LeadingAge PA

2023 FALL FINANCE CONFERENCE

SENIOR LIVING INDUSTRY TRENDS, REIMBURSEMENT AND OPERATIONAL CONSIDERATIONS

Nov. 1, 2023

9:45 - 10:45 a.m.

LeadingAge PA 2023

FALL FINANCE CONFERENCE

MEET YOUR PRESENTERS

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AGENDA

- Industry update
- Reimbursement considerations
- Operational considerations
- Contact information
- Questions

INDUSTRY UPDATE

Census

Workforce

SNF stressors

Consolidation drivers

Strategic planning

Mergers, acquisitions and affiliations

Financial impact

Key performance indicators

Refocus

Operational considerations

Reimbursement

Outlook

Census	Workforce

• Impacted all levels of care within a senior living organization:
  • Skilled nursing (SNF)
  • Assisted living (AL)/personal care (PC)
  • Independent living (IL)
• Access to staff
	• Staffing shortages
	• Staff burnout
	• Wage and bonus competition
	• Nurse agency utilization
	• Increase in hours per patient day (HPPD) requirements
	• Enhanced focus on recruitment/retention

SNF stressors	Consolidation drivers
• Aging nursing homes • Private room needs • Occupancy • Workforce shortages • Technology needs • Reimbursement	• Financial pressures • Leadership turnover • Complexities of healthcare • Ability to attract and retain talent • Access to capital • Technology demands

Strategic planning

- Perform SWOT analysis
- Identify culture/mission
- Engage board members and committee members
- Strategic considerations
  - ✓ Campus repositioning and right-sizing analysis
  - ✓ Evaluate service lines for expansion/contraction
  - ✓ Engage with referral sources and narrow networks

Mergers, acquisitions and affiliations

- Consider all opportunities
- Engage in internal discussions
- Identify opportunities to partner with other providers
- Process takes considerable time and effort
- Evaluate and include considerations as part of the strategic planning process

Financial impact	Key performance indicators
• Impact on balance sheet • Impact on operating margins • Inflation and inflationary factors • Volatility of the market and investment portfolios • Debt covenant violations	• Days cash on hand • Days in accounts receivable • Bad debt expense as a percentage of net resident revenue • Debt service coverage • Operating margin • Average daily PDPM rate • Nurse agency cost per day

Refocus	Operational considerations
• Sunsetting of Government Funding • Sunsetting of Public Health Emergency Waivers • Challenging operating environment • Financing challenges • State level reimbursement changes • Regulatory requirements • Benchmarking/Comparative Analysis	• Focus on building census and revenue drivers: ✓ Evaluate daily rates ✓ PDPM rate analysis ✓ State rate analysis • Focus on controlling expenses: ✓ Evaluate all departments ✓ Nurse agency/contracted labor ✓ Value based/group purchasing

Reimbursement

- Medicare Managed Care/Advantage:
  - Rapidly increasing
  - Financial Impact
  - Length of Stay
  - Administrative Requirements
  - Audit Volume
  - Trending impact

Reimbursement

- FY24 SNF PPS final rule:
  - Net increase of 4.0% (includes a 2.3% reduction for PDPM parity adjustment this is being phased in over a two-year period)
  - Changes in PDPM ICD-10 code mappings, SNF QRP Program, and SNF VBP Program
  - Minimum staffing requirements

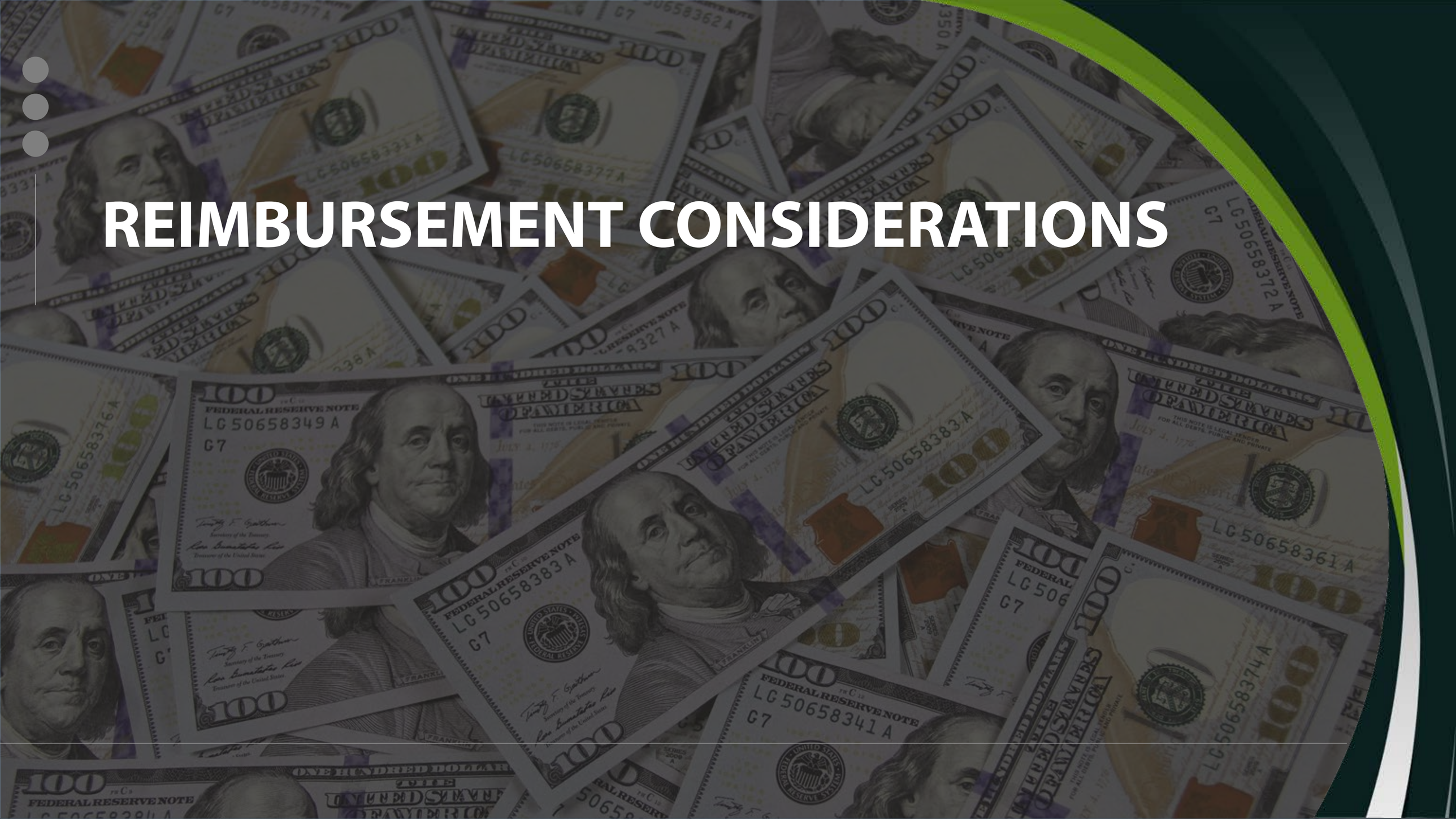
Outlook

- Hot topics and greatest focus areas:
  - Nursing in Life Plan Communities
  - Aging in Place
  - Labor
  - Technology
  - Consolidations/Affiliations
  - Cost of Capital

Outlook

- Hot topics and greatest focus areas:
  - Revenue and Expense Pressures
  - SNF Reimbursement
  - Strategic Planning
  - Creative Business Models
  - Hospital & Post-Acute Relationships
  - Market infiltration of Managed Care

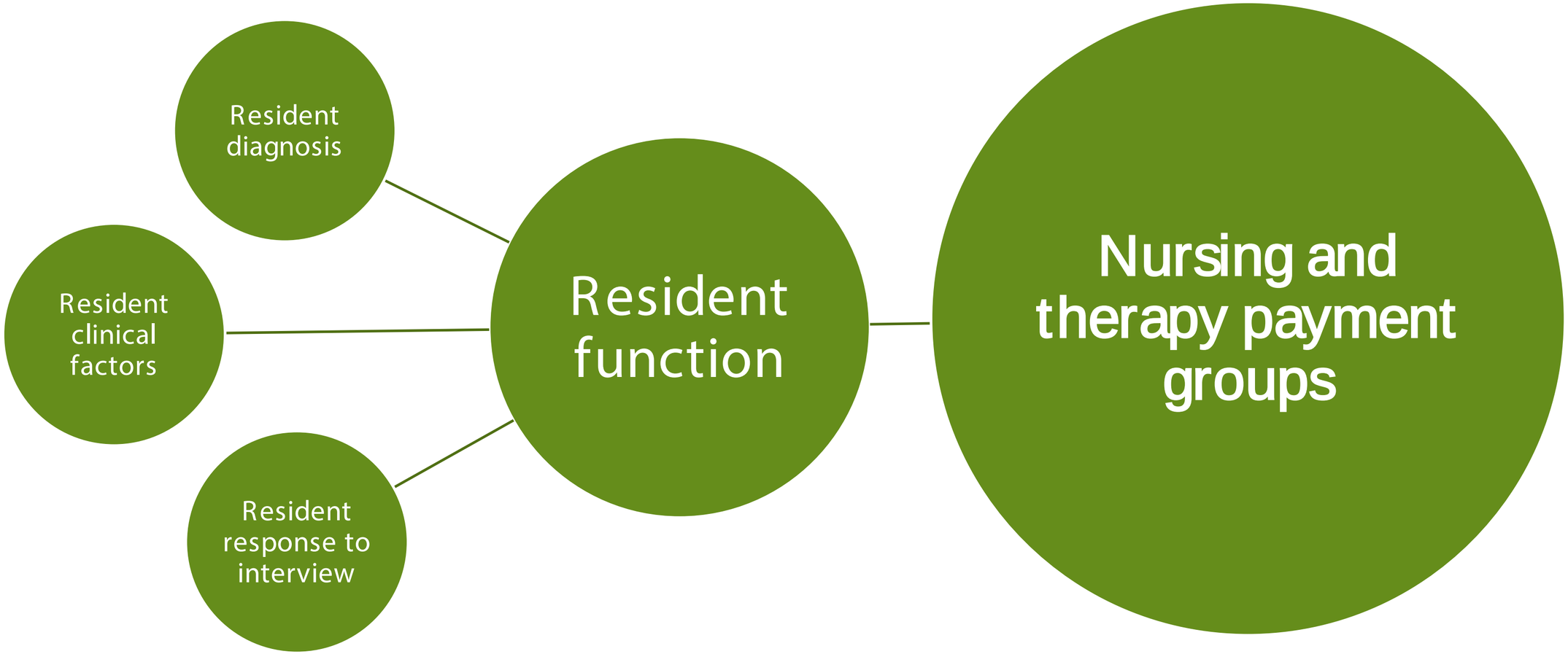
REIMBURSEMENT CONSIDERATIONS



REIMBURSEMENT CONSIDERATIONS

- Medicare is expected to begin denying claims in a similar manner to managed care denials
- This news comes as CMS is rolling out the five claim probes (which we have not yet seen)
    - MAC did not accept interview responses that were coded directly onto the MDS
- Mechanically altered diet that was in a nurse's notes
- Interview PHQ-2 to 9, BIMS
- Denials will occur after medical reviews and are focused on medical necessity, LOS and signatures/dating by physician
- If not completed, inaccurate or unsupported these areas will result in denials:
    - Section GG
    - Section I active diagnosis
    - NTA items not supported
    - Mechanically altered diet
    - Swallowing disorders
    - Skin conditions
    - BIMS not completed timely

REIMBURSEMENT CONSIDERATIONS: POST-PAYMENT TARGET AREAS

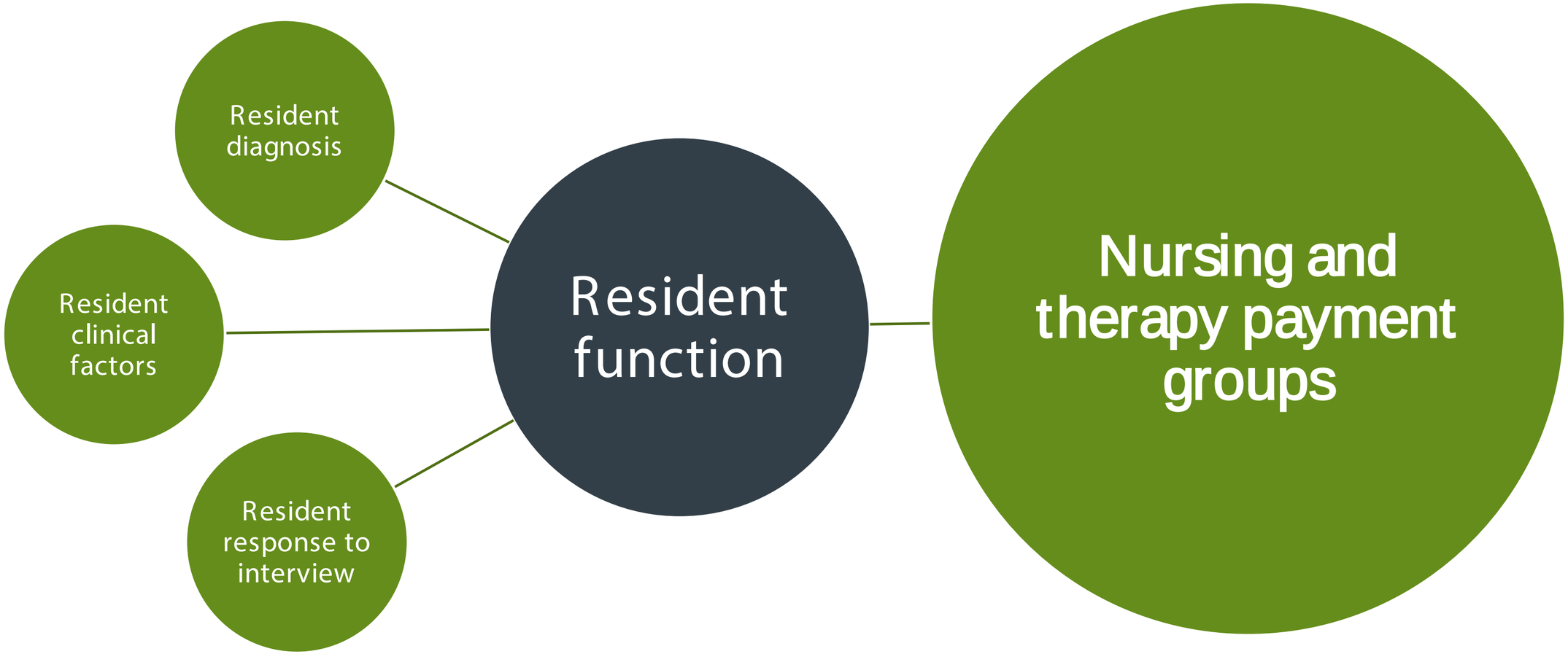


REIMBURSEMENT CONSIDERATIONS: POST-PAYMENT TARGET AREAS

Medicare advantage scrutiny of the Patient-Driven Payment Model (PDPM)

- Cost containment
  - Controlling length of stay (LOS)
  - Using Medicare's PDPM with regular post-payment reviews and payment take-backs
  - **Post-payment reviews focused on select minimum data set (MDS) areas:**
    - Section GG (resident function)
    - Active diagnosis (diagnosis)
      - NTA items not supported (diagnosis / clinical conditions)
    - Skin conditions (clinical conditions)
    - BIMS not completed timely (resident interview responses)
    - PHQ-9

REIMBURSEMENT CONSIDERATIONS: POST-PAYMENT TARGET AREAS



REIMBURSEMENT CONSIDERATIONS: POST-PAYMENT TARGET AREAS

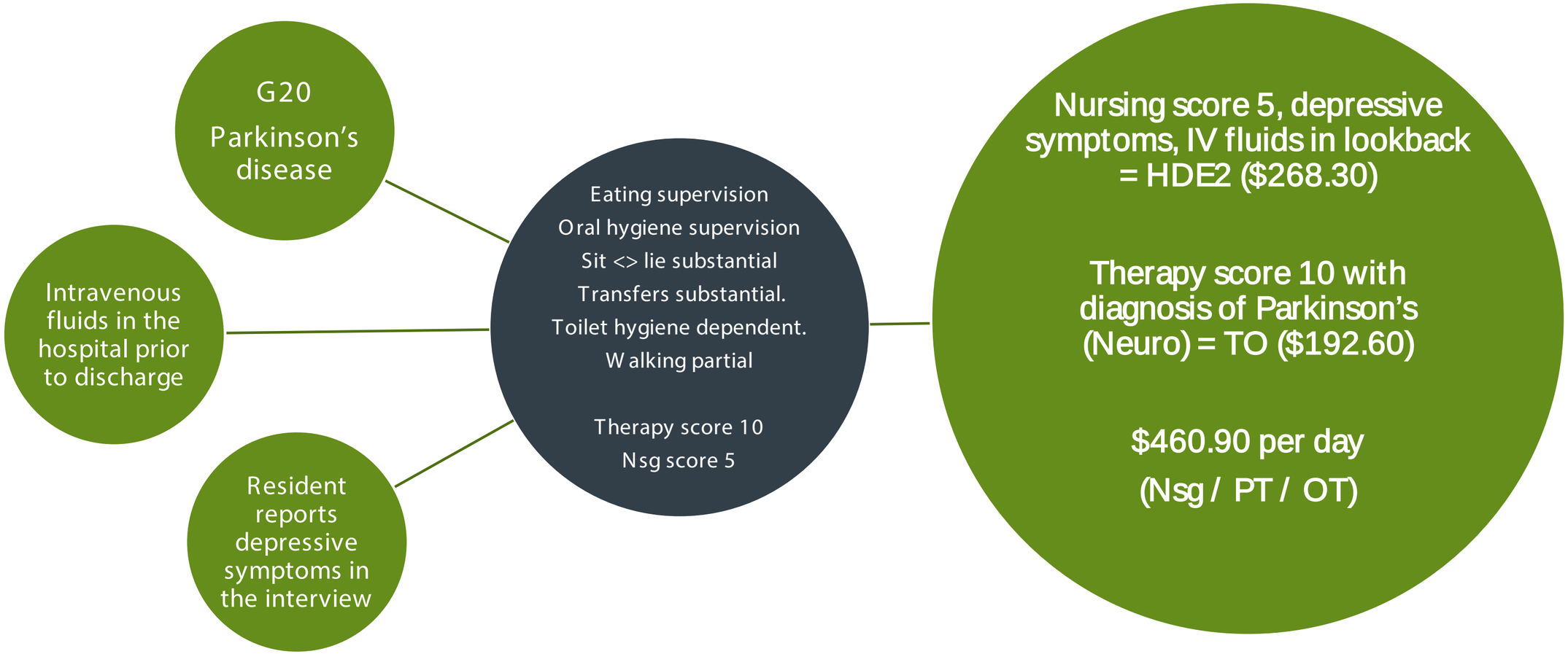
- Function
- Reimbursement considerations: Post-payment target areas
- "Assess…based on direct **observation**, incorporating resident **self-reports** and **reports** from qualified clinicians, care staff, or family **documented in the resident's medical record during the assessment period.** CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the assessment period."*
- "USUAL PERFORMANCE"

(*CMS's RAI Version 3.0 Manual CH 3: MDS Items [GG] October 2023 Pages GG-15 (self care) GG-43 (mobility)*)

REIMBURSEMENT CONSIDERATIONS: POST-PAYMENT TARGET AREAS

- Nursing functional score
  - "Usual performance" of late-loss ADLs, **MDS Section GG**
    - Bed mobility: Lie to sit, sit to lying position
    - Transfers: Sit to stand, chair/bed to chair, and toilet transfers
    - Eating
    - Toilet hygiene
- Therapy functional score
  - "Usual performance" of the nursing ADLs used for the score, and:
    - Oral hygiene
    - Walking: 50' with 2 turns, 150'

REIMBURSEMENT CONSIDERATIONS: POST-PAYMENT TARGET AREAS



REIMBURSEMENT CONSIDERATIONS: POST-PAYMENT TARGET AREAS

RESIDENT functional performance

- Not in dispute by interdisciplinary team – all agree.
- Therapy evaluations day four
- Assessment added into medical record on day four to support MDS coding.

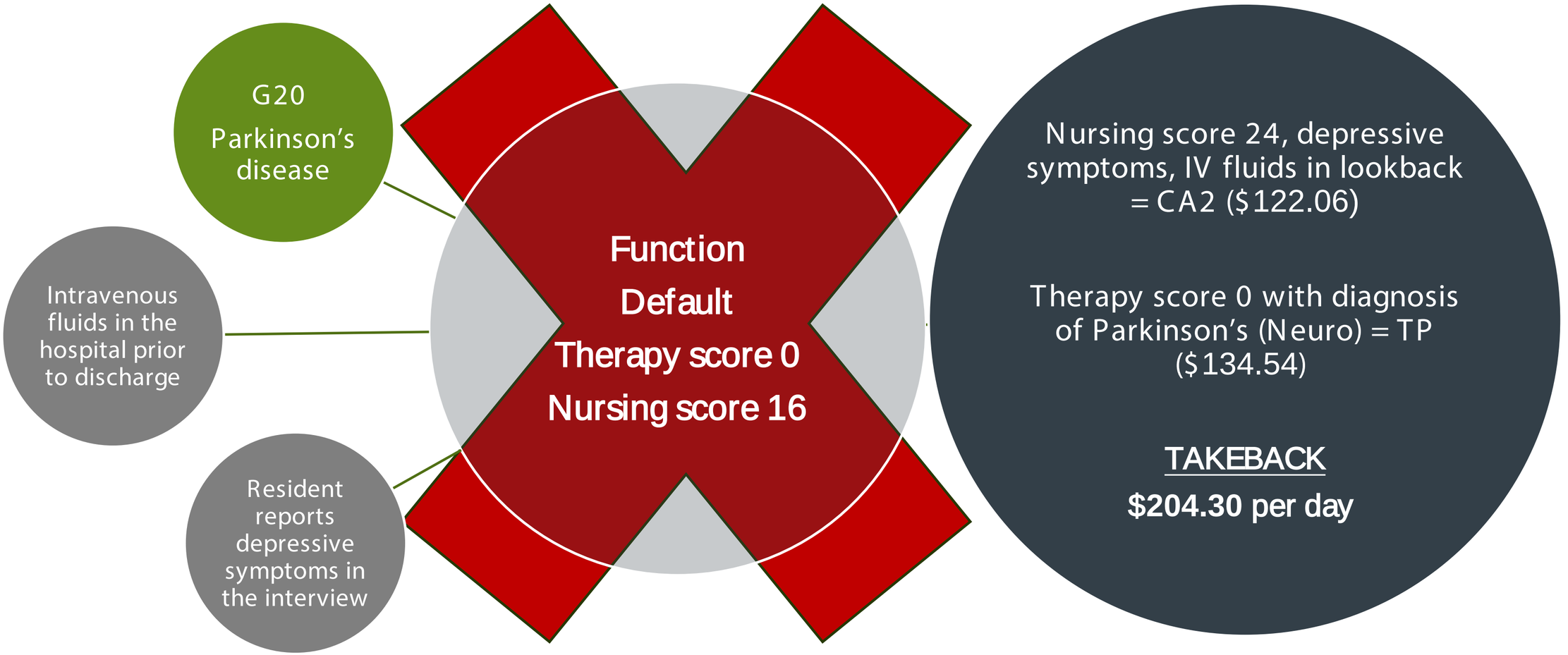
Supporting documentation concerns

- *Variety of performance levels*
- *No documentation of performance coding decision in the lookback*
- *Documentation dated after the lookback*

Assessment encoding at risk

- PT payment
- OT payment
- Nursing payment

REIMBURSEMENT CONSIDERATIONS: POST-PAYMENT TARGET AREAS



REIMBURSEMENT CONSIDERATIONS: POST-PAYMENT TARGET AREAS

Medicare advantage scrutiny of the Patient-Driven Payment Model (PDPM)

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  - **Post-payment reviews focused on select minimum data set (MDS) areas:**
    - Section GG (resident function)
    - SLP-related resident function
    - Active diagnosis (diagnosis)
      - NTA items not supported (diagnosis/clinical conditions)
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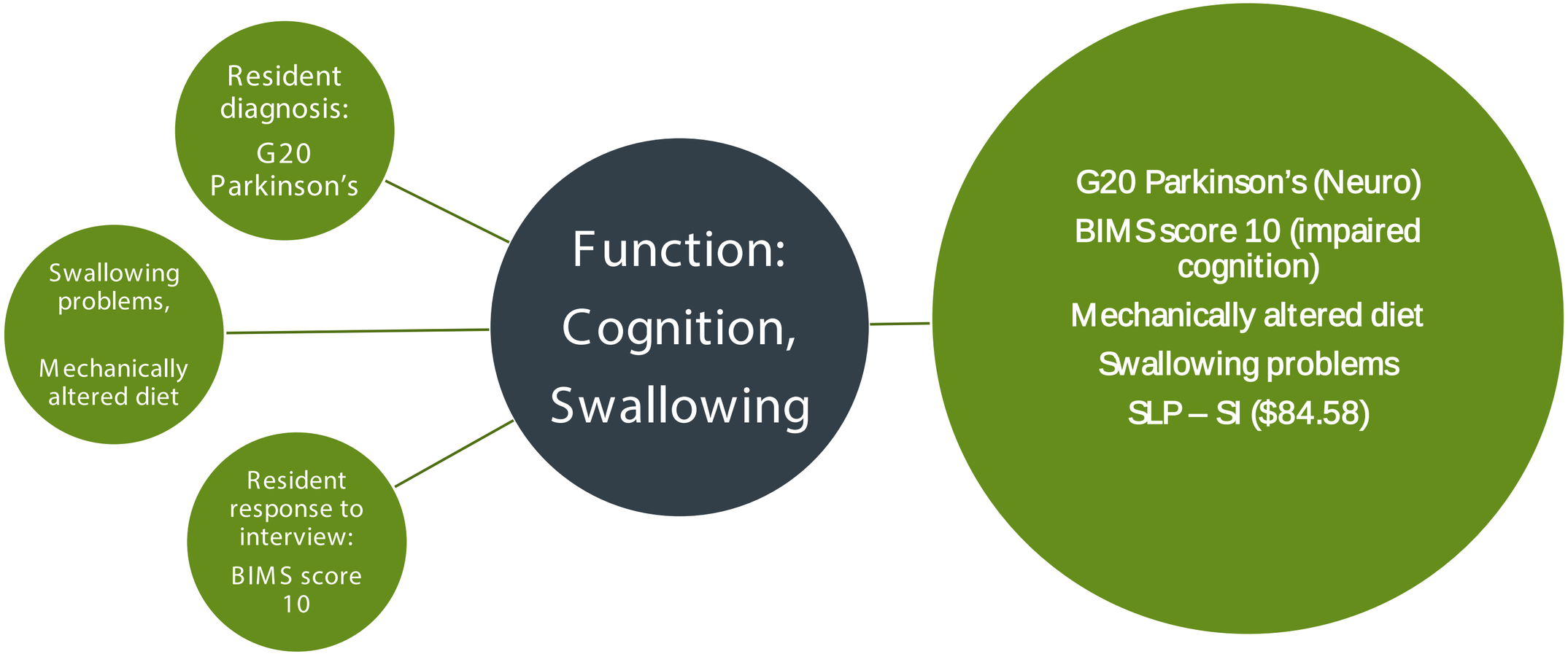
    - BIMS not completed timely (resident interview responses)
    - PHQ-9

REIMBURSEMENT CONSIDERATIONS: POST-PAYMENT TARGET AREAS



REIMBURSEMENT CONSIDERATIONS: POST-PAYMENT TARGET AREAS

C0100: Should brief interview for mental status be conducted

- Coding tips
  - Attempt to conduct the interview with ALL residents. **This interview is conducted during the look-back period** of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood.
    - *-CMS's RAI Version 3.0 Manual CH 3: MDS Items [K] October 2023 Page C-2*

K0100: Swallowing/nutritional status

- Coding tips:
  - Do not code a swallowing problem when interventions have been successful in treating the problem and **therefore the signs/ symptoms of the problem (K0100A through K0100D) did not occur** during the 7-day look-back period.
  - Code **even if the symptom occurred only once** in the 7-day look-back period.
    - *-CMS's RAI Version 3.0 Manual CH 3: MDS Items [K] October 2023 Page K-2*

K0520: Nutritional approaches

- DEFINITIONS
  - MECHANICALLY ALTERED DIET A diet specifically prepared to alter the texture or consistency of food to facilitate oral intake. Examples include soft solids, puréed foods, ground meat, and **thickened liquids**. A mechanically altered diet should not automatically be considered a therapeutic diet.
- Coding instructions
  - Check **all nutritional approaches performed** after admission/entry or reentry to the facility and within the 7-day look-back period.
    - *-CMS's RAI Version 3.0 Manual CH 3: MDS Items [K] October 2023 Page K-11*

REIMBURSEMENT CONSIDERATIONS: POST-PAYMENT TARGET AREAS

RESIDENT functional performance

- BIMS interview completed
  - Encoded direction onto the MDS
  - Z0400 dated for data entry date
- **Resident coughing** during fluid intake
  - SLP referral
    - Documents coughing
  - Nursing initiating **thick liquids**

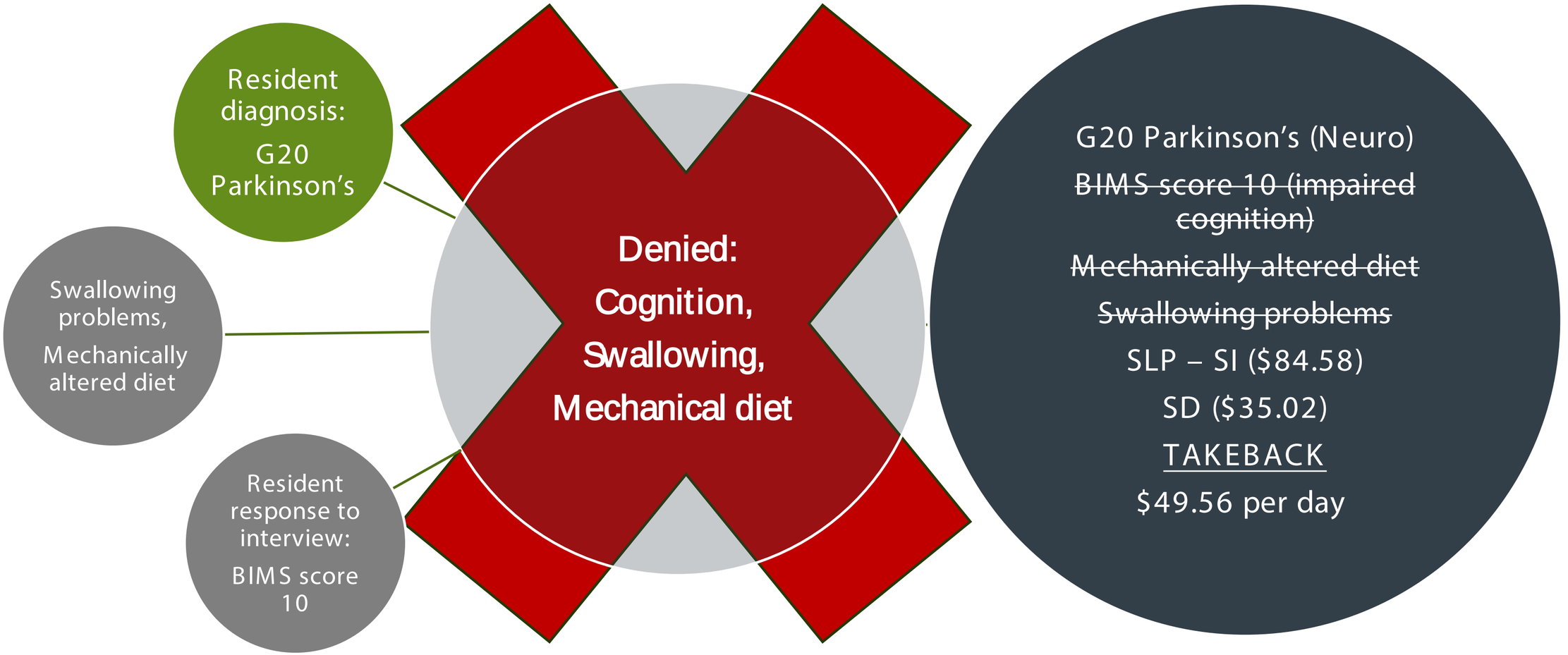
Supporting documentation concerns

- *Interview performed*
  - *No note of this during the lookback.*
- *Information obtained by discussing resident condition with care staff.*
- *Note by MDS nurse after the ARD*
- *SLP daily notes not sent with information request*

Assessment encoding at risk

- SLP Payment items
  - Mechanically altered diet
  - Swallowing problem
  - Impaired cognition

REIMBURSEMENT CONSIDERATIONS: POST-PAYMENT TARGET AREAS



REIMBURSEMENT CONSIDERATIONS: POST-PAYMENT TARGET AREAS

Medicare advantage scrutiny of the Patient-Driven Payment Model (PDPM)

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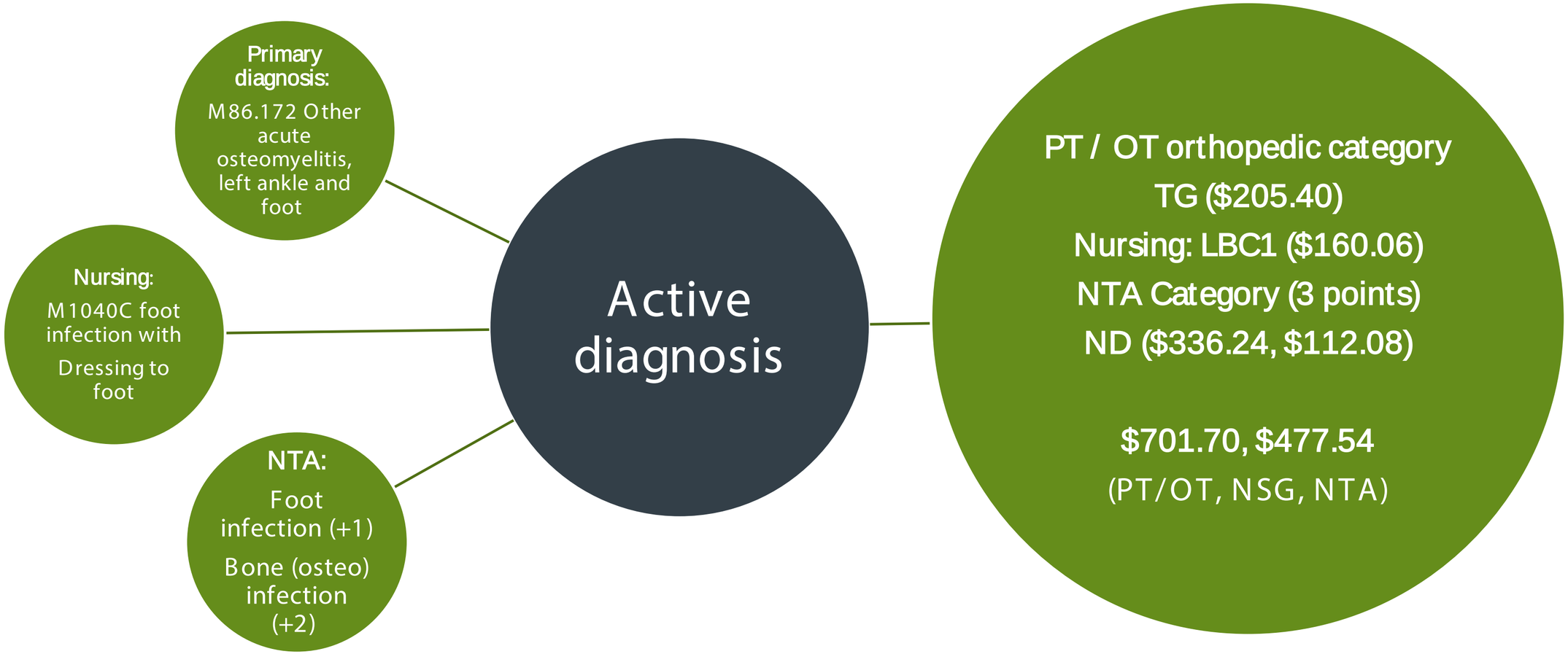
  - **Post-payment reviews focused on select minimum data set (MDS) areas:**
    - **Section GG (resident function)**
    - **SLP-related resident function**
    - **Active diagnosis (diagnosis)**
      - **NTA items not supported (diagnosis / clinical conditions)**

REIMBURSEMENT CONSIDERATIONS: POST-PAYMENT TARGET AREAS



REIMBURSEMENT CONSIDERATIONS: POST-PAYMENT TARGET AREAS

I. Active diagnoses in the last seven days

- Active diagnoses
  - **Physician-documented diagnoses** in the **last 60 days** that have a **direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death** during the 7-day look-back period.
    - CMS's RAI Version 3.0 Manual CH 3: MDS Items [I] October 2023 Page I-7
  - Recent onset or acute exacerbation of the disease or condition indicated by a **positive study, test or procedure, hospitalization for acute symptoms** and/or recent change in therapy in the last 7 days. Examples of a recent onset or acute exacerbation include the following: new diagnosis of pneumonia indicated by chest X-ray; hospitalization for fractured hip; or a blood transfusion for a hematocrit of 24. Sources may include **radiological reports, hospital discharge summaries, doctor's orders, etc.**
    - CMS's RAI Version 3.0 Manual CH 3: MDS Items [I] October 2023 Page I-11

REIMBURSEMENT CONSIDERATIONS: POST-PAYMENT TARGET AREAS

Active diagnosis:
Osteomyelitis

- Hospital discharge summary includes diagnosis
- Nursing documents care for surgical wound
- Resident remains on antibiotics for infection

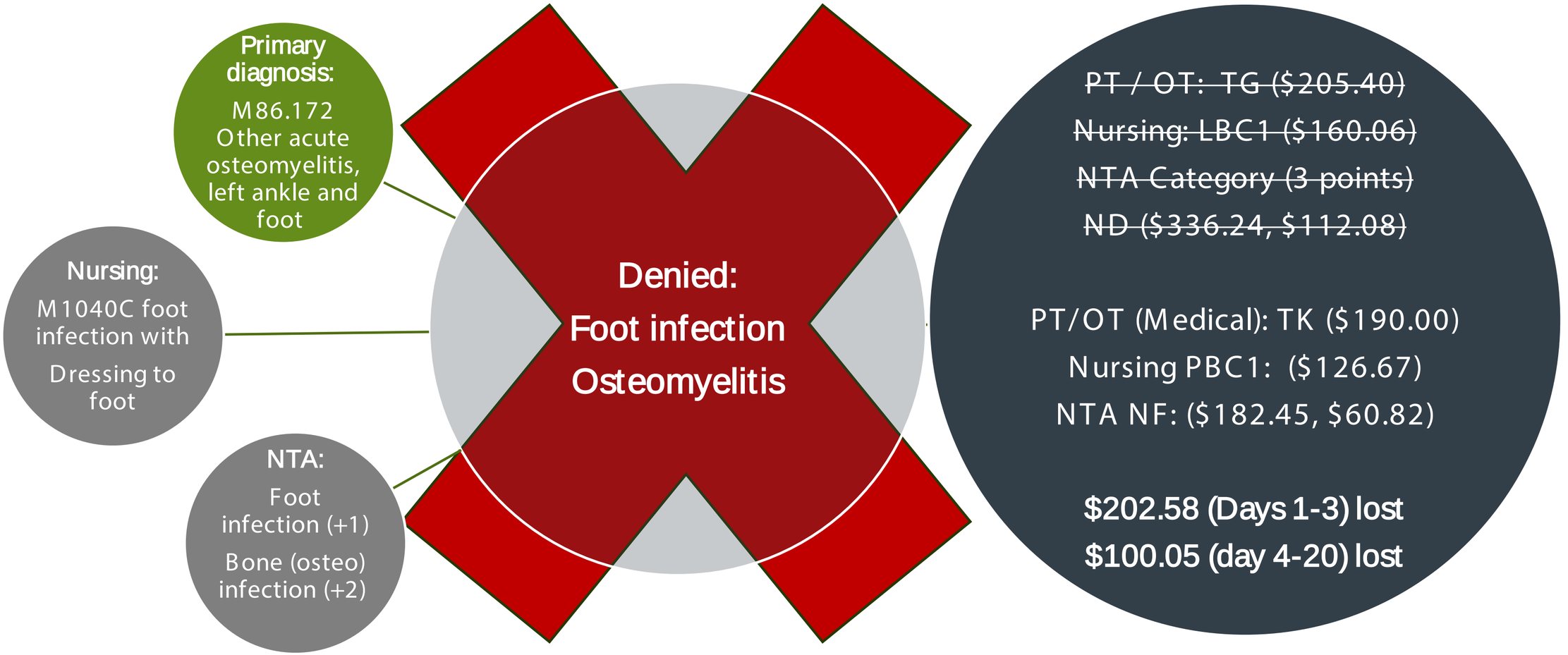
Supporting documentation concerns

- *Nursing notes document surgical area of foot*
- *Physician after the ARD, references osteomyelitis of the foot, antibiotics, post-surgical care and therapy.*
- *Discharge summary from hospital not sent in information request.*

Assessment encoding at risk

- PT payment
- OT payment
- Nursing payment
- NTA payment

REIMBURSEMENT CONSIDERATIONS: POST-PAYMENT TARGET AREAS



REIMBURSEMENT CONSIDERATIONS: POST-PAYMENT TARGET AREAS

Significance of takebacks

- Physical function: $150 / day
- Cognitive and swallowing function: $50 / day
- Active diagnosis: $100 - $200 / day

Potentially up to $400 per day in the examples above

Medicare – Started five claim reviews in June 2023

- Not much information out there on these yet…
- Interviews denied
- Mechanically altered diet denied

REIMBURSEMENT CONSIDERATIONS: PEPPER CLUES FOR FOCUS

PEPPER (Program for Evaluating Payment Patterns Electronic Report)	
Target area	**Target area definition**
High PT and OT case mix (new as of the Q4FY21 release)	Numerator: count of SNF claims where the first character of the Health Insurance Prospective Payment System (HIPPS) code, representing the physical and occupational therapy component, is one of the following: **C, D, F, G, J, K, N, or O** Denominator: count of all SNF claims
High speech language pathology case mix (new as of the Q4FY21 release)	Numerator: count of SNF claims where the second character of the HIPPS code, representing the speech language pathology component, is one of the following: **C, F, I, or L** Denominator: count of all SNF claims
High nursing case mix (new as of the Q4FY22 release)	Numerator: count of SNF claims where the third character of the HIPPS code, representing the nursing payment group, is one of the following: **A, B C, D, H, or L** Denominator: count of all SNF claims

REIMBURSEMENT CONSIDERATIONS: PEPPER CLUES FOR FOCUS

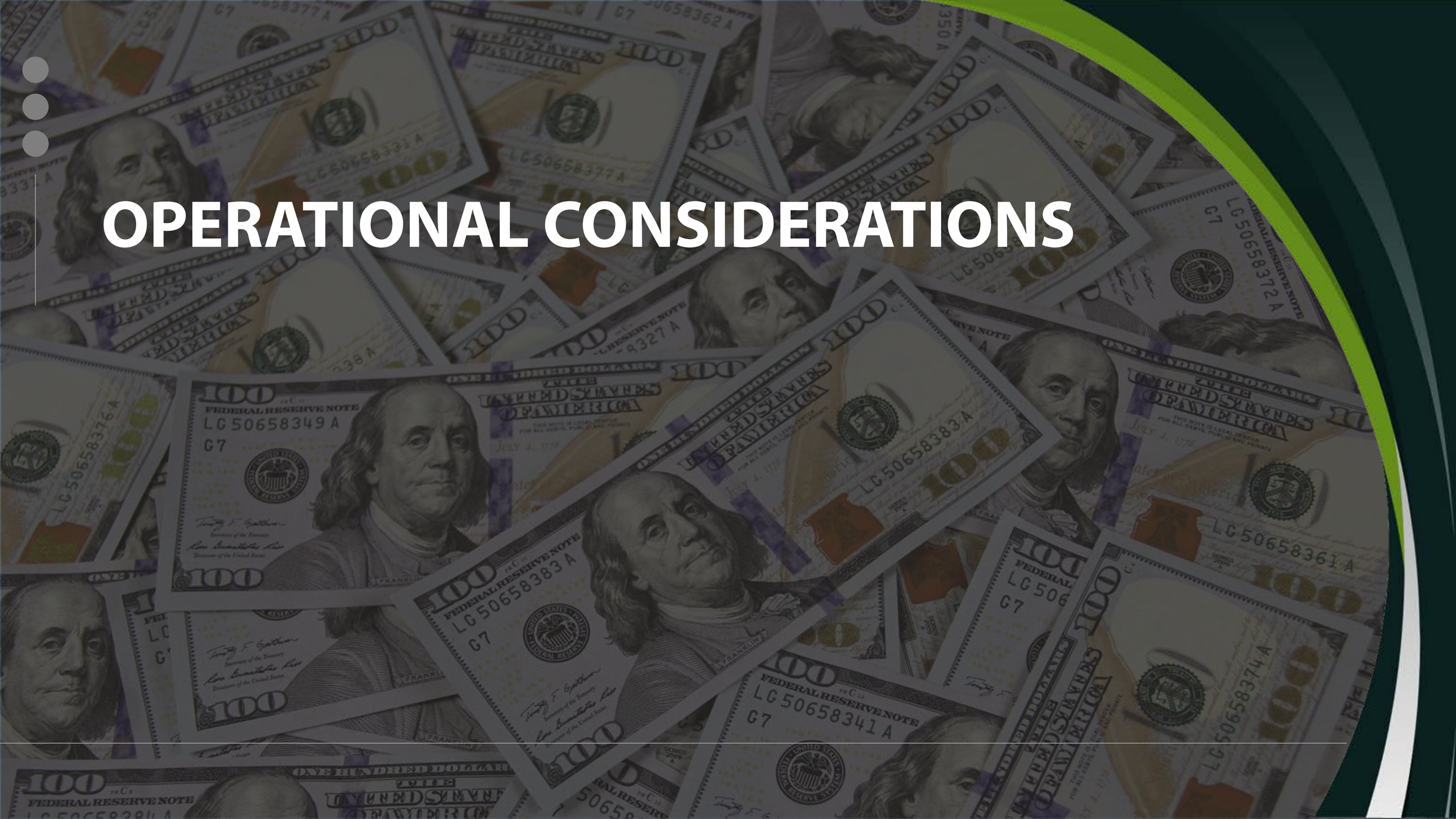
PEPPER (Program for Evaluating Payment Patterns Electronic Report)	
Target area	**Target area definition**
20 days	Numerator: count of episodes of care ending in the report period with a length of stay (LOS) of 20 days Denominator: count of episodes of care ending in the report period
90+ days	Numerator: count of episodes of care ending in the report period with a LOS of 90+ days Denominator: count of all episodes of care ending in the report period
Three-to-five day readm	Numerator: count of readmissions within three to five calendar days (four to six consecutive days) to the same SNF for the same beneficiary (identified using the Health Insurance Claim number) during an episode that ends during the report period Denominator: count of all claims associated with SNF episodes ending during the report period, excluding patient discharge status code 20 (expired); (See Appendix 1 in the SNF PEPPER User's Guide for how readmissions are identified)

REIMBURSEMENT CONSIDERATIONS: PEPPER CLUES FOR FOCUS

PEPPER Relationships

- **PT/OT HIPPS**: C, D, F, G, J, K, N, or O = scores 6-23 (except D = MJ, 24)
  - Function
  - Diagnosis
- **Nursing HIPPS**: A, B C, D, H, or L (ES3, ES2, ES1, HDE2, LDE2, CDE2)
  - Function
  - Clinical factors
  - Diagnoses
  - Resident interview response
- **SLP HIPPS**: C, F, I, or L (BOTH Swallowing d/o and mechanically altered diet)
  - Clinical factors
  - Diagnoses
  - Resident interview response
- **Length of stay / readmission timing**

OPERATIONAL CONSIDERATIONS



OPERATIONAL CONSIDERATIONS

Federal compliance – Medicare and Medicare advantage

- PEPPER Resources and Retrieval
- Triple check process – Part A and Part B claims
  - Who is a part of the process?
  - Checklists
  - Retention of the results should be part of the compliance program
- Third-party medical record and claim audits
  - More common
  - Occur in "bunches"
  - Time sensitive
  - Results are at times not communicated

OPERATIONAL CONSIDERATIONS

Skilled nursing facility 5-claim probe and educate review

- The Centers for Medicare & Medicaid Services (CMS) has recently announced the start of the SNF (skilled nursing facility) 5 Claim Probe and Educate Review program. As part of the effort to lower the SNF improper payment rate, Medicare Administrative Contractors (MACs) will be reviewing a small number of claims from every Medicare-billing SNF in the country. The SNF will then be offered education to address any errors identified, helping them to avoid future claim denials and adjustments.

OPERATIONAL CONSIDERATIONS

Skilled nursing facility 5-claim probe and educate review

- The proposed 5 claim strategy will extend the broadest reach to all SNFs. Similar to the current Targeted Probe and Educate (TPE) medical review strategy, the SNF 5 Claim Probe and Educate Program will include one on one provider education at the completion of a small sample of claim reviews. However, instead of the 1-3 rounds of review a provider receives through TPE, each SNF will undergo only 1 round of review.
  - MACs will review 5 claims from each SNF.
  - MACs will complete one (1) round of probe and educate for each SNF, not the potential three rounds that may occur in the traditional TPE program.
  - Education offered will be individualized based on the claim review errors identified in the probe. Review results letters will detail the denial rationales for each claim, as appropriate.
- The SNF 5-Claim reviews commenced on June 5, 2023 and will affect claims for services furnished after Oct. 1, 2019. Claims containing the COVID-19 diagnosis will be excluded from the review.

OPERATIONAL CONSIDERATIONS

State compliance – PA Managed Care CHCs
• Community HealthChoices (CHCs) Contractors: • UPMC for UPMC Community HealthChoices • Resolution Management for PA Health & Wellness • Resolution Management for AmeriHealth Caritas / Keystone First

OPERATIONAL CONSIDERATIONS

State compliance – PA Managed Care CHCs
• CHC claims review process back to inception of providers CHC implementation date • Similar to the previous “UMR” financial reviews • Review request letters – time sensitive • Claims tracker • 30-day review for additional information • Final results letter • Settlement outcomes • Continues to rollout in phases – retroactive reviews and be prepared

OPERATIONAL CONSIDERATIONS

Compliance in billing

- Risk areas associated with billing have been most frequent subjects of investigations and audits by the OIG
  - Criminal sanctions
  - Monetary penalties
  - Medicare payments suspended
  - Excluded from Medicare program participation
- Organizations must continually reassess its billing procedures and policies for both Federal and State programs

OPERATIONAL CONSIDERATIONS

Current billing challenges

• Workforce staff/turnover
• Lack of SNF billing experience
• Implementation of new billing software
• Lack of accounts receivable monthly meeting
• Increase in accounts receivable (AR) balances
  • Limited claim follow-up
  • Lack of clear policy for collections
  • Resident/families not cooperative in application process

OPERATIONAL CONSIDERATIONS

Accounts receivable report (example: 100-bed SNF)

Payer type summary	Outstanding balance	Sep.	Aug.	July	June	May	Apr.	Mar.	Feb.	Jan.	Dec.	Nov.	Oct.	≥Sept.
Commercial insurance	192.498.08	33,242.1	14,173.5	2,737.87	7,605.05	18,700.6	15,781.1	31,247.5	14,612.5	12,592.1	12,410.6	6,519.75	5,820.90	17,054.24
Like Medicare Part A	704,393.45	26,943.7	88,306.6	11,814.03	44,286.3	35,971.4	39,674.0	76,770.3	57,875.5	63,790.8	29,372.9	46,889.9	44,850.8	137,846.7
Like Medicare Part B	173,814.26	14,310.6	25,227.2	22,600.29	11,197.82	3,552.86	15,116.53	8,203.61	3,348.33	8,345.67	6,726.41	6,128.67	8,138.89	40,917.28
Medicaid (state)	706,294.22	179,190.4	185,248.1	70,007.12	60,813.53	19,871.91	20,069.01	5,276.11	15,243.07	11,161.56	12,164.04	6,706.40	(19,312.79)	139,855.6

OPERATIONAL CONSIDERATIONS

Accounts receivable report (example: 100-bed SNF)

Payer type summary	Outstanding balance	Sep.	Aug.	July	June	May	Apr.	Mar.	Feb.	Jan.	Dec.	Nov.	Oct.	≥Sept.
Medicare Part A	339,635.97	148,780.8	76,443.23	10,978.31	17,151.51	24,881.44	23,695.94	12,046.74	(15,050.20)	3,297.48	35.18	(2,132.26)	3,892.16	35,615.61
Medicare Part B	66,741.06	12,726.43	4,005.74	3,790.08	2,771.97	4,197.77	3,177.08	2,029.86	2,737.21	3,799.09	331.61	1,335.74	1,110.82	24,727.66
Private	1,346,887.33	68,350.37	73,817.25	66,337.64	44,804.72	23,707.80	16,506.12	19,012.03	32,461.77	41,926.75	17,976.56	25,846.03	40,078.55	876,061.74
Payer type total	3,530,264.37	483,544.6	467,221.7	188,265.34	188,630.96	130,883.90	134,019.8	154,586.27	111,228.19	144,913.53	79,017.35	91,294.26	84,579.42	1,272,078.93

OPERATIONAL CONSIDERATIONS

Accounts receivable aging report

- Each payer will have different rules for review based on time limits
- Chargemaster reviews – based on payer contracts
- Monthly posting and variance tracker
- Payer critical time limits
  - MA: 180 days
  - Medicare: 365 days
  - Medicare advantage: Based on contract with the facility (could be 30 to 120 days)

OPERATIONAL CONSIDERATIONS

SNF monthly billing cycle

• Example of timelines for payers and monthly follow-up
  • Private pay
  • Medicaid
  • Part B
  • Part A
  • AR meeting and collection follow-up

OPERATIONAL CONSIDERATIONS

- Accounts receivable monthly meeting is CRITICAL!
- Communication is important for claims review
- Billers, AR manager, facility staff, etc.
- Claims that have been denied/rejected – follow-up on claims from last month’s meeting
- Monthly action items on claim follow-up
- Follow-up, follow-up, follow-up!

OPERATIONAL CONSIDERATIONS

Medicare Cost Report Benchmarking

Provider Name			Day of Cost Report Period End
GARVEY MANOR			December 31, 2021
State	**City**	**County**	**CBSA**
PA	HOLLIDAYSBURG	BLAIR	11020

Number of Providers

CBSA		State		National
11020	9	PA	646	14,061

Medicare Profitability

Provider Specific		CBSA Medians		State Medians		National Medians	
Total Medicare Per Diem Reimbursement	$522.12	Total Medicare Per Diem Reimbursement	$533.79	Total Medicare Per Diem Reimbursement	$561.11	Total Medicare Per Diem Reimbursement	$566.44
Total Medicare Per Diem Cost	$477.18	Total Medicare Per Diem Cost	$460.66	Total Medicare Per Diem Cost	$445.08	Total Medicare Per Diem Cost	$418.01
Total Medicare Per Diem Profit or (Loss)	$44.94	Total Medicare Per Diem Profit or (Loss)	$73.12	Total Medicare Per Diem Profit or (Loss)	$116.03	Total Medicare Per Diem Profit or (Loss)	$148.43
Profit (loss) as a % of Per Diem	8.61%	Profit (loss) as a % of Per Diem	13.70%	Profit (loss) as a % of Per Diem	20.68%	Profit (loss) as a % of Per Diem	26.20%

-Provider specific information represents information only for the facility
-Medicare Per Diem Reimbursement, Cost and Profit (loss) as a % of Per Diem are medians for CBSA, State and National geographic definitions
-Per Diem Profit or (Loss) is a calculation based on the Per Diem Reimbursement and Cost

OPERATIONAL CONSIDERATIONS

Medicare Cost Report Benchmarking

Provider Name	Day of Cost Report Period End	State	City	County
GARVEY MANOR	December 31, 2021	PA	HOLLIDAYSBURG	BLAIR

Number of Providers

CBSA		State		National
11020	9	PA	646	14,061

Other Statistics

Provider Specific		CBSA Medians		State Medians		National Medians	
Co Insurance	$143,206.00	Co Insurance	$125,027.00	Co Insurance	$165,652.00	Co Insurance	$233,359.00
Reimbursement Bad Debt	$0.00	Reimbursement Bad Debt	$46,924.50	Reimbursement Bad Debt	$58,343.00	Reimbursement Bad Debt	$26,318.00
Reimbursement Bad Debt Dual Eligible	$0.00	Reimbursement Bad Debt Dual Eligible	$46,739.00	Reimbursement Bad Debt Dual Eligible	$51,784.50	Reimbursement Bad Debt Dual Eligible	$63,438.00
Vaccine	$0.00	Vaccine	$1,332.00	Vaccine	$2,600.00	Vaccine	$1,600.50

-Provider specific information represents information only for the facility
-CBSA, State and National metrics represent medians across geographic definitions for cost reporting timeframe

OPERATIONAL CONSIDERATIONS

Benchmarking reimbursement Key Performance Indicators (KPIs) is CRITICAL!

- Census
- Payer mix
- Days cash on hand
- Average PDPM rate
- Average Medicaid/CHC rate
- Days in accounts receivable
- Medicare Part A FFS Reimbursable Bad Debt
- Medicare Part A UPMC SNP Reimbursable Bad Debt
- Bad debt expense as a percentage of Net Resident Revenue

OPERATIONAL CONSIDERATIONS

Take-Aways
• Skilled Nursing Facility (SNF) component of a CCRC: • SNFs require additional time and consideration in today's challenging operating environment • SNFs have unique risks and complexities involved in the revenue cycle that requires continued evaluation • Be proactive with internal auditing and monitoring as it relates compliance • Benchmarking analysis and detailed review of outliers is CRITICAL! • REFOCUSING on operations is CRITICAL to current and future financial VIABILITY and SUSTAINABILITY!

THANK YOU!

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