NURSING HOME BOARD OF DIRECTORS AGENDA

County of Champaign, Urbana, Illinois
Monday, August 9, 2010 – 6:00pm

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

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

ITEM

I. **CALL TO ORDER**

II. **ROLL CALL**

III. **APPROVAL OF AGENDA/ADDENDUM**

IV. **APPROVAL OF MINUTES**
July 12, 2010

V. **PUBLIC PARTICIPATION**

VI. **OLD BUSINESS**

None

VII. **NEW BUSINESS**
a. East Central Illinois Ombudsman
b. IDPH Update (Buffenbarger & Noffke)
c. Budget Assumptions for FY 2011
d. Management Report
e. Salary Administration Discussion

VIII. **OTHER BUSINESS**

None

IX. **NEXT MEETING DATE & TIME**
a. September 13, 2010

XII. **ADJOURNMENT**

Attachments: Budget Memorandum for FY 2011, Management Report, Draft Salary Administration Proposal, Management Update

Board of Directors
Champaign County Nursing Home
Urbana, Illinois
July 12, 2010

Directors Present: Nudo, Hirsbrunner, Lansford, Czajkowski

Directors Absent/Excused: O'Shaughnessey, Hambrick, Anderson

Also Present: Busey, Scavotto, Noffke, Buffenbarger

1. Call to Order

The meeting was called to order at 6:00pm by Acting Chair Hirsbrunner

2. Roll Call

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

3. Agenda & Addendum

On motion by Lansford (second Nudo) the agenda was approved (unanimous).

4. Approval of Minutes

On motion by Lansford (second Nudo), the Board approved the minutes of June 14 2010.

5. Public Participation

There was no public participation...

6. Old Business

There was no old business.

7. New Business

a. IDPH Report

Noffke updated the Board on the status of recent complaint survey. Two deficiencies were cited: one involving a medication error and the other a laceration. The medication error is being appealed through the Informal Dispute Resolution and it appears that CCNH has the documentation from the physician and pharmacy to support its appeal. The laceration resulted

in a G-level citation, which is serious. The Board spent considerable time questioning the background and details of the case. Buffenbarger provided the specifics on how the regulatory process would proceed – IDPH surveyors exited June 17; Plan of Correction was submitted with a compliance date of June 22; once IDPH accepts the Plan of Correction, a re-visit will be re-scheduled; if June 22 remains the compliance date – meaning that CCNH passes the re-visit – civil monetary penalties of $300 per day will accumulate from June 17-22.

b. Budget Assumptions FY 2011

Budget assumptions for 2011 were accepted as submitted. Management is assuming an average daily census of 195. Private Pay rates will increase 3 percent, although there may be room for additional changes in specific areas. Medicaid and Medicare reimbursement is expected to remain flat. There are some regulatory changes that may decrease Medicare reimbursement. In regard to expenses, IMRF and health insurance are expected to increase by significant amounts. The budget will assume a wage freeze. The first draft of the budget will be ready within a week and the Board will be updated on the results. FY 2011 is shaping up to be a difficult year.

c. Management Report

Scavotto reviewed the financial affairs through May.

Census for May continues to reflect positive developments. ADC for May was 206, consisting of 31 Medicare A, 98.2 Medicaid, and 76.8 Pvt Pay. Net income reflected a gain of $91k, which does not reflect any corrections still due from the denial of payment. (The IDPH fines are still awaiting resolution.) Year-to-date the operating loss has improved to about $(12)k.

June's census closed at an average of 203, which continues to be excellent. Medicare volume in June was 892 days versus 976 in May; accordingly, revenues will be lower than May, but should still be significantly better than in earlier months.

Salary expense per resident day was down over previous months. In contrast, agency expense was up to $122k, which is a major departure from the levels we have seen in recent months. The PRN group of nurses has surpassed its IMRF-related ceiling of 1,000 hours; as a result, CCNH

must turn to agency staff to fill position; we continue to seek new hires.

8. Other Business

There was no Other Business

9. Next Meeting Date

Monday August 9, 2010, 6 pm.

10. Adjournment

Acting Chair Hirsbrunner declared meeting adjourned at approximately 7:00 pm.

Respectfully submitted

Michael A. Scavotto
Recording Secretary

To: Board of Directors
Champaign County Nursing Home

From: M. A. Scavotto
Manager

Date: August 2, 2010

Re: Budget Assumptions and Projections
Fiscal 2011

The following are the critical assumptions and budget summaries for Fiscal 2010. Appended to this memorandum are the budget worksheets and Income Statement for Fiscal 2010. *If you wish to view the budget worksheets on your monitors, you may want to adjust the View or the magnification, particularly with the Assumptions. If you are comfortable with the Assumptions and the narrative below, then skip to the forecast income statement, the second page in the budget exhibit package.*

1. **Inpatient Volume**

Average Daily Census:	195
Total Days	71,775
Occupancy Pct based on 243 beds	81 pct
Pvt Pay	35 pct (68.2 ADC)
Medicaid	50 pct (97.5 ADC)
Medicare	15 pct (29.3 ADC)

The ADC target is realistic but not easily achieved. Recent census experience has been excellent; early in Fiscal 2010, however, CCNH had difficulty reaching the target of 195 ADC. So much of CCNH's volume remains hospital-dependent that we should not over-reach in setting a census objective.

Where the budget program remains aggressive is with the mix. Through May 2010, CCNH's year-to-date payer mix has been:

Pvt Pay	72.9 ADC	38%
Medicaid	96.3	50%
Medicare	22.4	12%
Total	191.6	100%

The budget forecast calls for more Medicare volume, which will require a combination of increased admissions from the hospitals and/or longer length of stay. At the same time, if CCNH can maintain its current Private Pay

concentration, the impact on the overall payer mix and financial performance will be positive.

For the 2011 budget, the percentage of Private Pay census is 35 percent, which is slightly lower than what CCNH has been averaging (38 pct thru May 2010). The total number of resident days forecast for 2011 is the same as budgeted for 2010: 71,175, yielding an ADC of 195.

Special Note: The forecast ADC of 195 represents a volume increase of 3.3 percent of the current year-to-date actual census. The 2011 budget for variable labor costs will be up 3.3 percent solely due to volume; there is no increase in the hourly rate. You will see under fixed labor that there is no percentage increase in salaries.

2. **Revenues**

General price level escalation	3 pct
Private Pay Rates	$159 basic rate; $184 Alz
Medicare per diem	$410
Medicaid IGT, alternate rate	$139.64
Property Taxes, 2010	$972k
Property Taxes, 2011	$996k

The Private Pay element of revenues is straight-forward; multiply the applicable number of days by the correct rate and you've got your number.

Our market survey indicates that CCNH is where it needs to be on rates. Here's a summary of the area facility rates:

	Private	**Semi-Pvt**
Area High	$356	$235
Area Low	$115	$105
Area Avg	$215	$166
CCNH Basic		$159
CCNH Alz		$184

CCNH has 9 private rooms that are used as medical isolation rooms. CCNH does not charge extra for the use of these rooms. It does charge extra to a semi-private room that is converted for private use.

The situations CCNH face with Medicare and Medicaid are quite different. We are forecasting no increase for either payer. Historically, Medicare has always provided some sort of reimbursement increase. However, for 2011, there is no assurance that a Medicare rate increase will materialize. The Medicare per diem reimbursement that we have budgeted represents our current experience; we are anticipating that it will be more difficult to qualify for current therapy levels under the new reimbursement rules that are effective October 1, 2010. Any increases in rates will be modest and are likely to be off-set by other adjustments

to the rules. There is no prudent way to expect an increase in the rate of Medicare reimbursement. At this writing we do not know which set of rules or combinations of rules will be implemented, and that makes detailed planning more difficult.

Here's an illustration of what skilled providers are facing in the new Medicare RUGS-IV classification system. You'll see in a minute that the system shifts utilization away from today's high costs classifications into the lower paying RUGs. Some of the lower paying RUGs experience an increase in volume; you will see this reflected in the Medically Complex area, below. As profiled below, it will be tough to qualify for the Extensive Service modifier. As a practical matter, CCNH never had much, if any, "Extensive" volume. CCNH's sweet spot has been in Ultra High and Very High therapies and some decreased volume must be expected.

Percent of Medicare Part A Cases Expected

Type of Service	RUGS III (current)	RUGs IV (new)
Rehab w/Extensive	36.5%	3.8%
Rehab Only	51.8%	75.9%
Total Rehab	**88.2%**	**79.8%**
Medically Complex	**10.5%**	**16.7%**
Ultra High and Very High		
W Extensive Svc	20.8%	1.12%
W/O Extensive	34.8%	30.2%
Total Ultra & Very Rehab	**55.5%**	**31.3%**

Totals will add to more than 100 percent as some RUGs are counted in multiple categories.

Source: AAHSA, 7-6-09

Clearly, there is a policy directive to move away from high-cost levels of rehab – or, stated another way, to make it extremely difficult to qualify for payment for such services. This translates into learning new coding skills and testing our competence regularly. Maintaining the current per diem will be a challenge.

For Medicaid, we are assuming that the rate effective July 1, 2010 will remain the same for all of Fiscal 2011. In other words, we are planning for a rate freeze. There is no indication that Illinois' financial position will be improving; there are

several indications that the State's Medicaid budget will face extreme difficulty. Currently, the FMAP is set to decline gradually from 62 to 52 percent; the State budget assumed that an FMAP percentage of 62 percent be in effect for the entire year. State HFS may not be in a position to process claims in accordance with Federal procedures; on this latter point, recent changes to the implementation dates for RUGs and MDS systems may allow for some relief; there is no assurance of any kind as of this writing.

Property taxes represent about a 2 percent increase over 2011.

3. Expenses

Non-Labor Items

Assume 2 percent for most items
Utilities and food projected higher at 5 percent
Therapy costs on per diem, vary with census
Variable items flex with census
Depreciation included
Interest expense ($4 m plus $1.3 m loans) makes a first appearance
IGT transfer expense likely to be revised and eliminated; timing unknown

Where accounts do not vary with the volume of resident days, increases were projected at 2 percent; food and utilities, however, were forecast higher at 5 percent. Office supplies, housekeeping items, and general maintenance are examples of accounts that are not affected by volume.

For those accounts that a do feel the impact of volume – Medicare drugs, professional services in the therapy areas, medical supplies, food and nutritional supplements, for example - a 2 percent increase was applied to a cost-per-day and multiplied by the projected volume of resident days.

CCNH continues to pay interest expense on $4m of construction loans plus $333k of County loans.

CCNH continues to absorb tremendous agency costs and it is difficult to budget for this line item. As much as we would like to eliminate agency usage, the practicality of doing so is questionable. Agency costs decreased dramatically beginning in September 2009 and were held to relatively modest levels until May 2010. One of the drivers behind the increased expense is the return of the PRN pool to agency status; in other words, the retired PRN nurses have reached their maximum 1,000 hours under IMRF rules and can no longer work for CCNH. They continue to work at CCNH, but as agency employees.

Labor Items

Salaries are frozen for all job classes…. See Special Note under Inpatient Volume, above, Item 1.

Benefits are budgeted at 34 percent of salaries; the figures reflect actual increases for IMRF and estimates for health insurance.

We still await some definition from the bargaining process. Once details are better known, we can adjust the budget. However, we have been firm in our position that CCNH can ill afford any salary increases. The current staffing pattern remains in place; nursing continues to flex its staff according to census requirements.

4. **Net Income and Cash Flow**

From operations, CCNH is still losing money.

With Property Tax revenues included, CCNH projects to end the year with a loss of $(419)k. In terms of cash, CCNH should have a positive cash flow (after depreciation of $742k) of $323k. From a cash standpoint, CCNH is still struggling as accounts payable remain over $1.6 million. Increased IMRF costs plus the usual obligations attendant to employee TOPS time off will keep the pressure on cash flow.

Census and the related payer mix are the determinants of success. The basic elements of the business are under control; these include the staffing pattern and routine operating costs. Agency expenses for contract labor remain troublesome. Nonetheless, if CCNH can realize higher census levels, it will be in a position to improve its cash position and reduce its outstanding bills.

5. **A Word of Caution**

Census has been higher in May and June. As a result, CCNH's financial performance has been better, particularly with Medicare. Unfortunately, two months do not provide a basis for predicting an entire year. If the hospitals stay busy, the area nursing homes will benefit.

Fully 65 percent of CCNH's patient service revenues are from government payers – 15 percent Medicare and 50 percent Medicaid. With no increases in government reimbursement projected, the private payer represents CCNH's only source of increased revenue. Accordingly, expense control takes on heightened significance as it is the only strategy available to management.

To: Board of Directors
Champaign County Nursing Home

From: M.A. Scavotto
Manager

Date: August 2, 2010

Re: Management Report

As I write this update, census has continued to run over 200.

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

	Dec-09	Jan-010	Feb	Mar	Apr	May	June	July
Admits								
Pvt Pay/Insurance	12	8	10	17	4	8	1	8
Medicare A	18	16	6	23	21	21	24	19
Medicaid	1	1		1			1	
Total	**31**	**25**	**16**	**41**	**25**	**29**	**26**	**27**
Discharges								
Pvt Pay/Insurance	11	13	17	13	11	14	8	6
Medicare A	11	7	5	6	9	12	14	12
Medicaid	4	1	1	1	3	1	3	1
Total	**26**	**21**	**23**	**20**	**23**	**27**	**25**	**19**

June's payer mix was 37 percent Private Pay, 49 percent Medicaid, and 14 percent Medicare. Compared to May, the difference is one percent – Medicaid is one percent higher than May while Medicare is one percent lower.

June's results reflect a gain of $73k. Year-to-date, CCNH is reporting a gain of $61k which reflects both the government sanctions for April plus the full impact of all conversion days.

Medicaid revenues were down versus May; Medicare was also down but still represented a strong performance for CCNH. *(Figures will not add to 100 percent.)*

	Mar-10	As Pct of Pt Revenue	Apr-10*	As Pct of Pt Revenue	May-10	As Pct of Pt Revenue	Jun-10	As Pct of Pt Revenue
Medicare A	$326k	27.4%	$283k	25.2%	$433k	33.3%	$349k	29%
Medicaid	$388k	32.7%	$540k	48%	$480k	37%	$422K	35%
Pvt Pay	$434k	36.4%	$253	22.5%	$312k	24%	$363	30%

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

Expenses were under budget by about $14k. We still had some areas that warrant explanation. Administration salaries were over budget due to the final payout (benefits) to the former Comptroller. Electric service was up $10k; gas was down by the same amount, so utilities were a wash. Agency costs were up over budget by $18k and remained significantly higher than in recent months. Across all departments, line items for benefits (TOPS and TOPS FICA) are causing departments to be over budget. The budget was prepared using salaries only; CCNH has been in the habit of recording benefits liability monthly rather than annually.

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

CCNH Average Daily Census
Dec 2008 thru June 2010
without bedholds

Dec	190.9	Aug	182.4
Jan 09	198.4	Sep	181.5
Feb	195.8	Oct	183
Mar	188.4	Nov	179.2
Apr	186.9	Dec	187.7
May	188.6	Jan-10	188.5
June	178.9	Feb	185.2
July	179.8	Mar	192.1
		Apr	195.9
		May	205.9
		June	205.6

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

Medicare days were 852 in June for an ADC of 28.4, including the Medicare Advantage days, which does not pay on a par with traditional Medicare. Based on CCNH's recent experience, the last 4 months' Medicare experience has been positive. Here's the pattern:

Dec	884	July	442	Feb 10	471
Jan 09	938	Aug	485	Mar	803
Feb	755	Sep	470	Apr	741
Mar	675	Oct	528	May	976
Apr	540	Nov	448	June	852
May	573	Dec	451		
June	396	Jan 10	644		

March's Medicare A revenues snapped our slump; April, without considering the government sanction, was better than many prior months, but not equal to March. In May, CCNH scored big, thanks to increased activity at Carle. June kept things rolling. Compare the results for Medicare A for the last 12 months versus the start of last fiscal year; we had been mired right around $200k and hadn't been able to get back to earlier levels, which approximated $400k.

Medicare A Revenues

First 4 months		Last 11 Months	
Dec	$379k	May 09	$211k
Jan-09	$396k	June	$195k
Feb	$313k	July	$179k
Mar	$308k	Aug	$198k
		Sep	$196k
		Oct	$226k
		Nov	$218k
		Dec	$209k
		Jan-10	$276k
		Feb	$208k
		Mar	$434k
		Apr*	$283k*
		May	$433k
		June	$349k

*Without deduction for government sanction

Med B came in at $41k -- not a great performance.

In terms of days, the Medicaid pattern had been smoothing out. Medicaid revenues, however, reflect adjustments for conversion days; as a result, there is still some fluctuation in the revenue figures. Overall, the Medicaid trend is positive.

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

Medicaid Revenues Compared

Month	Net Revenues	Chg	Days	Chg
April	$633k		2885	
May	$596k	(5.8)%	2941	1.9%
June	$497k	(16.6)%	2725	(7.3)%
July	$538k	8.2%	2791	2.4%
Aug	$511k	(5)%	2652	(5)%
Sep	$561k	9.8%	2818	6.3%
Oct*	$382k	(32)%	3160	12.1%
Nov	$416k^	8.9%	2837	(10.2)%
Dec	$377k	(9.4)%	2937	3.5%
Jan 10	$430k	14%	2839	(3.3)%
Feb	$376k	(13)%	2788	(1.8)%
Mar	$389k	3.5%	2982	7%
Apr#	$540k	38.8%	2935**	(1.7)%
May	$480k	(11.1)%	3043	3.7%
June	$422k	(12.1)%	3038	(0.2)%

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

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

Comparative Payer Mix
CCNH

	Dec-07 thru June	Sep-08 thru Jun-10
Medicaid	62%	52.0%
Medicare	9%	11.3%
Pvt Pay	29%	36.8%
Totals	**100%**	**100%**

The Medicare per diem has been consistently over $400. June continued this trend with a result of $409.

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

Last Four Months w/Property Tax and County Overhead Allocated Monthly

	Mar-10	Apr-10	May-10	Jun-10
Medicare A	$326,417	$202,660	$433,080	$348,832
Medicare B	$23,882	$31,245	$52,030	$41,374
Medicaid	$388,912	$525,733	$480,162	$421,974
Pvt Pay	$434,007	$253,218	$311,516	$363,049
Adult Day-Private	$4,666	$8,234	$8,179	$10,049
Adult Day-TXX	$13,108	$12,949	$13,122	$12,030
Miscellaneous	$7,002	$3,595	$3,004	$9,228
Property Tax	$80,973	$80,973	$ 80,973	$80,973
All Revenues	$1,278,967	$1,118,607	$1,382,065	$1,287,509
All Expenses	$1,228,928	$1,262,798	$1,290,299	$1,214,917
Net Income/(Loss)	$ 50,039	$(144,191)	$91,766	$72,592
Census	5956	5876	6383	6169
Change		(1.3)%	8.6%	(3.4)%
ADC	192.1	195.9	205.9	205.6
Change		2.0%	5.1%	(0.1)%
FTE	182.6	184	179	181

Cash position remains tight and this should come as no surprise even as census targets materialized over the last 3 months. At June 30, cash was at $904k. There are 3 payrolls in July. Currently, CCNH has payable over 90 days of $525k (excluding salaries, most benefits and FICA; including IMRF); total accounts payable are $1.7 million. Any way you evaluate this, cash position is still critical.

Month	Forecast High Balance	Forecast Low Balance
July	$791k	$589k
Aug	$618k	$341k
Sept	$845k	$287k
Oct	$1.373 million	$696k

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

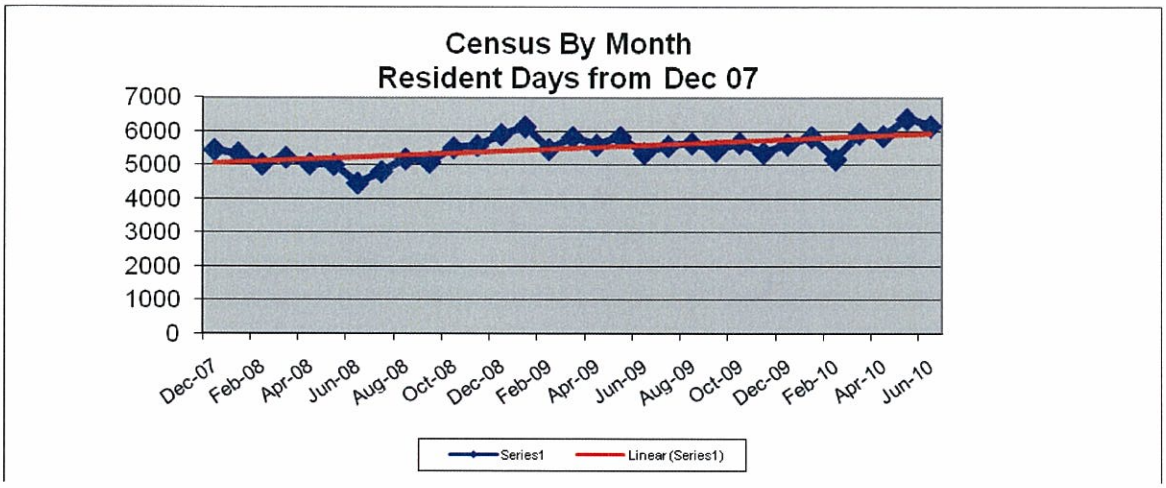
The solid line is a trend line for the displayed data and it should appear in red on your computers. (These graphs will display best when viewed on your screens.)

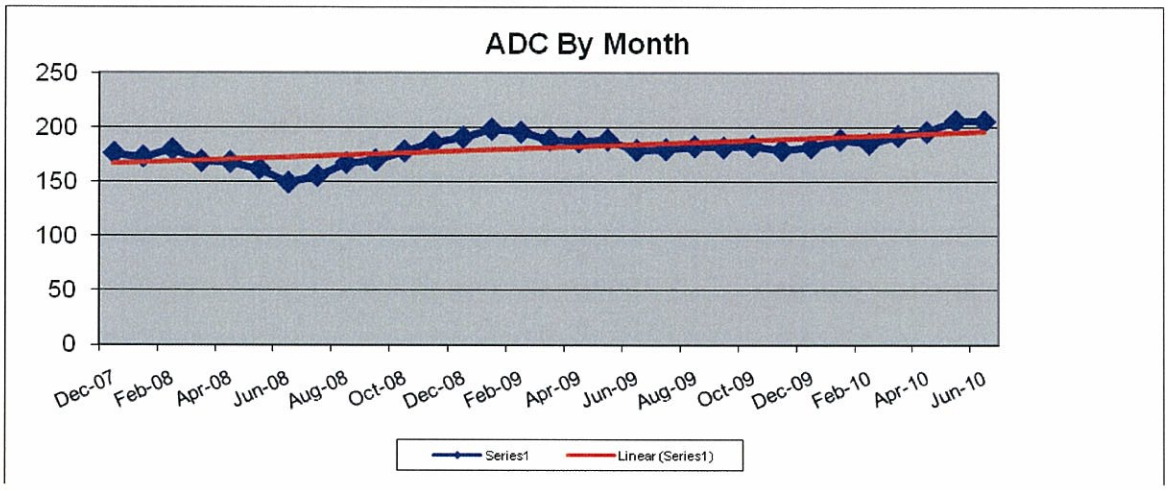
Census

Census continues to receive a lot of attention. Fiscal 2010 is off to a decent start with an ADC of 199.4 versus our target of 195. The last three months of strong census have pushed us very close to our goal.

Current Census by Payer by Month
(without bedholds)

Month	Pvt Pay	Medicaid	Medicare	Total
Aug -2008	1707	3140	341	5188
Sep	1587	3003	505	5095
Oct	1796	3069	607	5472
Nov	1704	3070	917	5691
Dec	1788	3246	884	5918
Jan-2009	1906	3306	938	6150
Feb	1773	2955	755	5483
Mar	2102	3064	675	5841
Apr	2183	2885	540	5608
May	2332	2941	573	5846
June	2248	2725	396	5369
July	2342	2791	442	5575
Aug	2517	2652	485	5654
Sep	2156	2818	470	5444
Oct	1985	3160	528	5673
Nov	2092	2837	448	5377
Dec	2244	2937	451	5632
Jan-2010	2362	2839	644	5845
Feb	1926	2788	471	5185
Mar	2171	2982	803	5956
Apr	2200	2935	741	5876
May	2364	3043	976	6383
June	2279	3038	852	6169





Revenues

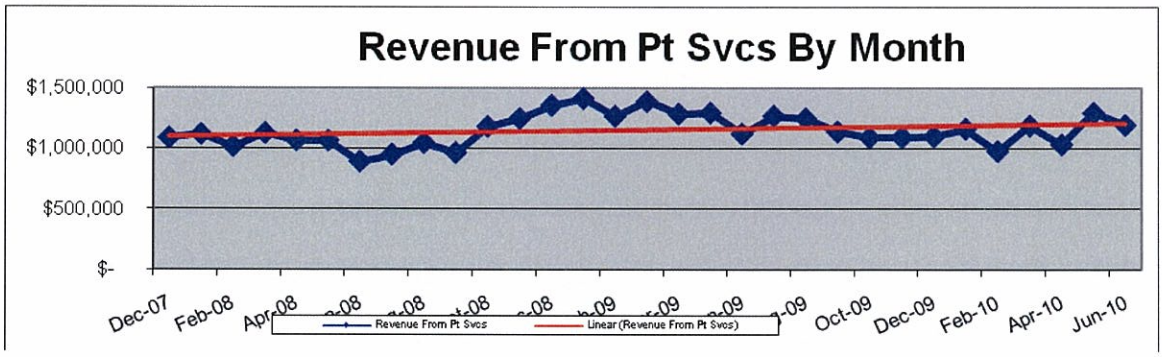
March's Medicare A activity reversed the sharp drop in Medicare volume that dates back to April 09. May was a great month for Medicare A with revenues totaling $433k – essentially a record performance in what has been a very difficult revenue segment to crack. June followed up with another good performance.

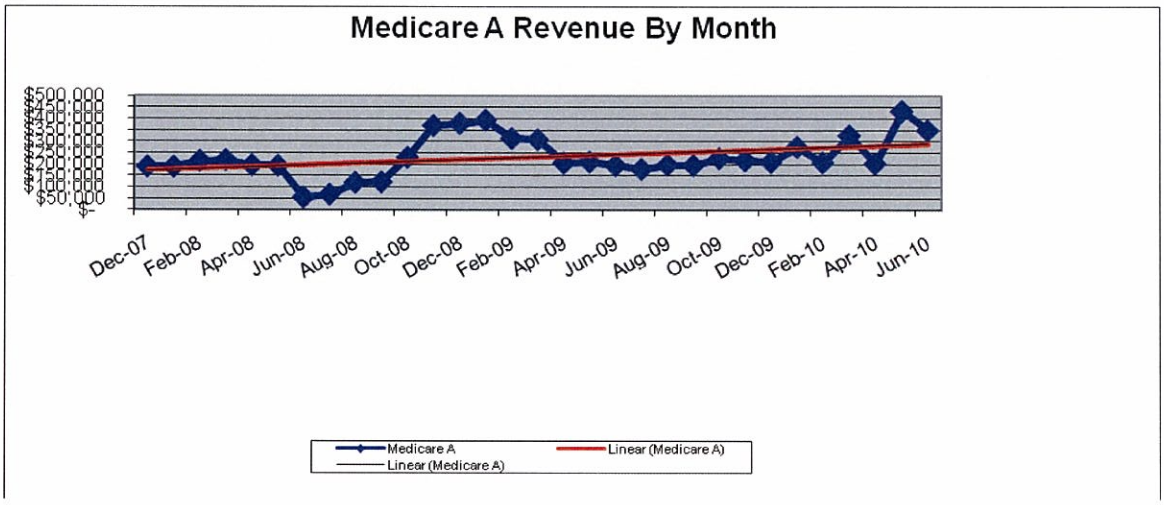
The Medicare per diem is a critical factor in building a better revenue base and we have significant improvements to make in our performance. June's per diem of $409 was good in that it remained over $400; lately, CCNH has had excellent per diem experience.

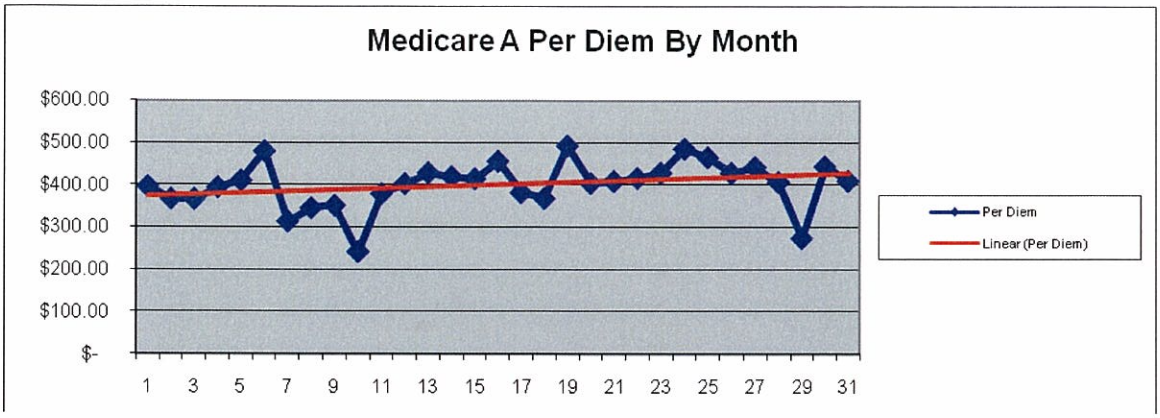
The trend line in Medicare A is fragile. Because of better volumes in April, May, and June the trend has returned to positive. Medicare census remains a critical ingredient to success and it also remains elusive. Also, take a look at the chart for Part B revenue; this classification continues to defy classification. The imposition of therapy caps played a

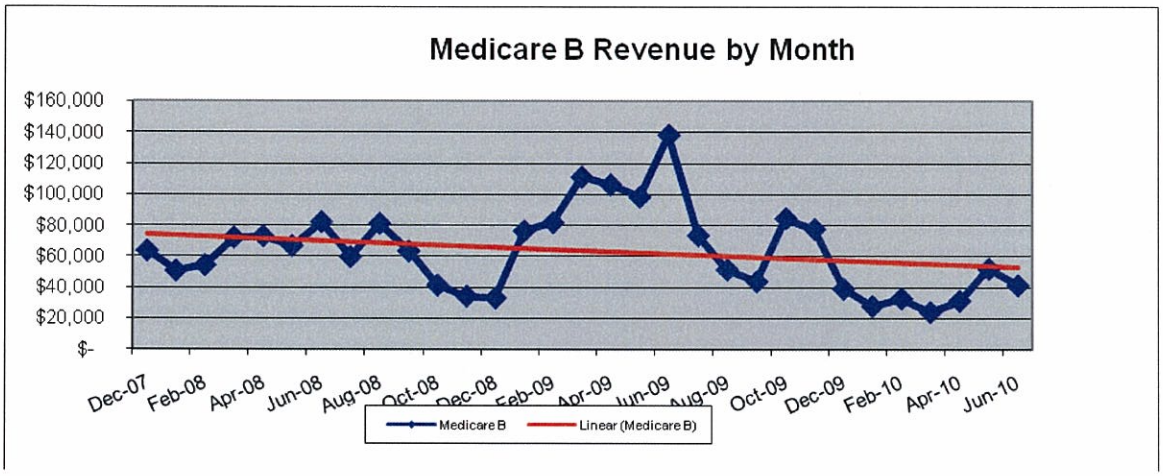
huge role in reducing Med B revenues. However, with the recent removal of the therapy caps, Med B revenues bounced back in April and more so in May.

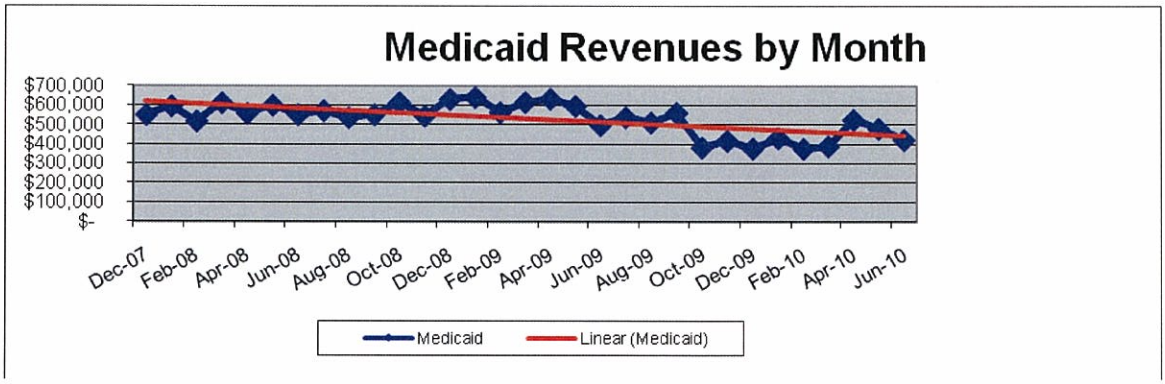
For the most part, Medicaid revenues continue to be stable. You will see from the graph that Medicaid revenues dived with the elimination of the old IGT program; however, our expenses also were reduced significantly. Generally, Medicaid revenues have been stable with some exceptions caused by conversions from Private Pay to Medicaid. As CCNH has had better total volume in April and May, Medicare has done much better and Pvt Pay has been holding steady.






Medicare A Per Diem By Month
$600.00
$500.00
$400.00
$300.00
$200.00
$100.00
$-
1 3 5 7 9 11 13 15 17 19 21 23 25 27 29 31
Per Diem
Linear (Per Diem)


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


Medicaid Revenues by Month
$700,000
$600,000
$500,000
$400,000
$300,000
$200,000
$100,000
$-
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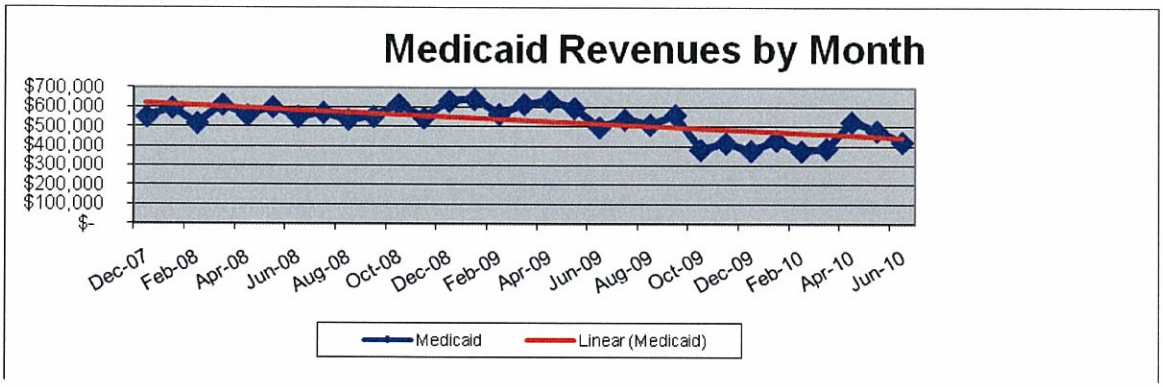
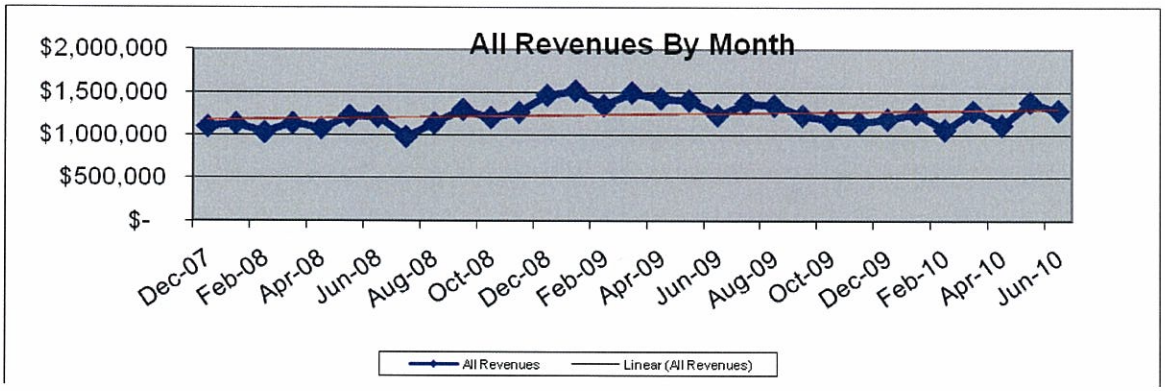
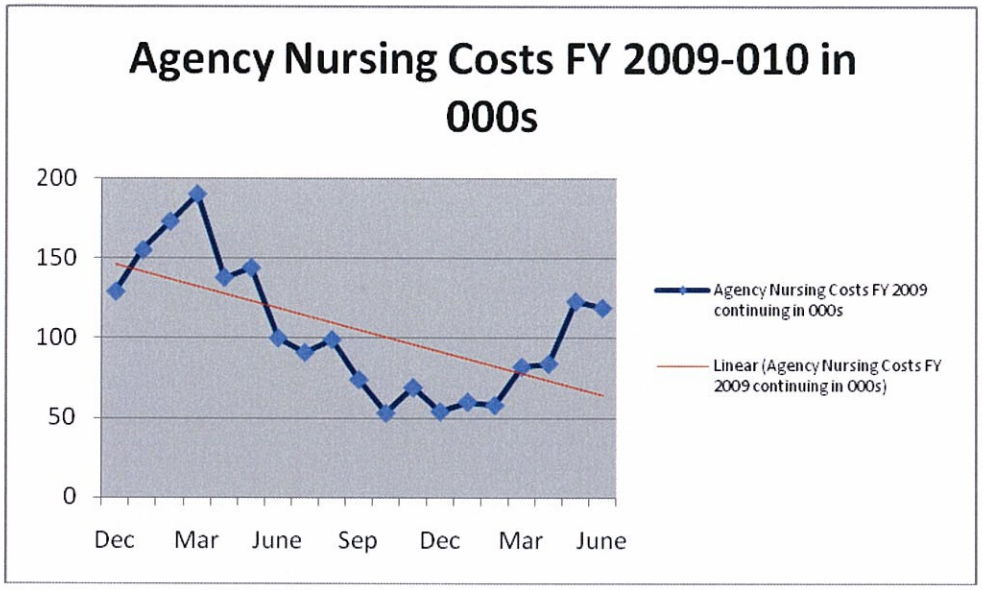




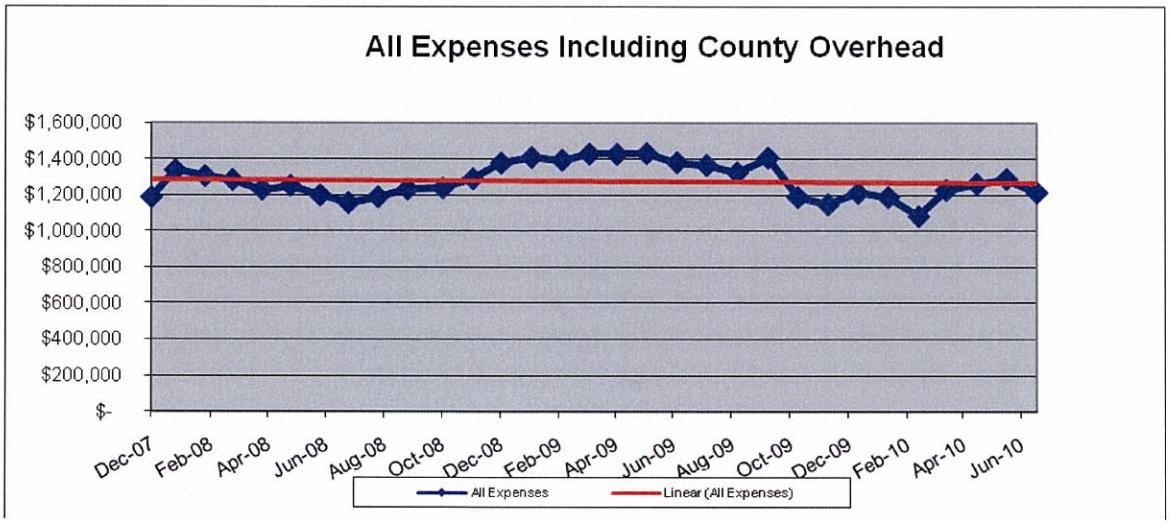
Expenses

CCNH's expense control continues to be pretty solid. Total expenses were under budget. Specific issues remain with accounting for TOPS (benefit) time. The fact that CCNH historically has expensed benefit accruals monthly makes labor costs appear greater than they are. We have separated TOPS and TOPS FICA from routine salary costs – and these line items are factors that were not considered in the budget.

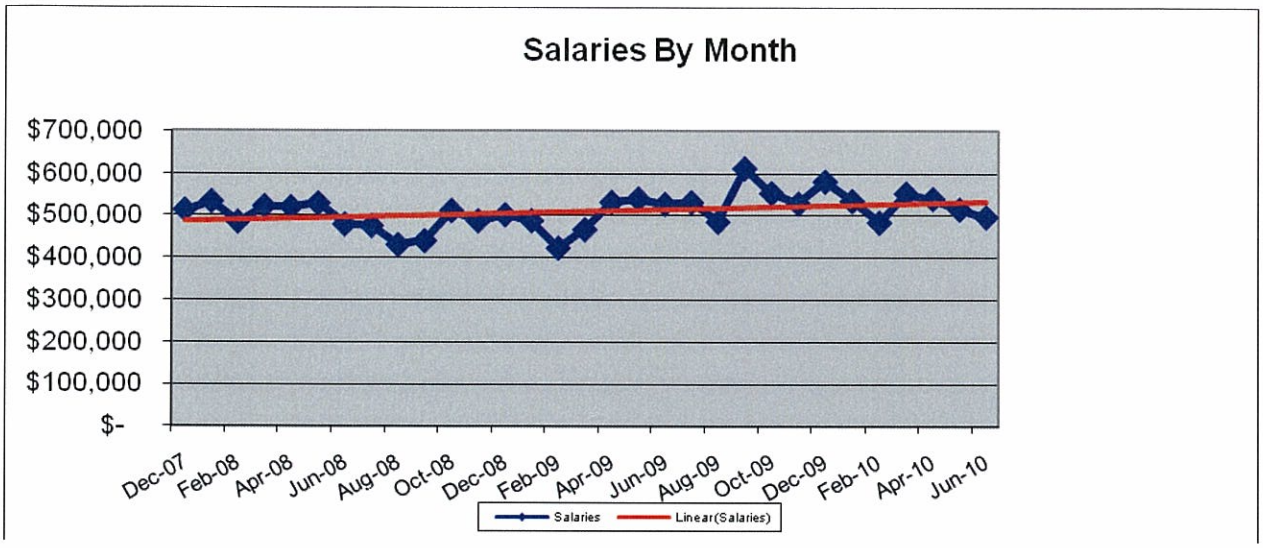
Contract nursing costs remained up and I suspect that nobody is surprised. Admittedly, the current circumstance is not a welcome one.



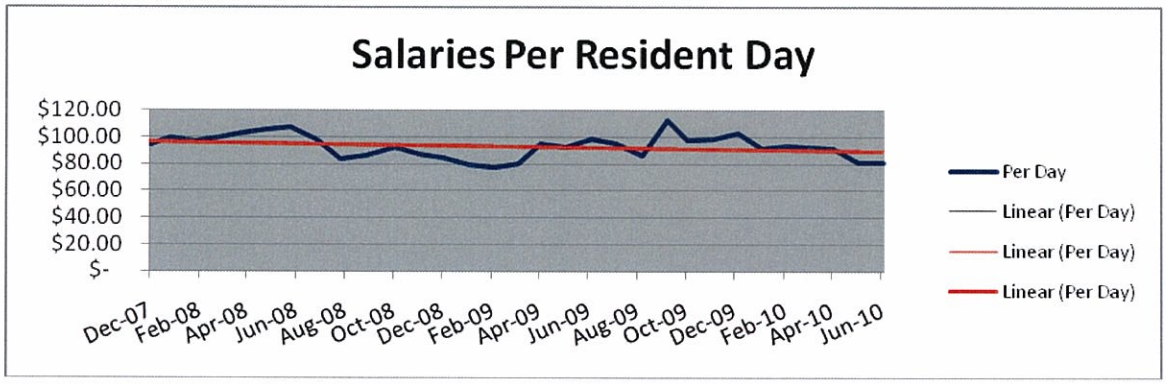
With the exceptions noted above, particularly in salaries, expenses were within reasonable limits. We will strive to get agency costs to lower levels. The figures since October 09 reflect the elimination of the transfer expense associated with IGT program.



Salaries continue to be our biggest cost. Graphically, the salary relationship is presented below.



June's salary expense reflects the same performance as May's. Overall, salaries per resident day were down over prior months, largely due to the fact that Agency staffing was up. The cause-and-effect here is that CCNH has been unable to staff using its own personnel.



Summary

Census continues to be the big determinant of success and one can see the results of improved census in the past few months. This is certainly a welcome development. Accounts Payable – particularly items over 90 days – remain a major source of concern as they totaled over $1 million at June 22; collectively, payables amounted to over $2 million. Cash remains very tight.

To: Board of Directors
Champaign County Nursing Home

From: M.A. Scavotto
Manager

Date: August 2, 2010

Re: CCNH Salary Administration Program

This memorandum introduces the first of several discussions on CCNH's salary administration program. This memorandum concentrates on non-union positions; union positions are governed by the collective bargaining agreement.

Appended to this memorandum is a revised version of Chapter 9, CCNH Salary Administration Guidelines. Chapter 9 provides the statement of salary policy in both the County and Nursing Home manuals. For those of you who want to take a look at the original Chapter 9, go to the County's website. Click on Champaign County Policies & Labor Contracts; then go to Nursing Home Personnel Policies; Chapter 9 starts on page 30.

My purpose in introducing this topic is two-fold:

1. To develop a recommendation to the County Board whereby the Nursing Home Board is delegated the responsibility for salary administration. Currently, the County Board has this responsibility; and

2. To streamline Chapter 9 so that it better reflects the Nursing Home's needs. Many -- in fact, almost all -- of the jobs at the nursing home do not exist at the County and the nature of the nursing home's operation is fundamentally different.

As you read through the revised Chapter 9, you will note that it continues the structural elements of the County's policy: grading, point-rating, competitive mid-points. These structural benchmarks are excellent. The definitions included in the revised Chapter 9 are, in many cases, the same as the County's; in a few cases they have been updated with the intent remaining the same.

The major differences occur with the approval process, which has been delegated to the Nursing Board, and with the introduction of one salary increase based on performance. With the exception an increase tied to an annual performance review, all other salary increases are eliminated. The Nursing Board establishes the annual salary posture by adopting the aggregate increase provided during the budget process; employees can receive up to that amount given solid performance. Also, the County's compa-ratio

(progression-to-midpoint) practice is eliminated; the revised Chapter 9 emphasizes the annual performance evaluation as the basis for progressing through the salary scale. The revised Chapter 9 streamlines the approval procedures and minimizes administrative layers involved in salary decisions.

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There are other elements to the program that we will discuss at a later date, assuming that you agree to move forward with my recommendation. For instance, a salary scale for CCNH non-unionized personnel has been developed using competitive surveys to establish the mid-point and then the salary scale. All non-union positions were then point-rated and graded. The resulting "fit" was excellent with all but two of twelve positions fitting the new scale; the two exceptions revealed an internal equity problem that can be resolved.

The purpose of our August discussion is to determine the basis on which the Nursing Board should be delegated the responsibility for salary administration. I believe the revised Chapter 9 establishes the necessary standards. There are many factors to consider in evaluating any salary administration proposition. The style and comfort level of the Nursing Board are chief among them. Accordingly, let's approach this discussion by ascertaining the salary policy that works best for CCNH.

CHAPTER 9

CCNH Salary Administration Policy

9-1 Definitions

9-1.0 Program Administrator: The term Program Administrator refers to the CCNH Administrator. To improve the effectiveness of this salary administration program, other management officials may be delegated specific responsibilities. The Nursing Board of Directors remains responsible for policy determination and for oversight; routine operating authority for implementing this salary administration program rests with the CCNH Administrator.

9-1.1 Position Description - A written set of criteria regarding the essential duties and responsibilities performed in a position and the minimum knowledge, skills, abilities, education, training, and experience required to perform the job. Position descriptions will be coordinated and maintained by the Program Administrator, in consultation with the appropriate department managers.

Position descriptions may be modified to reflect changing job requirements. Positions undergoing such modification may be reevaluated and graded to account for changes in responsibilities.

9-1.2 Authorized Position - A single job slot allocated to the Nursing Home and authorized by the Nursing Home Board of Directors as full-time or part-time. Part-time positions are stated as a percentage of full-time or average hours worked. All authorized positions shall be identified by a CCNH position description.

9-1.3 New Position - Creation of a new authorized position which has been approved by the Nursing Home Board of Directors. No hiring into a new position can occur until the new position had been described, point-rated, graded, and authorized.

9-1.4 Reclassification/Position Re-Evaluation - The process of deleting an existing authorized position and creating a new authorized position based upon an existing or new position description.

9-1.5 Midpoint - The midpoint, as a control point, represents the dollar value that the Nursing Home is willing to pay an experienced employee for performing consistently competent work that fully meets all position requirements in a job of a given level of difficulty and responsibility. It also should reflect favorable competitive rates paid in the employment market for experienced employees in similar jobs.

9-1.6 Maximum - The maximum salary is the highest salary paid for a particular position. The maximum is expressed as 120% of the midpoint.

9-1.7 Minimum -The minimum salary is the lowest beginning salary for a particular position. The minimum is expressed as 75% of the midpoint.

9-1.8 Salary Range - A salary range is established based on the midpoint and represents the dollar value of an experienced employee for performing consistently competent work that fully meets all position requirements The salary range represents the normally expected range an individual can expect as compensation for good, consistent performance. Structurally, the salary minimum is 75% of the midpoint, and the maximum is 120% of the midpoint.

9-1.9 Experienced - A candidate whose Knowledge, Skills, Abilities, and Education and Experience substantially exceed the minimum requirements as stated in the position description.

9-1.10 Inexperienced - A candidate whose Knowledge, Skills, Abilities; and Education and Experience meet the minimum requirements as stated in the position description.

9-1.11 Exempt/Non-Exempt Pay Practice Status - Determination made by the State's Attorney's Office, or other delegated legal counsel, according to the Fair Labor Standards Act (FLSA) Guidelines of the salary grid applicable to a position.

9-1.12 Promotion – A promotion exists when an employee is proposed to be hired to an open position or when a re-evaluation of a current position has resulted in the position being placed in a higher salary grade.

9-1.13 Transfer to a Lower Salary Range – Transfer to a lower salary range is defined as a permanent change from a position in one salary range to a position where the job is placed in a lower salary range, as expressed by job content evaluation points.

9-1.14 Lateral Transfer – A lateral transfer occurs when an employee moves to a new position, which is assigned to the same grade as the employee's previous position. An employee who makes a lateral transfer to a position in the same grade will not receive a salary adjustment, and shall keep full credit for time served with the employer (Champaign County).

9-2 Schedule of Authorized Positions & Salary Grid

9-2.1 The Schedule of Authorized Positions reflects the quantity and position title of all permanent positions in the Nursing Home as approved by the Nursing Home Board of Directors. The Nursing Home Board of Directors' appropriations for salaries in the Nursing Home's' budget will only be made to positions approved in the Schedule of Authorized Positions. No full-time, part-time, or per diem employee may be paid except through service in a position authorized on the Schedule of Authorized Positions. Additions or deletions to the Schedule of Authorized Positions will be made via the annual budget process or on an exception basis by Nursing Home Board of Directors. The CCNH Administrator will be responsible for maintaining the Schedule of Authorized Positions.

9-2.2 The Salary Grids reflect every position title in the Nursing Home personnel system, with the exception of positions represented by bargaining units, with a minimum, midpoint, and maximum salary for each position. Per diem employees are reflected in the salary grids with a single daily per diem figure.

The Nursing Home maintains two salary grids, one determining a pay practice for Exempt positions and one determining a pay practice for Non-Exempt positions. An employee's salary will be between the minimum and maximum, but may not exceed the maximum. Per Diem employees are reflected in the salary grids with a single per diem figure.

A position analysis is conducted to assign a point rating to each position. Point ratings correspond to the facility salary grid. Positions are assigned a salary using the position analysis score and with consideration for salary equity. The CCNH Administrator is responsible for maintaining equitable salaries within the Home.

9-3 Administration

The effective planning and control of salary costs requires a systematic procedure which includes:

* Review and adjustment of the midpoint salary policy consistent with competitive and economic conditions.

* Determination of funds required for policy implementation.

* Distribution of allocated funds among departments via the budget process.

* Efficient control of fund utilization throughout the budget period.

No change or addition to the Schedule of Authorized Positions or to the Salary Grid will be made except in accordance with the following procedures:

9-3.1 Hiring Procedures – Employees meeting the definition of "Inexperienced" should be hired at the minimum salary. There may be extenuating market circumstances that, on occasion, may require the approval of the CCNH Administrator to hire above the minimum. Inexperienced candidates should not be hired above the mid-point salary.

Employees meeting the definition of "Experienced" may be hired at any point up to the mid-point commensurate with experience, credentials, and market conditions. Where extenuating conditions make hiring past the mid-point a necessity, the approval of the CCNH Administrator is required.

9-3.2 Salary Midpoint Adjustment – Related Adjustments to Salary Ranges

1. The Nursing Home Board of Directors will review the salary midpoint policy annually during the budget review process.

2. The CCNH Administrator will recommend appropriate adjustments to the Nursing Home Board of Directors based upon data regarding employment and competitive market trends, inflation forecasts, projected salary movement, pertinent economic factors, and other relevant information.

3. The CCNH Administrator shall cause the midpoint for each position to be established for each fiscal year; the midpoint should reflect the current market wage for comparable positions.

4. Unless otherwise specified, any midpoint salary adjustment– and any related adjustments to the salary ranges -- shall take effect on the first day of the fiscal year immediately following approval by the Nursing Home Board of Directors.

9-3.3 Merit Adjustments - Determination of individual merit increases will be made by the Administrator based on employee performance as recorded on the employee's annual performance appraisal or on any interim performance appraisal.

9-3.4 Eliminated Positions – Positions that have been eliminated from CCNH may be dropped from the salary grid.

9-3.5 New Positions – New positions may be created from time to time to further the mission of CCNH. No position may be added without having a written position description evaluated, point-ranked, graded, and **reviewed** for internal equity. The number of FTE in a particular position is controlled by the nursing home budget and its current operating performance.

9-3.6 Above Max Increases – There will be no increases granted above any salary grade's maximum.

9-3.7 Market Inequities – Occasionally, a position will be point-rated and graded properly. But, due to market aberrations, the salary assigned to the grade may not be sufficient to attract personnel. In such cases, the position shall remain in the correct grade, but the employee may be paid out of a higher grade. The approval of the CCNH Administrator is required.

To: Board of Directors
Champaign County Nursing Home

From: M. A. Scavotto
Manager

Date: August 2, 2010

Re: Management Update

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

1. **Census:** CCNH's mix continues to improve. June's census of 205 plus May's great showing of 206 gives us a year-to-date average of 194.4. The goal is 195. We are certainly within striking distance provided the hospitals stay busy. We are direct beneficiaries of their discharge activity.

2. **Operations:** Our issues with IDPH continue to occupy a great deal of time and effort, particularly in the nursing department. The fact that IDPH exited with no findings after its re-visit of July 28 is a great moment for CCNH. That said, CCNH must continue to be diligent in its pursuit of providing better nursing care. The fact that CCNH has had such regulatory difficulties is a sign that care processes need to improve.

   Thankfully, nursing management has responded exceptionally well. There is a heightened effort to be much more pro-active in responding to families. I can think of one recent case mentioned by Mary Ellen where we were not at all pro-active, and I hope there are no more repeats. However, there are still incidents that indicate that CCNH is plagued by a deep-rooted culture that is not customer-sensitive. Solving this problem is of the utmost importance.

   We have received a proposal from U of I to conduct a customer service awareness audit and we are moving ahead with that ($800). Customer service development is a big challenge and there will be more movement on this initiative in the weeks ahead.

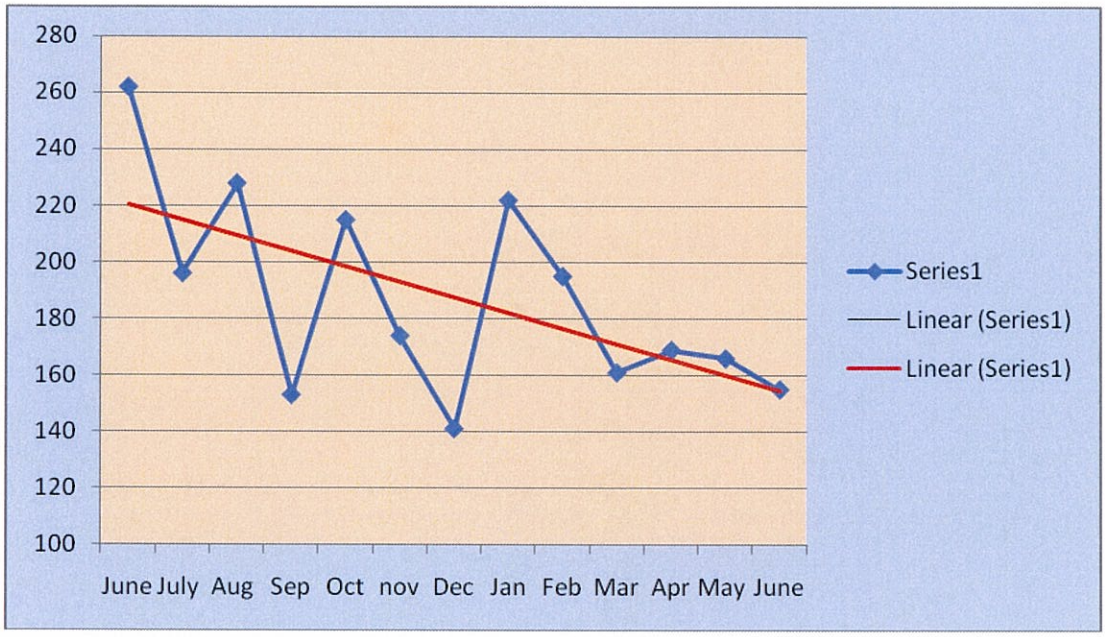
   There is no word on the IGT – and that is the routine these days. We had expected negotiations to begin in August. Our source on this is HFS itself. I'll keep you posted if and when anything actually develops.

   On the regulatory front, CMS has decided to implement MDS (Minimum Data Set) 3.0 along with RUGs-IV. Originally, RUGs-IV was to be delayed but the two systems

are so intertwined that bifurcating them proved to be unworkable. There will be quite a bit of scrambling as providers adapt to the new systems. CCNH staff has been attending the requisite training sessions. In addition, CCNH will be using the CareWatch software to practice MDS 3.0 in real time on real residents. The new MDS is a big deal, folks, as it represents a fundamental change in the way residents are scored, classified, followed, etc. How well providers manage the new system will determine their future reimbursement and regulatory experience with IDPH and the Feds.

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

Unscheduled Absences January 2009 thru June 2010



The bargaining team continues to press for a wage freeze. When all factors are taken into account, there is no basis for any salary increases. Cash flow remains very thin and there is no margin for error in any of CCNH's projections.

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