.

## Conclusion

It is hard to be a SNF owner or operator in the current environment. However, with some prudent management of your resources and smart utilization of some of the tools at your disposal, you can survive and even thrive.