THE JOURNEY TOWARD FINANCIAL AND OPERATIONAL EXCELLENCE

2015 FINANCE & STRATEGIC POSITIONING WORKSHOP

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OBJECTIVES

✓ Discussion of reimbursement trends
✓ Understand why data is important to all senior living providers and some of the available sources
✓ How two providers are using information to improve their operational/financial results
✓ Why tracking and reacting to information is critical to future success in senior living

AGENDA

Section 1 - Change is Inevitable
Section 2 - Data, Data and More Data!
Section 3 - Data → Information → Action!
Section 4 - The Future and its Implications
Questions & Answers
TOPIC 1: CHANGE IS INEVITABLE

SECTION ONE:

- Brief overview of reimbursement trends
- Provide insight into health reform initiatives
- Discuss impact on acute care (hospitals) and how that will push down to post acute (long-term care)
  - Readmissions
  - Bundled payments
- Review initiatives already impacting long-term care
- Explore risk sharing strategies for long-term care

MEDICAID TRENDS

- The Medicaid shortfall has reached historic levels:
  - Unreimbursed allowable Medicaid costs for 2013 are projected to exceed $7.7 billion nationally at $24.26 per patient day
  - Medicaid rates increases have not kept pace with cost increases
  - Use of provider taxes have been utilized to mitigate rate reduction
  - Medicare is no longer fully subsidizing
- Medicaid Data for 2013 - Florida Providers
  - Average Rate: $211.98
  - Average Cost: $225.32
  - Shortfall: ($13.34)
FLORIDA MANAGED MEDICAID

- Now under administration of managed care companies
- Goals:
  - Utilization management (lowest cost of care)
  - Quality Initiatives
- Single Year Rate Setting
  - 9/1/2015 single year rate setting
  - Based on filed cost report as of 4/30/2015
  - Going forward consider interim spending reviews

MEDICARE TRENDS

CMS Actuaries Expect Fee-for-Service Volume to Increase
Driven by Substantial Medicare Enrollment Growth

- ACOs and bundled providers have incentive to reduce utilization.
- Actuaries predict growth but impact of ACOs, bundled payment unclear.

RUG UTILIZATION TRENDS

RU and RV represent 75% of total days
MEDICARE TRENDS

Aggregate SNF payments are expected to grow by 6 percent per year over the 2014-2024 period. Payments to SNF are projected to grow faster than overall Medicare payments.

Estimated Medicare payments to skilled nursing facilities (SNFs) are expected to increase by $750 million during FY 2015.

MEDICARE MARGINS

SNF Medicare margins are higher than hospitals and other post-acute care facilities.

Although MedPAC reports SNF margins of 1.8 percent in 2012, Medicare margins were in the double digits.

First year that impact of reforms can be seen.

Source: MedPAC 2014 Data Book

HEALTHCARE REFORM

- Improve Access
- Improve Quality
- Payment Reform
- Cost Reform

Manage Population Health, Insurer Roles, Coordinate Care and Reduce Redundancy.
Value Based Purchasing Models

- P4P
- PCMH
- ACO
- Shared Savings
- Bundled Payments
- Risk, Financial Opportunity & Incentive Alignment

Changes in the Reimbursement Model

- Traditional Payment – Fee for service (FFS)
  - Viewed as insufficient at containing costs
  - Volume was rewarded
  - Limited shared risk
- Where are we headed:
  - Value-based purchasing
  - Direct link between payment and outcome (pay for performance)
  - Bundled payments
  - Greater focus on care coordination and prevention

Reform Impact on Post Acute

- Payers will begin to narrow networks of post acute providers
- Hospitals will build post acute networks that are committed to help manage the post acute care spend and manage readmissions
- Increase in operating cost as post acute providers:
  - Build out care management resources
  - IT to be able to track and report performance back to referral sources
  - Reduced admissions and lengths of stay
RELIANCE ON MEDICARE REFERRALS

- Partnerships will become important for survival / financial stability
  - Where would you be if your leading referral hospital began steering volume to another facility?
- Post acute providers on the continuum need to realize pressures in acute care
  - The better we all realize the hospital’s position – the better the other post acute providers can prove their value to the hospital and develop effective and efficient partnerships

REIMBURSEMENT MODELS

<table>
<thead>
<tr>
<th>Category 1: Fee for Service - No Impact From Quality</th>
<th>Category 2: Fee for Service - Impact From Quality</th>
<th>Category 3: Alternative Payment Models Using Fee For Service</th>
<th>Category 4: Population-Based Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments based on volume of services</td>
<td>A portion of payment is based on the quality or efficiency</td>
<td>A portion of payment is linked to management of a population or an episode of care (risk sharing)</td>
<td>Providers are paid and responsible for the care of a beneficiary for a period of time</td>
</tr>
<tr>
<td>Examples: RUGs</td>
<td>Hospital value-based purchasing</td>
<td>Accountable care organizations</td>
<td>Some Medicare Advantage Plans, PACE</td>
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<tr>
<td></td>
<td>Readmissions</td>
<td>Medical homes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quality Metrics</td>
<td>Bundled payments</td>
<td></td>
</tr>
</tbody>
</table>

HHS Medicare Goals:
- Category 1: Fee for Service - No Impact From Quality
  - HHS GOAL: 85% by 2018 and 90% by 2018 in value-based categories 2 through 4
- Category 2: Fee for Service - Impact From Quality
  - HHS GOAL: 30% by end of 2018 & 50% by end of 2018 in categories 3 & 4

REFORM INITIATIVES

- Mandatory
  - Readmission Reduction Program - Nursing Homes (2018)
  - Hospital Acquired Conditions
  - Value Based Payment Modifier
- Voluntary
  - Medicare Shared Savings Program
  - Bundled Payment for Care Improvement
  - Comprehensive Primary Care Initiative
  - Community Based Care Transitions Programs

Other Initiatives In Process
HOSPITAL MEDICARE REVENUE (AT RISKS)

<table>
<thead>
<tr>
<th>OCTOBER 1st OF</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmission Program (a)</td>
<td>1.0%</td>
<td>2.0%</td>
<td>3.0%</td>
<td>3.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Value Based Purchasing (b)</td>
<td>1.0%</td>
<td>1.25%</td>
<td>1.5%</td>
<td>1.75%</td>
<td>2.0%</td>
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<tr>
<td>Hospital Acquired Conditions (a)</td>
<td>1.0%</td>
<td>1.0%</td>
<td>1.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Potential Rates at Risk</td>
<td>2.0%</td>
<td>3.25%</td>
<td>5.5%</td>
<td>5.75%</td>
<td>6.0%</td>
</tr>
</tbody>
</table>

a: Represents a worst case scenario and a ceiling of the maximum penalties
b: Represents a withhold of payment that can be earned back based on quality metrics
* Based on past three years of results

THE FUTURE OF HEALTHCARE

• A significant decline in hospitalization will occur
• Enhanced consumerism will increase quality and reduce prices
• Consolidation / partnerships of all types of health, wellness, and insurance entities will continue
• Insurers and hospitals will look to narrow networks to help control cost
• Quality and value will drive market share
• Providers will need to increasingly assume and manage financial risk (or change strategies!)

FACILITY DATA

• Does your data support your ability to do it better?
• Are you tracking and trending?
  – What is your re-hospitalization rate?
  – What is your hospitalization rate?
  – What is your ER utilization?
  – What is your average length of stay?
• What are you doing to improve your quality measures?
  – Quality metrics accurate?
  – Driving care priorities?
FACILITY DATA

• What Performance Improvement Plans are in place?
  – Are they pertinent?
• How are you promoting wellness and prevention?
• Have you assessed your facility’s abilities related to care?
  – Are competencies documented?
  – Care transition programs in place
  – Clinical pathways to care for complex residents
• Use of physician extenders
• Working with others in continuum – ALs, home health, hospice
• Is your staffing mix appropriate?

UNDERSTAND YOUR COST STRUCTURE

• Compare costs to peer organizations
  – Benchmarking
• Determine whether cost differentials relate to:
  – Acuity differences
  – Efficiency and process issues
  – Price of supplies/services

PREPARING FOR CHANGES

• Assess your business model
  – Internal strengths, external threats and opportunities, and partner/provider network options
• Expand clinical competencies
• Increase finance/business office capabilities and skills
• Improve data analytics with respect to cost and clinical outcomes
• Focus on marketing and public relations
VALUE BASED PAYMENTS CONCERNS
• More financial risk is pushed to the provider
  ▪ Providers could be penalized for patients with chronic illness
  ▪ Risk adjustments could unjustly penalize
  ▪ In shared service models other providers action may cause financial loss
• Quality metrics aren’t fully vetted and often too simple
• Data collection and tracking is cumbersome and manual and creates additional administrative burden for the Provider
• Models are complicated and require additional IT resources
• Multiple models may be required to receive payment for single episode

CONCLUSIONS
• Traditional Fee for Service models will dwindle over time but will still be a valid payment method
• The payment landscape will not be dominated by a single VBP model
• Providers will have to handle a variety of payment types
• Financial risk to providers will increase
• Sophisticated IT and clinical integration will be required
• Data analytics and reporting will be key to successfully implementing value based purchasing models

TOPIC 2: DATA, DATA AND MORE DATA
SUCCESSFUL ORGANIZATIONS ARE:

- Embracing change
- Managing operations by exploring opportunities to decrease expenses
- Exploring technology in all operational areas
- Looking for new revenue streams
- Considering affiliations, partnerships, joint ventures, etc.
- Mitigating and managing risk

SUCCESSFUL ORGANIZATIONS ARE:

- Cognizant of the increased needs of its current residents while monitoring the next wave of residents
- Measuring, interpreting and acting on the information being received
  - Utilizing a organization dashboard to monitor performance (See August 2013 Ziegler CFO Hotline article)
- Improving governance structure to meet current and future needs
- Understanding healthcare reform and determining strategy based on their organizational strengths

WHY BENCHMARK AGAINST PUBLISHED MEDIANS?

- Assists in transforming data into information
- Helps identify trends and your relative financial position within the industry
- Can be used as a reporting and planning tool
- Quantifies areas of operational and/or management attention
- Assists in establishing goals on which an organization can be held accountable
- Provides high level direction for Management and the Board
WHY BENCHMARK AGAINST PUBLISHED MEDIANS?

- Create internal benchmarks to measure year over year performance
- Create benchmarks against external performance to measure a provider’s performance compared to the industry/competitors
- Measuring quality is going to be a key factor in future reimbursement

BENCHMARKING SOURCES

- Medicare and Medicaid cost reports
- Ziegler CFO Hotline
- Rating agencies
- Acute care providers
- Etc.

CHALLENGES OF BENCHMARKING:

- Not an exclusive tool to be used in isolation
- Ratios point to strengths and weaknesses, but do not identify them
- Various sizes and configurations of communities
- Very difficult transforming data into useable information
- Variances alone do not necessarily reflect an opportunity or challenge
CHALLENGES OF BENCHMARKING:

- Certain ratios or statistics can be meaningless or distorted by inconsistent reporting between organizations
- Data becomes “stale” quickly
- Definitions may vary among stakeholders
- “Nobody does it like we do” or “We’re different”
- If your community is “setting the standard”, the danger of complacency is significant
- The amount and variety of benchmarking can be overwhelming

TOPIC 3: TURNING DATA INTO ACTION!

PROVIDER EXAMPLE - OVERVIEW OF ENTITY

- Long standing and well respected senior housing provider
- Large skilled nursing facility
- Experienced management with tenure in the industry and with the organization
- Not for profit organization that is mission driven and focused on service and care
- Dominant provider of services for seniors in their community
PROVIDER EXAMPLE - STATISTICS AND RATIOS

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2013</th>
<th>2012</th>
<th>2011</th>
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</thead>
<tbody>
<tr>
<td>Operating Ratio</td>
<td>97.99%</td>
<td>99.50%</td>
<td>99.43%</td>
<td>98.53%</td>
</tr>
<tr>
<td>Ultra RUGs</td>
<td>83%</td>
<td>26%</td>
<td>17%</td>
<td>13%</td>
</tr>
<tr>
<td>Occupancy</td>
<td>95%</td>
<td>96%</td>
<td>97%</td>
<td>94%</td>
</tr>
<tr>
<td>Medicare Days</td>
<td>20%</td>
<td>17%</td>
<td>18%</td>
<td>18%</td>
</tr>
<tr>
<td>Medicare Revenue</td>
<td>30%</td>
<td>24%</td>
<td>25%</td>
<td>26%</td>
</tr>
</tbody>
</table>

PROVIDER EXAMPLE - THERAPY FOCUS
- Redesigned and remodeled the therapy center
- Created a program to provide personalized treatment plans
- Focus on improving health and quality of movement for existing residents through therapy plans
- Increased communication and working relationship with local hospital
- Expanded their adult day care and home health programs

PROVIDER EXAMPLE - FINANCIAL RESULTS
- Medicare revenue increased 52% and over $2 million from previous year
- Operating ratio improved 1.5%
- Therapy center added between $300,000 to $500,000 to the bottom line
PROVIDER EXAMPLE - QUALITATIVE RESULTS

- Increased specialization and abilities in rehab therapy
- Offer specialized treatment programs
- Created customized rehabilitation programs to strengthen functional abilities of residents
- Increased their capabilities and exposure with acute care provider and community
- Rehab therapy center became a marketing focal point
- Added to quality improvement measurements

PROVIDER EXAMPLE - QUALITATIVE REPORTING

Dashboard and Metrics
Skilled Nursing Facility Inspection Ratings Through March 2015
As Reported by AHCA (State Inspection Ratings) — The Agency for Health Care Administration

Provider Example - Qualitative Reporting

IBDS 3.0 Quality Measures Comparison Report Through: March 2015

- Anti-Psychotic Medications (30 days)
- Anti-Psychotic Medications (90 days)
- Physical Restraint
- Nebulizer/Neonatal Vent (30 days)
- Self-Fed/Feeding/Potential (30 days)
- UI - Urinary Tract Infection (30 days)
- Excessive Weight Loss
- Residents Given Seasonal Influenza Vaccine (90 days)
- Residents Given Seasonal Influenza Vaccine (30 days)

No adverse care indicators - 9 consecutives annual NCA/HCIS inspections 2012, 2013, 2014
10% - Staff with more than 30 years of service
80% - Clients who would absolutely recommend
• 25 year old established senior housing provider
• 255 IL, 78 AL, 120 SNF
• Not for profit organization focused on providing a place where seniors can *Live Their Best Life*
• Major financial challenges from 2006-2012
• Initiated turn-around procedures in 2013

### OVERVIEW OF WATERMAN VILLAGE

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
<th>2013</th>
<th>2012</th>
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<tbody>
<tr>
<td>Operating Ratio</td>
<td>92.59%</td>
<td>91.98%</td>
<td>94.33%</td>
<td>99.93%</td>
</tr>
<tr>
<td>Occupancy</td>
<td>89%</td>
<td>89%</td>
<td>89%</td>
<td>88%</td>
</tr>
<tr>
<td>Days Cash on Hand</td>
<td>30</td>
<td>28</td>
<td>22</td>
<td>18</td>
</tr>
<tr>
<td>Accounts Payable Days</td>
<td>35</td>
<td>65</td>
<td>70</td>
<td>70</td>
</tr>
<tr>
<td>Debt Service Coverage Ratio</td>
<td>2.07</td>
<td>2.25</td>
<td>1.72</td>
<td>1.08</td>
</tr>
</tbody>
</table>

### WATERMAN VILLAGE – STEPS TO SUCCESS

• Started with an Operational Review of every department within our organization
• Expense savings are tangible - revenue growth is speculative
• Used benchmarking data to address labor, square footage maintained and culinary services
• Analyzed every position on campus for essential need
• Avoided mass layoffs, benefit reductions and rate increases
WATERMAN VILLAGE - STEPS TO SUCCESS

• Confronted the challenge head on with Board, Staff, Residents and Vendors
• Brought in outside help with Marketing
• Focused efforts on being preferred rehab provider
• Focused efforts on Medicare Home Health
• Long way to go - making positive improvements every month

TOPIC 4: THE FUTURE AND ITS IMPLICATIONS

QUALITY REPORTING

• Impact Act of 2014 (Improving Medicare Post-Acute Transformation Act)
  • CMS to require case and outcome reporting for post-acute care providers (by October 2018).
  • 2% penalty on Medicare fee schedule for noncompliance.
• PAMA Act of 2014 (Protecting Access to Medicare Act)
  • By 10/1/2017, readmission rates for SNF will be publicly available.
  • By 10/1/2018, CMS will withhold 2% of all Medicare payments. Based on readmissions rate, the top 60% will get some incentive back and the bottom 40% will receive less than the scheduled RUG rate.
PEPPER REPORT ANALYSIS

- Program for Evaluating Payment Patterns Electronic Report
- Good analytical report format
- Provides tabular and graphical information
- Trend analysis and comparisons with National, State, and Jurisdiction with upper 80% and lower 20% benchmarks
- RUGs with high ADL, ultrahigh and therapy RUGs, change in therapy assessment, 90+ day episodes of care

WHAT SHOULD WE BE DOING?!?

- Know what your strategy is short-term and long-term
- Track and Act
- Information technology investment is critical
- Reporting of quality and outcomes will be increasingly important
- Increasing levels of scrutiny from all stakeholders

QUESTIONS & ANSWERS