

**Washington County  
Nursing Home  
Assessment - Phase I**

**December, 2010**

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Prepared for:  
**Washington County Board of Supervisors**

Prepared By:  
Donald Pryor, Ph.D.  
Project Director

1 South Washington Street  
Suite 400  
Rochester, NY 14614  
585.325.6360

90 State Street  
Suite 1436  
Albany, NY 12207  
518.432.9428

[www.cgr.org](http://www.cgr.org)



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## **SUMMARY**

[To be added following discussion with project Steering Committee, the  
Washington County Health Committee, on December 15]

## **Acknowledgements**

### **Staff Team**

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# CHAPTER I: INTRODUCTION

## Context and Purpose of the Study

The Washington County Board of Supervisors issued a Request for Proposals for a consultant to study several issues related to the future of the County-operated Pleasant Valley Nursing Home, Adult Home and Adult Day Health Care Program, and Public Health home care services, including the Certified Home Health Agency (CHHA), Long Term Home Health Care Program (LTHHCP) and Hospice. The Center for Governmental Research Inc. (CGR) proposed a phased study that would, in Phase I, describe the current and historical conditions of the various services. This report presents the results of Phase I.

## Methodology

### *Interviews*

CGR conducted more than 35 separate confidential interviews with 30 individuals involved with all of the services addressed in the study. Interviews were conducted with administrative, direct service and support staff of the affected facilities and programs; members of the Board of Supervisors; union representatives; and other County staff, including the County Administrator, Treasurer, and heads of the Department of Social Services and Office for the Aging. Each of these interviews helped CGR understand the operations of the various services, including financial, service delivery and staffing issues; factors in the external environment affecting current and future operations; strengths and limitations of the operations; and other factors influencing the future operations of the facilities and programs.

While each of these interviews was conducted confidentially and findings are reported in the aggregate, each individual interviewed offered insights that help to frame this report and contextualize our other data analysis.

### *Review of Data*

CGR conducted an extensive review of data relevant to each of the services addressed in this report. This review included financial statements, staffing and organizational charts, and data pertaining to patient characteristics and service volume.

## CHAPTER II: THE ENVIRONMENT

### Washington County

Washington County is a rural county in Northeastern New York State, bordered by Vermont to the east, Essex County to the north, Warren County to the northwest, Saratoga County to the southwest and Rensselaer County to the south.

The County has an approximate population of 62,000, with 41% of the population residing in rural areas with small populations. The County is 82 miles long (north to south) and 20 miles wide, and is comprised of 17 townships, no cities and 9 villages, the largest, Kingsbury, with a population of 11,171, and the smallest, Putnam, with a population of 645.<sup>1</sup>

### Senior Population

Long-term and home care services are largely (with some notable exceptions) utilized by seniors. The proportion of the population age 65 and over is increasing in New York State as in the rest of the country. While projections vary, it is safe to say that this trend is affecting Washington County as well. It is widely acknowledged that this change in the population will represent a significant burden on the health care system in the years to come. The capacity of the long-term care system will be stretched as demand for these services increases, and costs of providing these services is likely to grow significantly with demand. Other changes in the population, including an increase in the number of patients with dementia and with multiple, co-occurring chronic conditions, will place an additional strain on the system.

Efforts are being made, at local, state and federal levels to anticipate these changes and respond with approaches that will maximize patient outcomes while minimizing cost. This includes placing an emphasis on “lower” levels of care—those which allow patients to be treated in the least restrictive settings possible. Some health care policy makers feel that this approach represents better quality care, while also helping to keep costs down, since these lower levels of care may in some cases be less resource-intensive than care provided in long-term residential settings.

Regardless of the mix of services that will be needed in the coming years, these population changes will affect the ability of Washington County to provide adequate capacity of services for its senior population. The New

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<sup>1</sup> Washington County Community Health Assessment, 2010-2013.

York State Department of Health estimates that the County will need an additional 24 nursing home beds by 2016.<sup>2</sup> While population projections vary somewhat, we present those created by demographers at the Cornell Program on Applied Demographics in Table 1.

**Table 1: Projected Growth of Population 65 and Older, Washington County**

	2010		2020		2030	
	Total	Percent of Total	Total	Percent of Total	Total	Percent of Total
<b>Total Population</b>	62,332		62,057		60,136	
<b>65-74</b>	5,125	8%	7,118	11%	8,131	14%
<b>75-84</b>	2,958	5%	3,304	5%	4,541	8%
<b>85+</b>	1,388	2%	1,505	2%	1,702	3%
<b>65 and Older</b>	9,471	15%	11,927	19%	14,374	24%
<b>75 and Older</b>	4,346	7%	4,809	8%	6,243	10%
<b>85 and Older</b>	1,388	2%	1,505	2%	1,702	3%

Source: Cornell Program on Applied Demographics  
<http://pad.human.cornell.edu/counties/projections.cfm>

As illustrated in the table, over the next 20 years the population of residents age 65 and over is projected to increase by almost 5,000 (an increase of 52%), from 15% of the total population to about 24%. Within that subgroup, those 75 and older (the most significant subgroup in projecting need for long-term care) will increase by about 1,900 (+ 43%) from 7% of the population to 10%. Among those 85 and older—those expected to be most likely to need institutional care at that stage of their lives—projections suggest an increase of more than 300 (+23%) between now and 2030.

Projections are only that—projections—which can change dramatically as unforeseen events and realities intrude. But the number of elderly residents of the County will almost certainly be significantly higher over the next few years than it is now, and these increasing numbers will have significant implications for an array of long-term-care services for older citizens in the future. Within that, it is reasonable to conclude that there will continue to be a strong need for continuation of at least the current level of nursing home care in the County.

## Uncertainty of Funding Sources

The future of State and federal funding for long-term care in general, and nursing facilities in particular, is highly uncertain. There are significant indications that suggest strongly that New York State is creating disincentives for counties to continue to operate public nursing homes, and

<sup>2</sup> Estimates of RHCf Bed Need by County, [www.health.state.ny.us](http://www.health.state.ny.us).

that reimbursement and regulatory decisions are designed to discourage counties from investing in those facilities, or continuing in the business going forward. It remains to be seen whether a new administration in New York State will endorse or modify policy directions already in process or present new initiatives potentially more conducive to the future of public long-term care and nursing facilities, and their funding.

Some specific issues that remain uncertain for county nursing homes include:

- The status of reimbursement payments for new rebased Medicaid rates, effective back to April 1, 2009, that have not yet been paid, pending approval at the federal CMS level. The State Department of Health suggests that there should be no problem with the ultimate approval, but the fact remains that no payments have been made or suggested at the higher rebased levels, almost a year and a half after the new rates were supposedly to take effect.
- Even if the higher rebased rates do go into effect and result in retroactive additional payments, they will be undercut in part by the 1.1% across-the-board reduction to all Medicaid payments processed beginning September 16, 2010.
- Trend factors for future years on top of the rebased rates are likely to disappear, especially in light of the 1.1% Medicaid funding reductions.
- Regional pricing strategies have been proposed and discussed for some time, without resolution. It is not clear yet what impact this will have on specific homes. This is likely to be an area subject to further negotiation with the new Governor.
- It is not clear whether Intergovernmental Transfer (IGT) funds will be available in the future, and if so, for how long and in what amounts. Some long-term care stakeholders suggest that IGT funds will likely continue to flow, at least through 2011. Some expect the federal funding to continue at least until federal health care reforms begin to be fully implemented in 2014, with uncertainty after that. Others talk of phaseout beginning in 2012, while others expect the program to continue indefinitely. The uncertain makeup of the new Congress adds to the inability to anticipate decisions about IGT's future with any reasonable clarity. Clearly, any assumptions should be made cautiously; but as of now, there is no indication that IGT will cease to exist at any particular time, although the level of IGT funding remains uncertain. And even if IGT continues for the foreseeable future, it is important to note that payments are generally not received in the same year in which the funds are announced. Rather, there can be and typically is a significant lag time before funds are received at the county level.
- New York State will be taking over from the counties the administration of Medicaid functions, including the admission/approval process, over the next five years. This change will begin to go into effect as early as

April 2011 and will have implications for future decisions by the State and counties. But it is not likely to have any significant impact on overall Medicaid funding levels in the short term.

- The specter of what is likely to happen as a result of audits conducted by the NYS Office of the Medicaid Inspector General (OMIG) adds further uncertainty to assumptions about ongoing Medicaid funding and reimbursement patterns, and how well assumptions will hold up concerning what qualifies or not for reimbursement.

Certainly Washington or any county that is pondering its options, including consideration of staying in the public nursing home business, should be conservative in its assumptions about future non-County revenue sources.

## Unique Pressures on Publicly-Operated Long-Term and Home Care Services

Public nursing homes face difficult financial realities unique to the public sector, which have been made worse in recent years by the continuing increase in costs typically beyond the control of nursing home and public health administrators—primarily due to county- and state-negotiated increases in employee benefit costs, including the rising costs of health insurance and rapidly-escalating costs to the counties of paying into the public employee retirement/pension system.

Washington County is by no means alone in wrestling with issues related to the future of its publicly-operated nursing facility and related services. Counties throughout New York State are struggling with similar issues. To date, to CGR's knowledge, only Niagara County has decided to simply close its nursing home and walk away from the business completely, without even a sale of the facility. A handful of counties in recent years have sold their homes to other providers, and a few others are exploring the possibility of selling their nursing home to private non-profit or for-profit providers. Some counties have recently sold their CHHAs to other providers.

On the other hand, despite all the uncertainties about the future of county nursing homes, a number of counties have recently restated their commitments to the historic mission of their public homes, including in a few cases building new facilities, even if it means increases in future taxpayer subsidies to underwrite the operating costs of the facilities. Still other counties that as recently as a 2007 statewide study of county nursing homes expressed strong commitments to the future of their facilities are now raising questions about their future, in light of so many uncertainties about future funding support at the state and federal levels.

Reflecting the difficult and often emotional nature of the decision about whether to remain in the nursing home business, at least two and perhaps other counties are currently in the middle of highly confrontational public disagreements between executive and legislative branches of their governments concerning selling their public homes or finding other ways of continuing a public presence, including in one case building a new facility. These counties illustrate the intense and complex nature of the decisions concerning whether to continue with the public mission of nursing home provision, versus considering other ways of ensuring that the mission is carried out, but not necessarily under the public aegis.

## Local Health Care Environment

The Pleasant Valley Nursing Home, with its 122 beds, is one of four nursing homes located in Washington County. Fort Hudson Nursing Center, a not-for-profit provider in Fort Edward, has 196 beds and also has an adult day care program; Indian River Rehabilitation and Nursing Center, in Granville, has 122 beds, and the Orchard Nursing and Rehabilitation Center, also in Granville, has 88 beds. The latter two homes are for-profit operations.

Two adult homes in addition to Pleasant Valley (with its 33 beds) are located in Washington County: the Cambridge Guest Home, in Cambridge, with 34 beds, and Holbrook's Adult Home, in Granville, with 33 beds. Both are private proprietary adult homes.<sup>3</sup>

Washington County Public Health is the only operator of a certified home health agency, long-term home health care program and hospice in the County.

Glens Falls Hospital, located in neighboring Warren County, is the largest hospital in the local area. A hospital in Washington County, Mary McClellan Hospital, closed in 2003. Washington County residents also seek care in Saratoga and Albany counties, as well as in Vermont.

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<sup>3</sup> [http://www.health.state.ny.us/facilities/adult\\_care/county/washington.htm](http://www.health.state.ny.us/facilities/adult_care/county/washington.htm)

# CHAPTER III: DESCRIPTION OF CURRENT OPERATIONS – PLEASANT VALLEY

## Overview of all Pleasant Valley Services

### Overview

The Pleasant Valley facility, located in Argyle, New York, consists of a 122-bed skilled nursing facility (SNF or “Nursing Home”), 33-bed Adult Home, and 24-slot Adult Day Health Care Program (“Adult Day Care”). The presence of all three of these services creates a continuum of care not typically seen at the county level; Washington County is one of very few counties currently operating an adult home.

The facility’s mission statement is as follows:

“Pleasant Valley’s mission is to provide a coordinated network of resources to render personal and medical services to residents and their families.

Each Pleasant Valley staff member is committed to providing effective, timely and personalized service to residents and their families while promoting resident independence, choice and dignity.”<sup>4</sup>

### Campus

Pleasant Valley is located in a pleasant rural setting in Argyle, NY. While the campus dates back to the 1800s, when the County operated a poorhouse, the current configuration dates to 1970, when the two “traditional” nursing wings, one with 40 beds and the other with 42 beds, were opened. Both units were fully renovated in 2002. The 40 bed Alzheimer’s unit opened in 1999. The Adult Day Health Care Program is operated in the basement of the nursing home building. The 33-bed Adult Home is attached to the nursing home and was built in 2001.

### Administration and Staffing

A licensed nursing home administrator oversees the entire Pleasant Valley complex. Currently this position is filled on a part-time, temporary contract basis. Both the Adult Home and Adult Day Care program have directors who oversee day-to-day operations.

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<sup>4</sup> <http://www.co.washington.ny.us/Departments/Pv/Pv1.htm>

Physician care, and physical, occupational and speech therapies are provided through contracts with Glens Falls Hospital. Laundry services (with the exception of personal laundry) are also handled on a contract basis, as is dental care. Two contract agencies also provide backup nursing support as needed.

Housekeeping, dietary and maintenance functions are shared by all three components (NH, AH and ADC). The Adult Day Care Program makes some use of the contracted therapists that serve the nursing home, and transporters who are technically part of the Adult Day Care staff are shared by all three components.

CNAs and staff in the environmental and food services departments are all represented by the Teamsters Union. Nurses and administrative/clerical staff are not represented by a union.

Total staffing for Pleasant Valley is presented in Table 2.

**Table 2: Number of Staff, Pleasant Valley, 2010**

Department/Service	FT	PT	Total
<b>Nursing Home</b>			
Administration, Finance and IT Support	12	1	13
Nursing	87	30	117
Food Service	12	11	23
Environmental Services (Maintenance, Housekeeping, Laundry)	16	5	21
Other	3	0	3
<b>Total Nursing Home*</b>	<b>129</b>	<b>47</b>	<b>176</b>
<b>Adult Day Care</b>	<b>10</b>	<b>2</b>	<b>12</b>
<b>Adult Home</b>	<b>8</b>	<b>3</b>	<b>11</b>
<b>TOTAL PLEASANT VALLEY*</b>	<b>146</b>	<b>50</b>	<b>196</b>

\*One FT clerk is listed twice - this is a full time position shared by two departments within the nursing home. This position is represented as one FT position in the Total line.

Source: PVI Comptroller's Office

Of the 196 Pleasant Valley employees, 167 (85%) are Washington County residents. This proportion is consistent for both full-time and part-time employees.

## ***Enterprise Fund – Financial Status***

Pleasant Valley is organized as an Enterprise Fund of the County. It has a separate budget, is financed largely by reimbursement for services, and is, for accounting purposes, a separate entity from the County's General Fund.

### ***Fiscal Relationship to Washington County***

Some key exceptions to the independence of the Enterprise Fund involve transactions between the General Fund and the Enterprise Fund, specifically:

1. County Subsidy - transfers from the County's General Fund to the Enterprise Fund to cover operating losses. These are reflected in Enterprise Fund revenues.
2. Intergovernmental Transfers (IGT) – this Federal program to support public nursing homes requires the County to transfer an amount to New York State from the General Fund in order to receive a Federal dollar match that is then transferred to the Enterprise Fund. The County's transfer represents a 50% match (an enhanced rate in 2010 means the County currently has a 38% match, which will gradually increase to 50% in 2011) of Federal IGT funds, and the entire amount—the County match and the Federal portion—is ultimately transferred to the Pleasant Valley Enterprise Fund and cannot be recouped by the General Fund. In other words, neither the amount “fronted” by the County nor the Federal dollars received through the State come back to the General Fund. The IGT matching funds are not reflected in the Enterprise Fund expense budget, and therefore represent a form of “hidden cost” of operating Pleasant Valley.
3. Indirect Cost Allocation – The County's accountant assigns a set of indirect costs to various departments in the County, e.g., costs associated with County administration, payroll, IT, Human Resources, County Attorney, technical support, etc. Prior to 2008, the costs allocated to Pleasant Valley were booked as a revenue/“donation” to the Enterprise Fund. In the last two years, due to a healthier cash flow situation due to the influx of IGT funds, and to help offset various other County contributions to Pleasant Valley, this amount has been treated as a payment from the Enterprise Fund to the General Fund. This payment is viewed as helping to cover costs of services legitimately provided by County functions to Pleasant Valley.
4. Home Relief (also referred to as Safety Net) – Publicly-operated adult homes cannot accept Supplemental Security Income (SSI) payments. The County's Department of Social Services (DSS) pays 50% of the cost of care for all non-private pay Adult Home residents (i.e., typically SSI eligible). The other 50% is paid by New York State, funneled through the DSS portion of the County's General Fund. In recent years the County share of the amount paid by DSS has averaged almost \$450,000 per year. The total DSS payments (local + state share) are reflected in the Pleasant Valley Enterprise Fund as revenues to the Adult Home. However, the approximately \$450,000 county share of those payments are not shown as an expense against the Enterprise Fund, but are paid through DSS from the

County General Fund—and therefore represent another “hidden cost” of operating the Adult Home..

The above is intended to illustrate that the financial impact of Pleasant Valley is not limited to the net operating loss or gain of the Enterprise Fund or its components. Rather, the County makes significant contributions to maintain Pleasant Valley’s operations. Table 3 illustrates trends in these contributions over the last five years

**Table 3: Impact of Pleasant Valley Operations on County General Fund**

County Costs	2005	2006	2007	2008	2009	5 Year Total	5 Year Average
<b>County General Fund Appropriation (Subsidy)</b>	\$ 300,000	\$ 410,000	\$ 500,000	\$ 4,730	\$ -	\$ 1,214,730	\$ 242,946
<b>IGT Match</b>	\$ -	\$ -	\$ -	\$ 1,172,195	\$ 972,306	\$ 2,144,501	\$ 428,900
<b>Indirect Cost Allocation</b>	\$ 134,295	\$ 135,295	\$ 145,171	\$ (135,000)	\$ (261,107)	\$ 18,654	\$ 3,731
<b>SubTotal</b>	\$ 434,295	\$ 545,295	\$ 645,171	\$ 1,041,925	\$ 711,199	\$ 3,377,885	\$ 675,577
<b>DSS Contribution - Local 50% Match</b>	\$ 348,174	\$ 433,902	\$ 481,128	\$ 478,036	\$ 484,898	\$ 2,226,136	\$ 445,227
<b>Total Impact</b>	\$ 782,469	\$ 979,197	\$ 1,126,299	\$ 1,519,961	\$ 1,196,097	\$ 5,604,021	\$ 1,120,804

Note: CGR reviewed figures for the DSS Contribution that were provided by the Pleasant Valley Comptroller's Office and the Department of Social Services. Due to differences in accounting (i.e. when a payable was booked by DSS vs. when it was received by PVI), PVI's data exceeds DSS data by about \$268,000 over the 5 year period. We have used data from PVI here for the sake of consistency.

It is important to remember that the \$2.1 million in IGT matches in 2008 and 2009 generated more than twice that amount (more than \$4.8 million) in IGT revenues (see Table 4 below) that came directly to the Nursing Home during those two years—funds that would not have been available to the Home without the County matches. In fact, the generation of such IGT revenues made it possible for the Pleasant Valley Enterprise Fund to have sufficient surpluses in 2008 and 2009 that it required little or no direct County subsidies/contributions those years. Thus the IGT match portion of the County contribution to the Home can reasonably be viewed as an investment yielding a doubled return directly to the Home, and therefore has value different from a subsidy that is limited to filling a gap between expenses and other available revenues. However, from a County taxpayer and Supervisor perspective, these investments nonetheless do represent direct “hits” against the County’s General Fund and available tax resources in any year in which they are required.

The amount of the combined County contributions, and the fear that the amounts will continue to rise, has raised concerns about the implications for County taxpayers in the future. As indicated in Table 3, Washington County has made about \$5.6 million in direct or matching contributions to the entire Pleasant Valley complex, as described above, for the period between 2005 and 2009. This represents an average of about \$1.12 million per year over that period. The vast majority of those financial contributions (almost \$875,000 per year on average, or about 78% of the total contribution amount) reflects the “hidden” IGT and local DSS match costs not directly accounted for in the Pleasant Valley Enterprise Fund budget.

## Revenue and Expenses

Table 4 illustrates revenue and expenses in more detail for the Enterprise Fund over the last five years. Note that the data in the table do not reflect the “hidden cost” expenses of the IGT and local County DSS matches reflected in Table 3.

Table 4: Revenues and Expenses, Enterprise Fund, 2005-2009

	2005	2006	2007	2008	2009	5 Year Total	5 Year Average
<b>Operating Revenues</b>	<b>\$ 9,158,048</b>	<b>\$ 9,068,187</b>	<b>\$ 9,620,181</b>	<b>\$11,055,412</b>	<b>\$10,451,173</b>	<b>\$ 49,353,001</b>	<b>\$ 9,870,600</b>
<b>Patient Service Revenue</b>	<b>\$ 9,147,251</b>	<b>\$ 9,055,303</b>	<b>\$ 9,607,781</b>	<b>\$11,041,848</b>	<b>\$10,442,420</b>	<b>\$ 49,294,603</b>	<b>\$ 9,858,921</b>
<b>Inpatient</b>	<b>\$ 8,626,098</b>	<b>\$ 8,472,891</b>	<b>\$ 9,023,425</b>	<b>\$10,315,825</b>	<b>\$ 9,701,174</b>	<b>\$ 46,139,413</b>	<b>\$ 9,227,883</b>
<b>Outpatient</b>	<b>\$ 521,153</b>	<b>\$ 582,412</b>	<b>\$ 584,356</b>	<b>\$ 726,023</b>	<b>\$ 741,246</b>	<b>\$ 3,155,190</b>	<b>\$ 631,038</b>
<b>Other Operating Revenues</b>	<b>\$ 10,797</b>	<b>\$ 12,884</b>	<b>\$ 12,400</b>	<b>\$ 13,564</b>	<b>\$ 8,753</b>	<b>\$ 58,398</b>	<b>\$ 11,680</b>
<b>Vending Machine Commissions (Net)</b>	<b>\$ 10,797</b>	<b>\$ 12,884</b>	<b>\$ 12,400</b>	<b>\$ 13,564</b>	<b>\$ 8,753</b>	<b>\$ 58,398</b>	<b>\$ 11,680</b>
<b>Operating Expenses</b>	<b>\$10,457,893</b>	<b>\$10,341,611</b>	<b>\$10,899,963</b>	<b>\$12,869,665</b>	<b>\$12,346,099</b>	<b>\$ 56,915,231</b>	<b>\$11,383,046</b>
<b>Nonrevenue Support Services</b>	<b>\$ 4,444,074</b>	<b>\$ 4,498,490</b>	<b>\$ 4,746,192</b>	<b>\$ 7,259,488</b>	<b>\$ 6,384,474</b>	<b>\$ 27,332,718</b>	<b>\$ 5,466,544</b>
<b>Ancillary Service Revenue Centers</b>	<b>\$ 918,785</b>	<b>\$ 608,423</b>	<b>\$ 696,020</b>	<b>\$ 626,769</b>	<b>\$ 710,648</b>	<b>\$ 3,560,645</b>	<b>\$ 712,129</b>
<b>Program Services Revenue Centers</b>	<b>\$ 5,095,034</b>	<b>\$ 5,234,698</b>	<b>\$ 5,457,751</b>	<b>\$ 4,983,408</b>	<b>\$ 5,250,977</b>	<b>\$ 26,021,868</b>	<b>\$ 5,204,374</b>
<b>Operating Expenses Over Operating Revenues</b>	<b>\$(1,299,845)</b>	<b>\$(1,273,424)</b>	<b>\$(1,279,782)</b>	<b>\$(1,814,253)</b>	<b>\$(1,894,926)</b>	<b>\$ (7,562,230)</b>	<b>\$ (1,512,446)</b>
<b>Non-Operating Revenues</b>	<b>\$ 1,071,061</b>	<b>\$ 1,162,998</b>	<b>\$ 1,025,077</b>	<b>\$ 2,496,551</b>	<b>\$ 2,586,063</b>	<b>\$ 8,341,750</b>	<b>\$ 1,668,350</b>
<b>Total Income from Investments</b>	<b>\$ 21,136</b>	<b>\$ 30,312</b>	<b>\$ 23,303</b>	<b>\$ 19,055</b>	<b>\$ 20,862</b>	<b>\$ 114,668</b>	<b>\$ 22,934</b>
<b>Other Investment Income - Unrestricted</b>	<b>\$ 19,737</b>	<b>\$ 28,272</b>	<b>\$ 22,551</b>	<b>\$ 18,642</b>	<b>\$ 20,702</b>	<b>\$ 109,904</b>	<b>\$ 21,981</b>
<b>Other Investment Income - Restricted</b>	<b>\$ 1,399</b>	<b>\$ 2,040</b>	<b>\$ 752</b>	<b>\$ 413</b>	<b>\$ 160</b>	<b>\$ 4,764</b>	<b>\$ 953</b>
<b>Contributions from Other Funds</b>	<b>\$ 300,000</b>	<b>\$ 660,000</b>	<b>\$ 500,000</b>	<b>\$ 4,730</b>	<b>\$ -</b>	<b>\$ 1,464,730</b>	<b>\$ 292,946</b>
<b>Intergovernmental Transfers (I.G.T)</b>	<b>\$ 374,529</b>	<b>\$ 187,000</b>	<b>\$ -</b>	<b>\$ 2,344,390</b>	<b>\$ 2,531,389</b>	<b>\$ 5,437,308</b>	<b>\$ 1,087,462</b>
<b>Recruitment/Retention</b>	<b>\$ 106,650</b>	<b>\$ 128,605</b>	<b>\$ 129,603</b>	<b>\$ 21,896</b>	<b>\$ 9,509</b>	<b>\$ 396,263</b>	<b>\$ 79,253</b>
<b>Other</b>	<b>\$ 268,746</b>	<b>\$ 157,081</b>	<b>\$ 372,171</b>	<b>\$ 106,480</b>	<b>\$ 24,303</b>	<b>\$ 928,781</b>	<b>\$ 185,756</b>
<b>Total Revenues</b>	<b>\$10,229,109</b>	<b>\$10,231,185</b>	<b>\$10,645,258</b>	<b>\$13,551,963</b>	<b>\$13,037,236</b>	<b>\$ 57,694,751</b>	<b>\$11,538,950</b>
<b>Total Expenses</b>	<b>\$10,457,893</b>	<b>\$10,341,611</b>	<b>\$10,899,963</b>	<b>\$12,869,665</b>	<b>\$12,346,099</b>	<b>\$ 56,915,231</b>	<b>\$11,383,046</b>
<b>Excess of Total Revenues over Total Expenses</b>	<b>\$ (228,784)</b>	<b>\$ (110,426)</b>	<b>\$ (254,705)</b>	<b>\$ 682,298</b>	<b>\$ 691,137</b>	<b>\$ 779,520</b>	<b>\$ 155,904</b>

Note: 2006 Contributions from Other Funds is \$250,000 higher than the county subsidy amount that appears in Table 3. This reflects a cash loan from the County's General Fund received in that year.

Source: Cost Report, Part IV

Salaries and benefits make up the largest portion of expenses for the facility, averaging \$7.4 million a year between 2005 and 2009. The benefit level in that time period has averaged about 43% of salaries.

Based on available comparative data, Pleasant Valley's average salaries per hour are comparable to those of other nursing homes in the region, whether public, proprietary or public, even when functions that are

contracted at Pleasant Valley are excluded. For all cost centers, the overall regional average is \$16.57, compared to \$16.01 at Pleasant Valley.<sup>5</sup>

In Table 4, contributions from the County General Fund appear as revenues. The full payments from DSS (both local and state shares) for services in the Adult Home are included in Patient Service revenue, and IGT and the County subsidy for losses appear as non-operating revenues. In 2005-2007 the indirect cost allocation amount appears as an operating expense, and is also booked as a donation in non-operating revenue. In other words, in those years this amount does not affect the bottom line. But as noted above, in 2008 and 2009 this amount is included in operating expenses.

With these various sources of support from the County's General Fund, the Enterprise Fund shows a net gain or "surplus" for the total five year period of about \$779,000. With this positive financial picture, the Enterprise Fund has maintained a healthy Fund Balance, as shown in Table 5.

**Table 5: Enterprise Fund Balance, 2005-2009**

	2005	2006	2007	2008	2009
<b>Beginning of Year</b>	\$ 2,757,631	\$ 2,528,847	\$ 2,418,423	\$ 2,163,718	\$ 2,846,016
<b>Additions (Deductions)</b>	\$ (228,784)	\$ (110,426)	\$ (254,705)	\$ 682,298	\$ 691,137
<b>Transfers</b>	\$ -	\$ 2	\$ -	\$ -	\$ -
<b>Balance End of Year</b>	\$ 2,528,847	\$ 2,418,423	\$ 2,163,718	\$ 2,846,016	\$ 3,537,153

Source: Cost Report, Exhibit B

However, as emphasized above, it is misleading to only consider the Enterprise Fund in isolation—without also factoring in the "hidden costs" against the County General Fund, which are not captured in the Enterprise Fund but are incurred by the County. As noted earlier, *County support for Pleasant Valley, in the form of IGT and local DSS match amounts, have totaled more than \$4.37 million over five years. These amounts are detailed in Table 3. If these are subtracted from the \$779,520 five-year overall Enterprise Fund "surplus" shown in Table 4, a five-year "loss" of about \$3.59 million results—an average loss of about \$718,000 per year.*

Looked at another way, Table 6 illustrates the Enterprise Fund's Revenue and Expenses if County support in the form of the IGT match and the County subsidy had not been provided. This table assumes no County subsidy in any of the five years; prior to 2008 IGT is included, as no match was required from the County at that time, but in 2008 and 2009 the match from the County and the Federal match are excluded, as the Federal

<sup>5</sup> Fasttracker, 2008.

funds would not have been drawn down without the County match. Without these sources of support, the Enterprise Fund would have seen a net loss of nearly \$5,561,000 in the five-year period from 2005-2009—an average of about \$1.1 million per year, which the County presumably would have had to subsidize in its entirety. *In addition, the annual average of about \$445,000 local DSS match for the Adult Home would have to be added to that total, for an average annual cost to the County of about \$1.545 million per year, if the IGT payments had not been present.*

Table 6: Revenues and Expenses, Enterprise Fund, 2005-2009, Without County Support

	2005	2006	2007	2008	2009	5 Year Total	5 Year Average
Operating Revenues	\$ 9,158,048	\$ 9,068,187	\$ 9,620,181	\$11,055,412	\$10,451,173	\$49,353,001	\$ 9,870,600
Operating Expenses	\$ 10,457,893	\$10,341,611	\$10,899,963	\$12,869,665	\$12,346,099	\$56,915,231	\$11,383,046
Operating Expenses Over Operating Revenues	\$ (1,299,845)	\$ (1,273,424)	\$ (1,279,782)	\$ (1,814,253)	\$ (1,894,926)	\$ (7,562,230)	\$ (1,512,446)
Non-Operating Revenues	\$ 771,061	\$ 502,998	\$ 525,077	\$ 147,431	\$ 54,674	\$ 2,001,241	\$ 400,248
Total Income from Investments	\$ 21,136	\$ 30,312	\$ 23,303	\$ 19,055	\$ 20,862	\$ 114,668	\$ 22,934
Other Investment Income - Unrestricted	\$ 19,737	\$ 28,272	\$ 22,551	\$ 18,642	\$ 20,702	\$ 109,904	\$ 21,981
Other Investment Income - Restricted	\$ 1,399	\$ 2,040	\$ 752	\$ 413	\$ 160	\$ 4,764	\$ 953
Intergovernmental Transfers (I.G.T)	\$ 374,529	\$ 187,000	\$ -	\$ -	\$ -	\$ 561,529	\$ 112,306
Recruitment/Retention	\$ 106,650	\$ 128,605	\$ 129,603	\$ 21,896	\$ 9,509	\$ 396,263	\$ 79,253
Other	\$ 268,746	\$ 157,081	\$ 372,171	\$ 106,480	\$ 24,303	\$ 928,781	\$ 185,756
<b>Total Revenues</b>	<b>\$ 9,929,109</b>	<b>\$ 9,571,185</b>	<b>\$10,145,258</b>	<b>\$11,202,843</b>	<b>\$10,505,847</b>	<b>\$51,354,242</b>	<b>\$10,270,848</b>
<b>Total Expenses</b>	<b>\$ 10,457,893</b>	<b>\$10,341,611</b>	<b>\$10,899,963</b>	<b>\$12,869,665</b>	<b>\$12,346,099</b>	<b>\$56,915,231</b>	<b>\$11,383,046</b>
Excess of Total Revenues over Total Expenses	\$ (528,784)	\$ (770,426)	\$ (754,705)	\$ (1,666,822)	\$ (1,840,252)	\$ (5,560,989)	\$ (1,112,198)

Note: The DSS local share of revenue for the adult home has not been eliminated in this table, based on the assumption that as long as the County operates an adult home, this local share will be required.

## Revenue Sources

The majority of Patient Service Revenue across all three components of the Enterprise Fund is in the form of Medicaid reimbursements for care. In the five-year period from 2005-2009, 73% of resident and program participant revenues came from Medicaid. More detail about revenue sources is presented later in this report.

Table 7: Total Patient Service Revenue by Payer, 2005-2009

	2005	2006	2007	2008	2009	5 Year Total	Percent of Total
Medicaid	\$7,051,238	\$6,283,078	\$6,630,231	\$ 8,613,672	\$ 7,603,016	\$36,181,235	73%
Medicare	\$ 874,216	\$1,002,683	\$ 945,519	\$ 517,642	\$ 706,897	\$ 4,046,957	8%
Private Patient Revenue	\$1,180,562	\$1,678,292	\$1,929,025	\$ 1,752,543	\$ 1,860,976	\$ 8,401,398	17%
Other Patient Revenue	\$ 41,235	\$ 91,250	\$ 103,006	\$ 157,991	\$ 271,531	\$ 665,013	1%
<b>Total Revenue by Payer</b>	<b>\$9,147,251</b>	<b>\$9,055,303</b>	<b>\$9,607,781</b>	<b>\$11,041,848</b>	<b>\$10,442,420</b>	<b>\$49,294,603</b>	<b>100%</b>

Cost Report, Schedule 7

## Debt Service

Pleasant Valley has outstanding debt for two capital projects, the Alzheimer's Unit built in 1999 and the septic system. Table 8 shows both debt schedules. Including 2011, remaining debt obligations for the Septic Bond equal about \$476,000, and the remaining obligations for the Alzheimer's Unit total almost \$2.2 million—for total debt obligations of almost \$2.7 million. Septic Bond payments are scheduled through 2023; Alzheimer's Bond payments will be completed in 2018.

**Table 8: Pleasant Valley Debt Schedules**

Year	Septic Bond Principal and Interest Due	Alzheimer's Unit Principal and Interest Due	Total
<b>Paid to Date</b>	\$ 262,301	\$ 2,105,669	\$ 2,367,970
<b>2011</b>	\$ 37,406	\$ 282,788	\$ 320,193
<b>2012</b>	\$ 37,113	\$ 273,288	\$ 310,401
<b>2013</b>	\$ 37,405	\$ 288,194	\$ 325,599
<b>2014</b>	\$ 37,040	\$ 277,450	\$ 314,490
<b>2015</b>	\$ 37,260	\$ 266,650	\$ 303,910
<b>2016</b>	\$ 36,820	\$ 280,250	\$ 317,070
<b>2017</b>	\$ 36,357	\$ 268,188	\$ 304,544
<b>2018</b>	\$ 36,479	\$ 256,063	\$ 292,542
<b>2019</b>	\$ 36,552		\$ 36,552
<b>2020</b>	\$ 36,539		\$ 36,539
<b>2021</b>	\$ 35,866		\$ 35,866
<b>2022</b>	\$ 35,778		\$ 35,778
<b>2023</b>	\$ 35,597		\$ 35,597
<b>Total Remaining</b>	<b>\$ 476,210</b>	<b>\$ 2,192,869</b>	<b>\$ 2,669,079</b>

Source: Pleasant Valley Controller

## Skilled Nursing Facility

### Overview

Up to this point, we have focused on the entire Pleasant Valley facility and its three components. At this point the focus narrows to the largest of the facility's components—the 122-bed Skilled Nursing Facility (SNF). The Facility consists of a 40-bed Alzheimer's unit created in 1999, and two traditional nursing units, one with 42 beds and one with 40 beds.

### Staffing

The Nursing Home is overseen by an Administrator, who also has oversight over the Adult Home and Adult Day Care, although these programs have directors who handle day-to-day operations. Currently, the

facility Administrator position is filled on a part-time temporary basis by a contracted administrator.

The Nursing Home currently employs 129 full-time and 47 part-time staff. The large majority of these are in the Nursing Department—clinical staff involved in direct patient service. This Department is overseen by a Director of Nursing. The largest segment of this department is made up of 54 full-time and 14 part-time certified nurse aides (CNAs), and 17 full-time and 9 part-time licensed practical nurses (LPNs). Other staff in the department include an Assistant Director of Nursing, registered nurses, a quality assurance nurse, supervising nurses and head nurses. The department is also supported by an inservice training coordinator, a part-time typist and a clerk that is shared with another department. An activities director and two social workers also support the facility.

Additional functions within the facility are finance, IT, maintenance, dietary and housekeeping. All of these functions are considered staff assigned to the Nursing Home, but support not just the Home, but also the Adult Day Care and Adult Home.

A full list of Nursing Home staff appears in Table 9 on the next page.

Table 9: Nursing Home Staff, 2010

<b>Administration, Finance and IT Support</b>	<b>FT</b>	<b>PT</b>	<b>Total</b>
Administrator	1		1
Comptroller	1		1
Sr. Account Clerk	1		1
Account Clerk	3		3
Bookkeeper	1		1
Micro Computer Specialist	1		1
Sr. Clerk	1		1
Clerk*	1	1	2
Typist	2		2
<b>Subtotal</b>	<b>12</b>	<b>1</b>	<b>13</b>
<b>Nursing</b>			
Director of Nursing Services	1		1
Asst. Director of Nursing Services	1		1
Quality Assurance Nurse	1		1
Registered Nurse	5	5	10
Supervising Nurse	3	1	4
Head Nurse	3		3
Licensed Practical Nurse	17	9	26
Aides	54	14	68
Inservice Training Coordinator	1		1
Typist		1	1
Clerk*	1		1
<b>Subtotal</b>	<b>87</b>	<b>30</b>	<b>117</b>
<b>Food Service</b>			
Dietitian		1	1
Diet Technician	1		1
Asst. Cook	4		4
Cook	1		1
Supervisor Dietetic Services	1		1
Dietary Clerk	1		1
Food Service Helper	4	10	14
<b>Subtotal</b>	<b>12</b>	<b>11</b>	<b>23</b>
<b>Environmental Services (Maintenance, Housekeeping, Laundry)</b>			
Head Maintenance Mechanic	1		1
Building Maintenance Mechanic	3		3
Maintenance Helper		1	1
Maintenance Worker	1		1
Cleaner	7	4	11
Laundry Worker	3		3
Sr. Cleaner	1		1
<b>Subtotal</b>	<b>16</b>	<b>5</b>	<b>21</b>
<b>Other</b>			
Leisure Activities Director	1		1
Assistant Social Worker	2		2
<b>Subtotal</b>	<b>3</b>	<b>0</b>	<b>3</b>
<b>Total</b>	<b>129</b>	<b>47</b>	<b>176</b>

\*One FT clerk is listed twice - this is a full time position shared by two departments. This position is represented as one FT position in the Total line.

Source: PVI Comptroller's Office

### **Issues Related to Staffing**

The nursing home is affected by a nursing shortage in the region as a whole, although new hires made recently may make up some of the gap. Any shortage the facility does experience is exacerbated by the need to hold positions open for staff that are out on disability. Until an employee has been out for a year, his or her position cannot be filled. A shortage of staff at both the nursing and CNA level can lead to increased costs due to overtime and the need to bring in agency nurses, as well as disrupting continuity for residents. As of July, 2009, nurses can no longer be mandated to stay for a second shift if there is a staff shortage. Instead, the facility must use voluntary overtime, per diem nurses, or agency nurses. CNAs can be mandated to stay, on the other hand.

Between 2005 and 2009, the nursing home incurred an average of nearly \$300,000 per year in overtime costs. Also, from August 2009, when Pleasant Valley entered into agreement with contract agencies to provide supplemental nursing services to respond to the change in the regulations about nurse mandation, through October 2010, the facility has spent \$222,545 on contract agency nurses.

**Table 10: Nursing Home Overtime Costs, 2005-2009**

2005	2006	2007	2008	2009	5 Year Average
\$322,538	\$240,045	\$231,526	\$316,803	\$354,309	\$293,044

Source: PVI Comptroller's Office

According to comparative data, Pleasant Valley has a higher level of hours paid per occupied bed per year than other nursing homes in the Northeastern New York region, by about 120 hours for all cost centers (2,476 hours at Pleasant Valley compared to an average of 2,356), excluding those for which Pleasant Valley uses contracted services. A caution in interpreting data is that all hours are included for homes with multiple services and are not isolated to SNF services alone.

### **Occupancy Rates**

The SNF has consistently had an occupancy rate of 96% or above in the past five years, with a high of 99% in 2005 and a low of 96% in 2009.

**Table 11: RHCf Occupancy Statistics, 2005-2009**

	2005	2006	2007	2008	2009
<b>Admissions</b>	85	75	100	79	93
<b>Discharges</b>	81	77	101	78	91
<b>Total Patient Days</b>	43,878	43,751	43,334	43,272	42,896
<b>Occupancy Rate</b>	<b>99%</b>	<b>98%</b>	<b>97%</b>	<b>97%</b>	<b>96%</b>

Source: Cost Reports, Exhibit N

## County of Origin

The majority of residents in the SNF were originally Washington County residents. In the three years for which data are available, 70% of patients, on average, were Washington County residents, with an additional 13% from Warren County and 10% from Saratoga County.

**Table 12: Total Number of Patients by Place of Origin, 2005-2009**

	2005	2006	2007	Total	% of Total
Washington	92	83	76	251	70%
Warren	13	16	19	48	13%
Saratoga	8	12	17	37	10%
Rensselaer	3	2	0	5	1%
Albany	2	2	2	6	2%
Schenectady	2	3	3	8	2%
Essex	0	1	1	2	1%
<b>Total</b>	<b>120</b>	<b>119</b>	<b>118</b>	<b>357</b>	<b>100%</b>

Source: Cost Report Part I-10

## Admission Sources

More than two-thirds of SNF residents over the past five years have been admitted from a hospital, with another 15% admitted from home, and the remainder admitted from another residential health care facility or an adult care facility. Between 2005 and 2009, about 76% of the hospital admissions were from Glens Falls Hospital, in neighboring Warren County. About 65% of admissions from an Adult Care Facility were from the Pleasant Valley Adult Home.

**Table 13: Admission Sources, 2005-2009**

	2005	2006	2007	2008	2009	5 Year Total	Percent of Total
<b>Admissions (Total)</b>	<b>85</b>	<b>75</b>	<b>100</b>	<b>79</b>	<b>93</b>	<b>432</b>	<b>100%</b>
<b>From Hospital</b>	53	55	73	53	63	297	69%
<b>From Private Residence</b>	20	8	11	11	15	65	15%
<b>From Another RHFC</b>	10	2	7	9	6	34	8%
<b>From ACF</b>	2	10	9	6	9	36	8%

Source: Cost Report, Part I-5

As shown by comparing Tables 13 and 14 below, compared to statewide figures, Pleasant Valley has a considerably lower proportion of admissions coming from hospitals and a considerably higher proportion of admissions from private residences/homes than the average nursing home, regardless of ownership.

**Table 14: Admission Sources,  
Average of Non-NYC Nursing Homes, 2008**

Sponsor	Hospital	Home	RHCF	ACF	Other
<b>Public</b>	79.3%	6.4%	8.4%	4.1%	1.8%
<b>Proprietary</b>	89.8%	4.8%	2.2%	0.4%	1.7%
<b>Voluntary</b>	91.3%	4.1%	2.9%	0.6%	1.1%

Source: Fasttracker 2008

If Pleasant Valley were able to increase its proportion of more lucrative hospital admissions (reimbursed through Medicare at between \$140 and \$150 more per day, on average, than Medicaid admissions) by 10 percentage points per year, to just the average level of other non-NYC public nursing homes around the state, that would mean an average of about nine additional hospital admissions per year, based on average admissions over the past five years. With such significantly higher Medicare rates for typical hospital admissions, this could have significant revenue implications for the facility in the future.

## Discharges

**Table 15: Discharges, 2005-2009**

	2005	2006	2007	2008	2009	5 Year Total	Percent of Total
<b>Discharges (Total)</b>	81	77	101	78	91	428	100%
<b>To Hospital</b>	16	11	17	17	24	85	20%
<b>To Private Residence</b>	23	11	25	18	14	91	21%
<b>To Another RHFC</b>	1	1	7	2	2	13	3%
<b>To ACF</b>	0	10	16	10	6	42	10%
<b>Deaths (In-House)</b>	41	44	36	31	45	197	46%

Cost Report, Part I-5

About 46% of residents over the most recent five years whose Pleasant Valley SNF days were terminated died in the Nursing Home. Another 20% of discharges were to a hospital and about 21% to a private residence. About 95% of all hospital discharges were to Glen Falls Hospital; and about 92% of discharges to an adult care facility were to the Pleasant Valley Adult Home. These admission and discharge data together suggest that about a half dozen or so residents each year enter the Nursing Home from the Adult Home, with perhaps an additional one or two a year going from the SNF to the Adult Home.

A comparison of Tables 15 and 16 indicates that the discharge patterns in the PV Nursing Home are in contrast to nursing homes across the State, which have a much higher proportion of discharges to hospital and home, and far fewer in-house deaths.

Table 16: Discharges, Average of Non-NYC Nursing Homes, 2008

Sponsor	Total Discharges	To Hosp	To Home	To RHCf	To ACF	To OMH/ OMR/ Other	In-House Deaths	Transfer
<b>Proprietary</b>	342	38%	38%	4%	4%	10%	17%	15%
<b>Voluntary</b>	250	30%	31%	3%	3%	14%	35%	0%
<b>Public</b>	303	26%	43%	4%	5%	2%	25%	6%

Source: Fastracker, 2008

## Payer Mix

As indicated in Table 17, over the past five years, upon admission, 26% of PV Nursing Home residents were Medicaid eligible. Another 34% were on Medicare with supplemental private insurance and 25% were dual eligibles (Medicaid/Medicare). By contrast, as shown in Table 18, in public nursing homes across the State (outside NYC), only about 19% of residents were Medicaid eligible upon admission (even smaller proportions in voluntary and proprietary homes), with about 45% Medicare/private pay eligible. Across facility types, more than 20% are private pay upon admission, compared with 14% at Pleasant Valley. *These differences create substantial losses of initial income for PV, because of the initial higher private pay and Medicare reimbursement rates (see further discussion below).*

Table 17: Primary Payer at Admission

	2005	2006	2007	2008	2009	5 Year Total	% of Total
<b>Medicare/Private</b>	21	34	33	21	19	128	34%
<b>Medicare/Medicaid</b>	18	14	25	17	22	96	25%
<b>Private and Other</b>	6	7	16	9	16	54	14%
<b>Medicaid</b>	31	17	14	18	20	100	26%
<b>VA</b>	0	0	1	0	3	4	1%
<b>Total</b>	76	72	89	65	80	382	100%

Note: the numbers here may vary from number of admissions presented in Table 13. The numbers above include only new admissions, not readmissions.

Cost Report, Part I-8

Table 18: Primary Payer at Admission, Average of Non-NYC Nursing Homes, 2008

Sponsor	Total Admissions	Medicare/Private	Medicare/Medicaid	Private and Other	Medicaid	VA
<b>Public</b>	204	45%	19%	20%	19%	2%
<b>Proprietary</b>	263	48%	20%	22%	13%	5%
<b>Voluntary</b>	283	51%	21%	24%	12%	3%

Source: Fastracker 2008

Medicare and private insurances typically pay only for a short-term nursing home stay. Many of the patients who are covered under these

plans upon admissions, and need to stay longer, will ultimately become Medicaid eligible. Likewise, many private pay patients will exhaust their resources and become Medicaid eligible.

These factors, along with the high proportion of PV Nursing Home residents who enter the Home with Medicaid status from day one, result in the vast majority of resident days per year being paid for at lower Medicaid rates. As indicated in Table 19, in the five years between 2005 and 2009, 82% of resident days in the Nursing Home were paid by Medicaid. As shown in Table 20, this is slightly higher than the average 79% of Medicaid days in non-NYC public nursing homes across the state, and as can be expected, significantly higher than the proportion of Medicaid days in private and voluntary homes statewide.

**Table 19: Patient Days by Payer**

	2005	2006	2007	2008	2009	5 Year Total	Percent of Total
<b>Medicaid</b>	36,813	34,606	34,360	36,224	35,424	<b>177,427</b>	<b>82%</b>
<b>Medicare</b>	3,087	3,490	2,782	1,680	1,634	<b>12,673</b>	<b>6%</b>
<b>Medicare - Managed Care Provider</b>	0	0	259	120	395	<b>774</b>	<b>0%</b>
<b>Blue Cross</b>	0	0	0	0	49	<b>49</b>	<b>0%</b>
<b>Private Pay</b>	3,601	5,290	5,169	4,516	4,455	<b>23,031</b>	<b>11%</b>
<b>Veterans Administration</b>	377	365	399	366	939	<b>2,446</b>	<b>1%</b>
<b>Other</b>	0	0	365	366	0	<b>731</b>	<b>0%</b>
<b>Total</b>	<b>43,878</b>	<b>43,751</b>	<b>43,334</b>	<b>43,272</b>	<b>42,896</b>	<b>217,131</b>	<b>100%</b>

Source: Cost Report

**Table 20: Patient Days by Payer, Average of Non-NYC Nursing Homes, 2008**

Sponsor	Total Days	Medicaid FFS Days	Medicare Days	Mcare/Mcaid HMO Days	Private Pay Days	Private Ins Days	Other Days
<b>Proprietary</b>	51,593	70%	13%	4%	12%	2%	2%
<b>Public</b>	78,530	79%	7%	2%	10%	1%	2%
<b>Voluntary</b>	50,096	68%	11%	4%	17%	3%	3%

Source: Fastracker, 2008

## Revenue Sources

As indicated in Table 21, about 73% of SNF revenues at PV come from Medicaid. Even though about 82% of all annual resident days are paid for each year by Medicaid, because of the larger daily reimbursement rates paid by Medicare and private pay sources, Medicaid accounted for an average of 73% of revenues between 2005 and 2009, with private pay and

Medicare making up an additional 16% and 10%, respectively, because of their higher daily reimbursement rates.

Table 21: Nursing Home Patient Revenue by Payer, 2005-2009

	2005	2006	2007	2008	2009	5 Year Total	Percent of Total
<b>Medicaid</b>	\$ 5,866,460	\$ 4,910,545	\$ 5,203,595	\$ 7,098,336	\$ 6,158,220	<b>\$29,237,156</b>	<b>73%</b>
<b>Medicare</b>	\$ 865,367	\$ 970,958	\$ 893,534	\$ 480,120	\$ 665,349	<b>\$ 3,875,328</b>	<b>10%</b>
<b>Private Patient Revenue</b>	\$ 910,715	\$ 1,400,396	\$ 1,560,333	\$ 1,330,895	\$ 1,336,289	<b>\$ 6,538,628</b>	<b>16%</b>
<b>Other Patient Revenue</b>	\$ 41,235	\$ 91,250	\$ 103,006	\$ 157,991	\$ 271,531	<b>\$ 665,013</b>	<b>2%</b>
<b>Total Patient Revenue</b>	<b>\$ 7,683,777</b>	<b>\$ 7,373,149</b>	<b>\$ 7,760,468</b>	<b>\$ 9,067,342</b>	<b>\$ 8,431,389</b>	<b>\$40,316,125</b>	<b>100%</b>

Cost Report, Schedule 7

Reimbursement rates for private pay patients were \$280 per day in 2009, and have increased steadily over the last several years. Average Medicare daily rates have ranged between about \$290 and \$300 recently. By contrast, Medicaid rates are currently being booked and paid at \$152 per day, although the facility is anticipating a positive retroactive adjustment dating back to 2009. Uncertainty about when this adjustment will be received and how rates will change when and if the planned regional pricing methodology goes into effect has made it difficult to know how to project revenues for the coming year.

## Expenses

Costs per day in the PV Nursing Home are lower than the average of other nursing homes in the region, according to comparative cost data. Pleasant Valley's costs per day are nearly \$8 less than the average home in the region (\$188.57 versus an average of \$196.46).

## Quality of Care

The New York State Department of Health provides some information about quality of care in nursing homes. Between October 2009 and June 2010, Pleasant Valley performed worse than the State average on several measures, including the percentage of patients who are more depressed or anxious; have moderate or severe pain; have a catheter inserted and left inside the bladder; are physically restrained; have decreased ability to move about; have an increased need for help with daily activities; and who have urinary tract infections. The facility also had a higher than average percentage of patients who had pressure sores, delirium or moderate to severe pain during a short term stay.<sup>6</sup>

<sup>6</sup> [http://nursinghomes.nyhealth.gov/nursing\\_homes/quality/319](http://nursinghomes.nyhealth.gov/nursing_homes/quality/319)

More detailed indicators available internally indicate that there are opportunities for improvement in areas such as preventing falls, behavioral symptoms that affect others, and decline in range of motion, among others. Staff at Pleasant Valley have indicated that the availability of such data is providing an opportunity to address these areas and that action is being taken to do so.

## Revenue and Expenses

As indicated in Table 22, between 2005 and 2009, the Nursing Home component of the Pleasant Valley complex had an average of about \$8.1 million in operating revenues per year and almost \$9.4 million in operating expenses. Non-operating revenues, including County contributions and IGT payments, have made up the difference in the last two years, and have left the Nursing Home with a total net gain in those two years of more than \$2 million in the Enterprise Fund—and as a result, an average net gain across the most recent five years of about \$368,000 per year.

Table 22: Revenues and Expenses, Nursing Home, 2005-2009

	2005	2006	2007	2008	2009	5 Year Total	5 Year Average
<b>Operating Revenues</b>	<b>\$ 7,694,575</b>	<b>\$ 7,386,033</b>	<b>\$ 7,772,868</b>	<b>\$ 9,080,905</b>	<b>\$ 8,440,142</b>	<b>\$ 40,374,524</b>	<b>\$ 8,074,905</b>
Patient Service Revenue	\$ 7,683,778	\$ 7,373,149	\$ 7,760,468	\$ 9,067,341	\$ 8,431,389	\$ 40,316,126	\$ 8,063,225
Other Operating Revenues	\$ 10,797	\$ 12,884	\$ 12,400	\$ 13,564	\$ 8,753	\$ 58,398	\$ 11,680
Vending Machine Commissions (Net)	\$ 10,797	\$ 12,884	\$ 12,400	\$ 13,564	\$ 8,753	\$ 58,398	\$ 11,680
<b>Operating Expenses</b>	<b>\$ 8,826,243</b>	<b>\$ 8,571,367</b>	<b>\$ 8,954,973</b>	<b>\$10,465,097</b>	<b>\$10,056,980</b>	<b>\$ 46,874,660</b>	<b>\$ 9,374,932</b>
Operating Expenses Over Operating Revenues	\$(1,131,668)	\$(1,185,334)	\$(1,182,105)	\$(1,384,192)	\$(1,616,838)	\$ (6,500,136)	\$ (1,300,027)
<b>Non-Operating Revenues</b>	<b>\$ 1,071,061</b>	<b>\$ 1,162,998</b>	<b>\$ 1,025,077</b>	<b>\$ 2,496,551</b>	<b>\$ 2,586,063</b>	<b>\$ 8,341,750</b>	<b>\$ 1,668,350</b>
Total Income from Investments	\$ 21,136	\$ 30,312	\$ 23,303	\$ 19,055	\$ 20,862	\$ 114,668	\$ 22,934
Other Investment Income - Unrestricted	\$ 19,737	\$ 28,272	\$ 22,551	\$ 18,642	\$ 20,702	\$ 109,904	\$ 21,981
Other Investment Income - Restricted	\$ 1,399	\$ 2,040	\$ 752	\$ 413	\$ 160	\$ 4,764	\$ 953
Contributions from Other Funds	\$ 300,000	\$ 660,000	\$ 500,000	\$ 4,730	\$ -	\$ 1,464,730	\$ 292,946
Intergovernmental Transfers (I.G.T)	\$ 374,529	\$ 187,000	\$ -	\$ 2,344,390	\$ 2,531,389	\$ 5,437,308	\$ 1,087,462
Recruitment/Retention	\$ 106,650	\$ 128,605	\$ 129,603	\$ 21,896	\$ 9,509	\$ 396,263	\$ 79,253
Other	\$ 268,746	\$ 157,081	\$ 372,171	\$ 106,480	\$ 24,303	\$ 928,781	\$ 185,756
<b>Total Revenues</b>	<b>\$ 8,765,636</b>	<b>\$ 8,549,031</b>	<b>\$ 8,797,945</b>	<b>\$11,577,456</b>	<b>\$11,026,205</b>	<b>\$ 48,716,274</b>	<b>\$ 9,743,255</b>
<b>Total Expenses</b>	<b>\$ 8,826,243</b>	<b>\$ 8,571,367</b>	<b>\$ 8,954,973</b>	<b>\$10,465,097</b>	<b>\$10,056,980</b>	<b>\$ 46,874,660</b>	<b>\$ 9,374,932</b>
Excess of Total Revenues over Total Expenses	\$ (60,607)	\$ (22,336)	\$ (157,028)	\$ 1,112,359	\$ 969,225	\$ 1,841,614	\$ 368,323

Source: Cost Report, Part IV and PVI Comptroller

However, the apparent gains are somewhat illusory, and a reflection of additional revenues at the expense of the County General Fund. Specifically, the County has paid more than \$2.1 million in the five-year period to draw down IGT funds and has further subsidized the nursing home for a total amount of more than \$1.2 million in direct County subsidies (see Table 3). Thus, *the SNF five-year average “surplus” of about \$368,000 would become a net loss when County contributions and IGT matches of an average of about \$672,000 per year are factored in,*

leaving a net resulting average loss of roughly \$300,000 per year, with all Enterprise and non-Enterprise figures included.

Table 23 below illustrates how the Nursing Home's revenue and expenses would look without any County support. The table assumes no County contributions for 2005 – 2009, and assumes that without the County 'fronting' its IGT match to the State, IGT payments would not have been received in 2008 and 2009. Such a reality would leave the Nursing Home having faced annual deficits of about \$900,000 a year over the past five years.

Table 23: Revenues and Expenses without County Support, Nursing Home, 2005-2009

	2005	2006	2007	2008	2009	5 Year Total	5 Year Average
<b>Operating Revenues</b>	\$ 7,694,575	\$ 7,386,033	\$ 7,772,868	\$ 9,080,905	\$ 8,440,142	\$ 40,374,524	\$ 8,074,905
Patient Service Revenue	\$ 7,683,778	\$ 7,373,149	\$ 7,760,468	\$ 9,067,341	\$ 8,431,389	\$ 40,316,126	\$ 8,063,225
Other Operating Revenues	\$ 10,797	\$ 12,884	\$ 12,400	\$ 13,564	\$ 8,753	\$ 58,398	\$ 11,680
Vending Machine Commissions (Net)	\$ 10,797	\$ 12,884	\$ 12,400	\$ 13,564	\$ 8,753	\$ 58,398	\$ 11,680
<b>Operating Expenses</b>	\$ 8,826,243	\$ 8,571,367	\$ 8,954,973	\$10,465,097	\$10,056,980	\$ 46,874,660	\$ 9,374,932
Operating Expenses Over Operating Revenues	\$ (1,131,668)	\$ (1,185,334)	\$ (1,182,105)	\$ (1,384,192)	\$ (1,616,838)	\$ (6,500,136)	\$ (1,300,027)
<b>Non-Operating Revenues</b>	\$ 771,061	\$ 502,998	\$ 525,077	\$ 147,431	\$ 54,674	\$ 2,001,241	\$ 400,248
Total Income from Investments	\$ 21,136	\$ 30,312	\$ 23,303	\$ 19,055	\$ 20,862	\$ 114,668	\$ 22,934
Other Investment Income - Unrestricted	\$ 19,737	\$ 28,272	\$ 22,551	\$ 18,642	\$ 20,702	\$ 109,904	\$ 21,981
Other Investment Income - Restricted	\$ 1,399	\$ 2,040	\$ 752	\$ 413	\$ 160	\$ 4,764	\$ 953
Contributions from Other Funds	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Intergovernmental Transfers (I.G.T)	\$ 374,529	\$ 187,000	\$ -	\$ -	\$ -	\$ 561,529	\$ 112,306
Recruitment/Retention	\$ 106,650	\$ 128,605	\$ 129,603	\$ 21,896	\$ 9,509	\$ 396,263	\$ 79,253
Other	\$ 268,746	\$ 157,081	\$ 372,171	\$ 106,480	\$ 24,303	\$ 928,781	\$ 185,756
<b>Total Revenues</b>	\$ 8,465,636	\$ 7,889,031	\$ 8,297,945	\$ 9,228,336	\$ 8,494,816	\$ 42,375,765	\$ 8,475,153
<b>Total Expenses</b>	\$ 8,826,243	\$ 8,571,367	\$ 8,954,973	\$10,465,097	\$10,056,980	\$ 46,874,660	\$ 9,374,932
Excess of Total Revenues over Total Expenses	\$ (360,607)	\$ (682,336)	\$ (657,028)	\$ (1,236,761)	\$ (1,562,164)	\$ (4,498,895)	\$ (899,779)

Source: Cost Report, Part IV and PVI Comptroller

## Other Issues Related to the Skilled Nursing Facility

As described earlier in this report, funding sources for County nursing homes remain somewhat unpredictable, and the timing of payment of rate adjustments can make it difficult to project cash flow and budget revenues. For example, rate adjustments dating back to 2009 have not yet been received by Pleasant Valley, and regional pricing, the effects of which are unclear<sup>7</sup>, are set to go into effect in the middle of 2011, although this is by no means certain. These two issues alone make it difficult to determine

<sup>7</sup> Note that some stakeholders anticipate that Washington County will be a 'winner' as a result of the change to regional pricing – the outcome is likely to be determined by which region the County is placed in. If it is considered part of the same region as Albany, for example, where costs are likely to be higher, this could create a favorable rate structure for Washington County.

what reimbursement rates to use when budgeting, and whether to plan for a decreased rate due to regional pricing or a windfall if retroactive adjustments are received.

Regardless of these uncertainties, there may be some ways to maximize revenues. The County recently approved adding a position for an MDS Coordinator at Pleasant Valley. A new system of assessing patients (MDS 3.0) is now in place, and will have an effect on revenues in the nursing home. An MDS Coordinator would focus specifically on ensuring that patients are assessed accurately and that care is captured correctly in the MDS system, thus ensuring that reimbursement levels are kept at the highest level possible. The MDS reimbursement system will drive the way care is provided, and making the most of this will require thorough oversight. For example, because of the emphasis placed on rehab and therapy care, patients need to be receiving therapy starting on the first day they are admitted. This means that the home will need to be moving towards 7-day per week therapy. Such responses to the reimbursement system will need to be monitored and acted on in order to capture all revenues available to the home.

A dedicated screener at the local hospital may also help to maximize revenues<sup>8</sup>. Several stakeholders noted that the process of admitting a patient transferring from the hospital to nursing home care is lengthier at Pleasant Valley than in other facilities. Because of this, potential private pay and Medicare admissions may be lost to others. Determining Medicaid eligibility seems to be a particular problem. Pleasant Valley will not accept patients who are Medicaid-pending. Many individuals interviewed reported that it can take days or even weeks to determine whether a potential resident is Medicaid eligible. Not only does this mean that the potential resident may be filling an acute care bed in the meantime, but it also means that these people may be ‘snapped up’ by other nursing facilities. This exacerbates at least the perception, if not the reality, that Pleasant Valley “takes the patients no one else wants.” Various suggestions have been made in our interviews to make the PV Nursing Home less cautious and somewhat more aggressive in accepting residents within reasonable risk or tolerance levels, with potential enhanced revenue-generating implications. Such opportunities could be fleshed out in more detail if the County opts to proceed to a second phase of this project.

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<sup>8</sup> Public health currently has a liaison at Glens Falls who screens potential home care patients. This individual assists with screening for Pleasant Valley as well, but her priority is the Public Health programs.

Data management affects both the ability to maximize revenue as well as productivity within the home. Pleasant Valley's current data management systems leave significant room for improvement. The home currently has separate software systems for billing and clinical functions, and the two are not mutually supportive. As a result, a great deal of time is spent on data entry, often inefficiently, and important data about services and functions provided, that should be linked to revenue generation, are not always documented. Some individuals we interviewed noted that the culture of the nursing home is often one of resistance to change, and that efforts to increase automation of clinical and billing functions have been stymied by this culture. Some also noted that staff time is not allocated properly as related to data entry. There are currently no ward clerks dedicated to each unit, which may result in nurses being responsible for data entry – this is seen by some as an inefficient use of nurses' time.

Billing practices also contribute to inefficiencies. Procedures are typically manual rather than electronic, and staff in the business office are not cross-trained, which has led to significant delays in billing when one employee is out for periods of time. A greater degree of cross-training and enhanced technology seems vital to ensuring that billing is done in a timely fashion. Without staff that are able to fill in for each other, the facility faces the risk of losing a great deal of knowledge if any staff in the business office retires.

Perceptions of the Nursing Home vary. On the one hand, the home is described as a mission-driven operation valued by a community that has always known the facility as part of the County. Many community residents have had many family members cared for at Pleasant Valley, and have seen the home evolve over the years. On the other hand, some feel that while the home is needed it is not necessarily the role of the County to operate it, and that a private operator may be able to institute efficiencies that would make the home less costly.

## Adult Home

### Overview

The Pleasant Valley Adult Home serves residents who do not need skilled nursing or other medical assistance, but do require some supervision with activities of daily living. The Adult Home has 33 beds, in a building attached to the Nursing Home.

### Staffing

The Adult Home is overseen by a Director who is also a nurse, who reports to the Pleasant Valley Administrator and handles the day-to-day operations of the Adult Home. Resident services are provided by personal care aides (PCAs), who distribute medication and meals, engage in

activities and field trips with residents and provide other personal care services.

**Table 24: Adult Home Staffing, 2010**

	FT	PT	Total
Director/LPN	1		1
Aides	7	2	9
Typist		1	1
<b>Total</b>	<b>8</b>	<b>3</b>	<b>11</b>

Source: PVI Comptroller's Office

## Occupancy

Between 2005 and 2009 the Adult Home had an average occupancy rate of 94%.

**Table 25: Adult Care Facility, Occupancy Rates, 2005-2009**

	2005	2006	2007	2008	2009	5 Year Total
<b>Admissions</b>	26	9	14	10	15	<b>74</b>
<b>Discharges</b>	23	12	11	9	10	<b>65</b>
<b>Patient Days</b>	11,261	11,024	11,509	11,291	11,785	<b>56,870</b>
<b>Patient Days</b>	<b>93%</b>	<b>92%</b>	<b>96%</b>	<b>94%</b>	<b>98%</b>	<b>94%</b>

Cost Report, Exhibit N

Adult Home residents are primarily referred by family members, although some come through the Department of Social Services and some transition from the Nursing Home, as noted above. About half of all adult home residents discharged between 2005 and 2009 were discharged to the PV Nursing Home (an average of about seven residents per year), with other destinations including home and hospital. Thus the Adult Home and the Nursing Home have clearly made exchanges back and forth to some extent over the years, suggesting that the intended continuum of care focus has had at least modest success regarding making referrals and placements in both directions.

Adult Home residents have two sources of payment—private pay or “home relief.” Since publicly-operated adult homes cannot accept SSI payments, residents who would otherwise be eligible for SSI receive support from the County, which covers 50% of costs, and the State, which covers the remaining 50%. Between 2005 and 2009, about 52% of patients were private pay on admission.

## Financial Analysis

Revenue over Expenses in the Adult Home varied widely between 2005 and 2009, as shown in Table 26, with the greatest loss, of \$227,768 in 2008, and a high net gain of \$62,927 in 2006. The total for the five-year

period shows a cumulative loss of about \$290,000 (an average of about \$58,000 per year). However, this does not reflect the additional impact on the County General Fund, where County home relief payments through the Department of Social Services, discussed above, are shown as an expense. These payments have totaled more than \$2.2 million in the five year period—an average of about \$445,000 per year. Thus, with these “hidden” costs added, the Adult Home average “loss” would be just over a half a million dollars a year.

**Table 26: Adult Home - Revenue Over Expenses, 2005-2009**

	2005	2006	2007	2008	2009	5 Year Total	5 Year Average
Revenue	\$ 942,321	\$1,099,742	\$1,262,956	\$1,248,483	\$1,269,785	<b>\$5,823,286</b>	<b>\$1,164,657</b>
Expenses	\$1,011,852	\$1,036,815	\$1,214,779	\$1,476,251	\$1,374,932	<b>\$6,114,629</b>	<b>\$1,222,926</b>
<b>Revenue over Expenses</b>	<b>\$ (69,531)</b>	<b>\$ 62,927</b>	<b>\$ 48,177</b>	<b>\$ (227,768)</b>	<b>\$ (105,147)</b>	<b>\$ (291,343)</b>	<b>\$ (58,269)</b>

Source: Cost Report, Stepdown Analysis

## *Other Issues Related to the Adult Home*

During the course of our study, discussions about a possible closure or sale of the Adult Home have been discussed in the local media, and both staff and family members are concerned about the future of their jobs and about the future care of residents. The home has little turnover and it has been suggested that staff in the home are strongly dedicated to residents and to creating a homelike atmosphere. A major concern in terms of a possible closure is the ability to transfer patients to other appropriate settings. There does not appear to be a significant available capacity in other local adult homes, and few residents would appear to be eligible for nursing home-level care. Transfer of ownership could be a lengthy process and would presumably need to be done with sensitivity to needs of residents and staff and in the context of how such a decision would impact on other possible options regarding the PV facility and Public Health functions..

Another issue that has been raised is that the Adult Home is physically part of the nursing facility, and utilities, maintenance, housekeeping and laundry functions are shared. Several stakeholders have noted that any changes in the Adult Home would only make sense in the context of changes to the entire facility or possibly in the context of a lease to another operator, with Pleasant Valley providing such functions to the operator on a shared services basis.

## **Adult Day Health Care**

### *Overview*

Adult Day Health Care (ADC) provides services to adults with functional impairments who do not need 24-hours-a-day nursing services. The

program provides services for participants during the day. Usually, a participant is brought in by an informal caregiver who cares for the participant at home but is unable to do so during the day, or at least on certain days. In other cases, the social and medical services provided may simply be in the participant's best interests, regardless of whether the informal caregiver is available to provide care during the day or not. A few of the participants live in the PV Adult Home. Participants are 18 years of age and older, and attend the program between one and five days a week, depending on needs. The ADC is currently run in the Nursing Home, and has a licensed capacity of 24 slots available.

All ADC programs by definition must be operated by nursing homes. The programs provide medically supervised services for individuals with various physical and mental impairments, as well as personal care, various activities, supervision and such services as are deemed appropriate for the participants in a community-based setting. The health care services and activities are designed for a group of registrants with various functional impairments to help them maintain their health status and enable them to continue to live in the community without becoming institutionalized.

## Staff

The Adult Day care is overseen by a Director who reports to the Pleasant Valley Administrator. One LPN and five CNAs provide patient services. The program is also supported by a secretary and two full-time and two part-time transporters. Transporters pick up and drop off participants and also take participants to medical appointments. One of the full-time and one of the part-time transporters are shared with the Nursing Home and the Adult Home.

**Table 27: Adult Day Care Staffing, 2010**

	FT	PT	Total
Program Director	1		1
Licensed Practical Nurse	1		1
Aides	5		5
Transport Aide FT/PT	2	2	4
Typist	1		1
<b>Total</b>	<b>10</b>	<b>2</b>	<b>12</b>

Source: PVI Comptroller's Office

## Attendance Rate

The program is licensed to serve up to 24 people per day (technically it can exceed the capacity on any given day by 10%, as long as that doesn't become the pattern. So the program can and does have more than 24 registrants. Over the past six years (including the first three quarters of 2010), an average of 30 registrants have been enrolled in the program. On a typical day, 19 or 20 are usually in attendance. In the last six years, the

average attendance rate (the percent of possible available days actually attended) has been 80%.

**Table 28: Adult Day Care Attendance History, 2005-2010**

	2005	2006	2007	2008	2009	2010 (as of 9/30)	6 Year Average
<b>Average Number of Registrants</b>	29	29	31	31	31	31	30
<b>Average Number of Registrants per Day</b>	19	19	19	18	19	20	19
<b>Average Attendance Rate</b>	78%	79%	80%	79%	82%	81%	80%

Source: Adult Day Care

## *Payer Status*

The primary payer source for the ADC is Medicaid. Between 2007 and 2010, 90% of registrants had Medicaid as their primary payer.

**Table 29: Proportion of Registrants Attending by Payer, 2007-2009**

Payer	2007	2008	2009	2010 (as of 7/30)	4 Year Average
<b>Private</b>	9%	2%	8%	9%	7%
<b>Medicaid</b>	83%	95%	91%	90%	90%
<b>VA</b>	0%	0.3%	1%	2%	1%
<b>Hill Burton</b>	8%	3%	0%	0%	3%

Source: Adult Day Care Program

## *Payer Rates*

As of January 1, 2009 all adult medical day care programs have been moved from a budget-based reimbursement to a cost-based reimbursement methodology. In 2008, the Adult Day Health Care Council surveyed members that had already moved to a cost-basis and found that on average, their rates had been reduced by about 20%. While the effect of the change on the Pleasant Valley Adult Day Care program is not yet clear, as rates from 2009 have not been adjusted retroactively yet, there is a fear that the program will lose money as a result. The new rates are calculated based on costs to run the program at a 90% occupancy rate. This means that a program running at a lower occupancy rate may not capture adequate reimbursement to cover costs. As a result, a proposal has been promoted to lower the capacity from 24 to 20, in order to make it easier to easily meet the 90% attendance rate on a regular basis, thereby presumably becoming more fiscally viable.

## Financial Analysis

The ADC has shown a loss in each of the 5 years between 2005 and 2009, with a total cumulative five-year loss of about \$770,000, an average of about \$155,000 per year.

**Table 30: Adult Day Care, Revenue Over Expenses, 2005-2009**

	2005	2006	2007	2008	2009	5 Year Total	5 Year Average
<b>Revenue</b>	\$521,152	\$ 582,412	\$ 584,357	\$ 726,024	\$ 741,246	\$ 3,155,191	\$ 631,038
<b>Expenses</b>	\$619,798	\$ 733,429	\$ 730,211	\$ 928,317	\$ 914,187	\$ 3,925,942	\$ 785,188
<b>Revenue over Expenses</b>	\$ (98,646)	\$(151,017)	\$(145,854)	\$(202,293)	\$(172,941)	\$ (770,751)	\$ (154,150)

Source: Pleasant Valley Controller

Officials are hoping that modifying the number of slots from 24 to 20 will create the potential for reducing the net costs by increasing the revenues and thereby hoping to eventually break even or yield financial “surpluses” for the program.

## Other Issues Related to the Adult Day Health Care Program

The changing reimbursement method appears to be the impetus for reducing the number of licensed slots for the program, not a change in perceived need for the program. If numbers in attendance each day remain as they have consistently in the past, the targeted 90% attendance should be readily achieved.

The program’s available space creates crowded conditions any time when attendance approaching 25 or more is reached, as not all registrants in those circumstances can fit comfortably around the program table. If lowered capacity also creates fewer instances of crowded conditions, so that all in attendance can comfortably fit within the existing space, that could be an added benefit of the change.

## CHAPTER IV: DESCRIPTION OF CURRENT OPERATIONS – HOME CARE SERVICES

The Washington County Public Health Department offers three home care services: a Certified Home Health Agency (CHHA), a Long Term Home Health Care Program (LTHHCP), and Hospice. Each of them was included in the County's original RFP to be reviewed and described in this first phase of the project.

Like County-operated nursing homes, public home care services face unique challenges, and many programs across the State are facing serious threats to their financial viability. In a recent study by the New York Association of Homes and Services for the Aging (NYAHS) and Home Care Association of New York State (HCANY), two-thirds of certified home health agencies surveyed had operating losses in 2007. Of County-operated CHHAs, 75% had operating losses. Some public health CHHAs have recently been sold to other providers. Long Term Home Health Care Programs experiencing operating losses increased by 65% from 2004 to 2007.<sup>9</sup> Funding sources are often inadequate and future rates are uncertain; increasing Medicare audit activity is an additional pressure on agencies, increasing the rate of denials and increasing the amount of administrative time needed to respond to audits and denials.

Within Washington County, the Public Health Department has attempted to deal with these and other management and fiscal realities by increasingly focusing on cross-training, expanded computerized electronic operations, organizational restructuring and right-sizing, aggressive management practices, a flattened organizational administrative structure, increased efficiencies on a variety of fronts, and various efforts to increase billing efficiencies and revenue generation.

### Certified Home Health Agency

The Washington County CHHA, with a mission “to enhance the quality of life through the delivery of compassionate and cost effective health care at home by skilled professionals continuously striving for excellence,” provides a variety of services to homebound patients who do not need and/or qualify for skilled nursing care in an institutional setting. The CHHA provides skilled nursing, home health aides, physical, speech and

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<sup>9</sup> [http://www.hca-nys.org/press\\_releases/documents/HCANYAHSALethalDosesReport09.pdf](http://www.hca-nys.org/press_releases/documents/HCANYAHSALethalDosesReport09.pdf)

occupational therapy, a nutritionist, medical social worker and personal care services.

## Staffing

All three home care services are overseen by the Public Health Assistant Director. This reflects reductions in administrative/supervisory positions within the agency over time. This position is shown in Table 31 of CHHA staff, and not shown again in tables related to hospice and the long term home health care program that will be presented later in this report.

**Table 31: CHHA Staffing, 2006-2011**

	2006	2007	2008	2009	2010	2011 (Budgeted)
<b>Assist. Director*</b>	1	1	1	1	1	1
<b>Clerical</b>	8	6	7	6	6	6
<b>Supervision</b>	5	5	5	5	5	5
<b>RN On Call/PT/PD</b>	7	6	6	9	6	5
<b>RN Full Time</b>	15	15	15	14	13	13
<b>LPN</b>	4	3	3	3	2	2
<b>Home Health Aide</b>	9	5	6	5	4	3
<b>Physical Therapist</b>			2	2	2	2
<b>Total</b>	<b>49</b>	<b>41</b>	<b>45</b>	<b>45</b>	<b>39</b>	<b>37</b>

\* The Assistant Director listed here oversees the CHHA, LTHHCP and Hospice Programs.

Source: Washington County Public Health

Since 2006, total staff in the CHHA has decreased about 20% from 49 positions to 39. The major decrease has been in home health aides, from 9 in 2006 to 4 in 2010, with only 3 positions budgeted for 2011. Several positions are interchangeable with hospice and long term home health care service provision, as the agency works to provide services as cost effectively as possible.

Two-thirds of the CHHA staff are residents of Washington County.

Registered nurses in the CHHA are represented by the New York State Nurses' Association (NYSNA) Union. Home Health Aides are represented by CSEA.

## Service Volume

### Total Patients

Between 2005 and 2009, the CHHA served an average of 1,418 patients each year, with more served in each of the last two full years than in previous years. For the first three quarters of 2010, the total numbers served is about the same (seven fewer) as at the same time last year. The numbers served were down by about 90 cases during the first six months, before a rally in the third quarter. *However, the more disturbing trend is that the numbers of Medicare cases, traditionally the more financially*

remunerative for the agency, were down by 43 (-8%) during the first quarter of 2010, and Managed Medicare cases were down by 10 (also an 8% reduction), while lower-paying Medicaid cases and cases for which a single visit was made at no charge, resulting in a determination not to open the case for various reasons, were both up—by 26 (12%) and 19 (28%), respectively).

**Table 32: Total CHHA Patients, 2005-2009**

	2005	2006	2007	2008	2009	5 Year Average
<b>Unduplicated Patient Count</b>	1323	1357	1420	1509	1480	1418

Source: Washington County Public Health

### Total Visits

CHHA staff made an average of more than 30,000 visits to these patients per year between 2005 and 2009. The majority of CHHA services are paid by Medicare; as shown in Table 33, about 61% of all visits over the last 5 years were paid by Medicare. Visits began to trend slightly downward in 2009, but have dropped more precipitously during the first three quarters of 2010, by almost 3,800, a 16% reduction from the same time last year.

**Table 33: CHHA Program Statistics - Total Visits/Hours by Payer, 2005-2009**

	2005	2006	2007	2008	2009	5 Year Total	5 Year Average
<b>Medicare</b>	18,772	18,415	19,339	18,527	17,412	<b>92,465</b>	<b>18,493</b>
<b>Medicaid</b>	5,606	5,640	5,148	4,832	4,647	<b>25,873</b>	<b>5,175</b>
<b>Other</b>	3,923	4,526	6,996	9,012	8,800	<b>33,257</b>	<b>6,651</b>
<b>Totals</b>	<b>28,301</b>	<b>28,581</b>	<b>31,483</b>	<b>32,371</b>	<b>30,859</b>	<b>151,595</b>	<b>30,319</b>

CHHA Cost Report, Schedule S-1

As indicated in Table 34, almost half (47.5%) of all visits were nursing visits, followed by physical therapy and home health aide visits. The number of visits per nurse per day has consistently averaged about 3.6 or 3.7 each of the past several years across the home care units.

**Table 34: CHHA Visits/Hours by Type of Service, 2005-2009**

	2005	2006	2007	2008	2009	5 Year Total	5 Year Average
<b>Nursing - General</b>	14,159	13,285	14,666	15,364	14,610	<b>72,084</b>	<b>14,417</b>
<b>Physical Therapy</b>	7,215	8,498	9,467	8,399	7,890	<b>41,469</b>	<b>8,294</b>
<b>Speech Pathology</b>	207	122	120	86	281	<b>816</b>	<b>163</b>
<b>Occupational Therapy</b>	451	502	896	1,176	1,195	<b>4,220</b>	<b>844</b>
<b>Home Health Aide Visits</b>	6,198	6,104	6,225	7,095	6,557	<b>32,179</b>	<b>6,436</b>
<b>Medical Social Service</b>	71	70	109	251	326	<b>827</b>	<b>165</b>
<b>Totals</b>	<b>28,301</b>	<b>28,581</b>	<b>31,483</b>	<b>32,371</b>	<b>30,859</b>	<b>151,595</b>	<b>30,319</b>
<b>Home Health Aide Hours</b>	8,164	7,623	7,653	8,972	7,994	<b>40,406</b>	<b>8,081</b>

CHHA Cost Report, Schedule S-1

## Medicare Episodes

Medicare pays for most CHHA services by episodes of care, encompassing varying numbers of visits needed per episode. Medicare patients in the CHHA received an average of 978 episodes of care between 2005 and 2009. These episodes accounted for more than 18,000 visits by CHHA staff each year on average (see Table 33).

**Table 35: CHHA Episodes, 2005-2009**

	2005	2006	2007	2008	2009	5 Year Average
<b>Full Episodes without Outliers</b>	829	750	828	797	755	792
<b>Full Episodes with Outliers</b>	30	32	28	15	15	24
<b>LUPA Episodes</b>	111	138	172	97	150	134
<b>PEP Only Episodes</b>	18	17	13	17	18	17
<b>SCIC within a PEP</b>	1					1
<b>SCIC Only Episodes</b>	23	10	24			19
<b>Total</b>	1012	947	1065	926	938	978

Source Medicare Cost Report - Part IV - PPS Activity Data

Table 35 above illustrates that payment depends partly on the number of visits a patient receives. An average of 134 patients per year in the last five years had a low number of visits. These episodes are referred to as Low Utilization Payment Adjustments (LUPA) and are paid per visit rather than by episode, typically at a financial disadvantage to the CHHA, given that much lower rates are paid for LUPA visits than for full episodes. Additional amounts are paid for outlier episodes, in which a high need patient requires a high number of visits within an episode. Full episodes, with and without outliers, have been down slightly in 2008 and 2009 from earlier peaks.

The overall reduction in visits, and particularly the reduction in Medicare cases, is of significant concern to Public Health leadership. A few reasons for this have been suggested. One is an increasing reluctance on the part of patients to accept home care when increasing copayments are required; another is that in a poor economy people may choose to forgo elective surgeries that would normally be followed by the need for home care. Increasing regulatory activities are also leading to increasing numbers of cases being denied. The Public Health staff are beginning to aggressively develop strategies to counter these developments.

## Referral Sources

The majority of CHHA patients between 2005 and 2009 (53%) were referred to the CHHA by a hospital. Physicians referred another 23%, and 13% were referred by nursing homes.

Table 36: CHHA Referrals, 2005-2010

CHHA	2005	2006	2007	2008	2009	2010 (as of 10/31/10)	2005-2009 Total	Percent of Total
Hospital	790	775	833	914	962	863	5,137	53%
Physician	411	408	458	406	274	245	2,202	23%
Adult Home	11	21	9	6	7	2	56	1%
Self/Family/Friend	32	43	48	48	27	19	217	2%
Long Term	1	-	1	-	6	-	8	0.1%
Health Center	1	-	17	6	23	-	47	0.5%
Other Agency	86	26	24	5	51	72	264	3%
Other CHHA	-	2	2	6	2	-	12	0.1%
Other Comm Agency	-	112	88	121	93	86	500	5%
Other Institutions	-	14	5	2	3	3	27	0.3%
Rehab	2	-	-	-	-	-	2	0.0%
Nursing Home	228	176	205	223	210	195	1,237	13%
<b>Total</b>	<b>1,562</b>	<b>1,577</b>	<b>1,690</b>	<b>1,737</b>	<b>1,658</b>	<b>1,485</b>	<b>9,709</b>	<b>100%</b>

Source: Washington County Public Health

## Financial Analysis

The CHHA has seen a surplus of revenue over expenses in each of the five years between 2005 and 2009, ranging from a high of more than \$350,000 in 2006 and a low of about \$133,000 in 2009. *The average “surplus” of about \$229,000 has helped subsidize operating costs of providing other key public health functions over the years.*

Table 37: CHHA Revenues and Expenses, 2005-2009

	2005	2006	2007	2008	2009	5 Year Total	5 Year Average
Operating Revenue	\$ 3,342,376	\$ 3,671,502	\$ 3,792,518	\$ 4,052,192	\$ 4,021,251	\$ 18,879,839	\$ 3,775,968
Total Patient Service Revenue	\$ 3,143,776	\$ 3,350,658	\$ 3,537,585	\$ 3,894,206	\$ 3,844,809	\$ 17,771,034	\$ 3,554,207
Other Operating Revenues	\$ 198,600	\$ 320,844	\$ 254,933	\$ 157,986	\$ 176,442	\$ 1,108,805	\$ 221,761
State Aid	\$ 71,526	\$ 163,859	\$ 123,496	\$ -	\$ -	\$ 358,881	\$ 71,776
2007 Retroactive Adjustment	\$ -	\$ -	\$ -	\$ 26,112	\$ -	\$ 26,112	\$ 5,222
Indirect services from County	\$ 127,074	\$ 156,985	\$ 131,437	\$ 131,874	\$ 176,442	\$ 723,812	\$ 144,762
<b>Operating Expense</b>	<b>\$ 3,075,523</b>	<b>\$ 3,318,695</b>	<b>\$ 3,588,268</b>	<b>\$ 3,863,417</b>	<b>\$ 3,888,171</b>	<b>\$ 17,734,074</b>	<b>\$ 3,546,815</b>
Nursing - General	\$ 1,871,968	\$ 1,973,019	\$ 2,175,497	\$ 2,327,407	\$ 2,351,168	\$ 10,699,059	\$ 2,139,812
Physical Therapy	\$ 697,604	\$ 811,331	\$ 883,592	\$ 892,129	\$ 880,032	\$ 4,164,688	\$ 832,938
Speech Pathology	\$ 16,585	\$ 11,435	\$ 10,526	\$ 7,472	\$ 24,024	\$ 70,042	\$ 14,008
Occupational Therapy	\$ 42,722	\$ 47,372	\$ 81,921	\$ 110,942	\$ 112,827	\$ 395,784	\$ 79,157
Medical Social Service	\$ 8,544	\$ 6,919	\$ 18,383	\$ 47,625	\$ 57,540	\$ 139,011	\$ 27,802
Home Health Aide	\$ 438,100	\$ 468,619	\$ 418,349	\$ 468,495	\$ 455,543	\$ 2,249,106	\$ 449,821
Operating Expenses Over Operating	\$ 266,853	\$ 352,807	\$ 204,250	\$ 188,775	\$ 133,080	\$ 1,145,765	\$ 229,153

CHHA Cost Report,  
Schedule D

## Revenue Trends

The major source of revenue is Medicare, representing an average of 60% of total revenues between 2005 and 2009.

Table 38: CHHA Patient Revenue by Payer Source, 2005-2009

	2005	2006	2007	2008	2009	5 Year Total	Percent of Total
<b>Medicare</b>	\$2,075,391	\$2,032,347	\$2,215,116	\$2,174,721	\$2,136,090	<b>\$ 10,633,665</b>	<b>60%</b>
<b>Medicaid</b>	\$ 706,262	\$ 743,878	\$ 646,075	\$ 636,601	\$ 629,108	<b>\$ 3,361,924</b>	<b>19%</b>
<b>Blue Cross</b>	\$ 60,965	\$ 107,468	\$ 95,569	\$ 147,877	\$ 155,528	<b>\$ 567,407</b>	<b>3%</b>
<b>Other Insurance</b>	\$ 281,463	\$ 452,949	\$ 571,254	\$ 921,938	\$ 916,128	<b>\$ 3,143,732</b>	<b>18%</b>
<b>Self Pay - Full</b>	\$ 7,694	\$ 7,908	\$ 7,364	\$ 11,455	\$ 6,950	<b>\$ 41,371</b>	<b>0.2%</b>
<b>Self Pay - Partial</b>	\$ 4,776	\$ 6,108	\$ 2,207	\$ 1,614	\$ 1,005	<b>\$ 15,710</b>	<b>0.1%</b>
<b>Total</b>	<b>\$3,136,551</b>	<b>\$3,350,658</b>	<b>\$3,537,585</b>	<b>\$3,894,206</b>	<b>\$3,844,809</b>	<b>\$ 17,763,809</b>	<b>100%</b>

Note: Some totals may not match Table 37 due to accounting differences

CHHA Cost Report, Schedule E

Average Medicare payments per episode have been approximately \$2,200 for the last two years. thus the loss of 43 such cases year to date in 2010 has significant financial implications of close to \$100,000 in lost revenues. Medicaid rates vary by type of visit—in 2009 nursing visits were paid at \$190, physical therapy at \$135 per visit, speech and occupational therapy at \$130 per visit, medical social service at \$125 per visit and home health aide visits at \$60 per hour.<sup>10</sup>

*Year-to-date CHHA revenues through September, driven in part by the reduction in Medicare episode-related revenues, were down by more than \$350,000 compared with the first three quarters of 2009, a reduction of 11%. This raises the risk that CHHA expenditures may exceed revenues in 2010 for the first time in the years we have analyzed.*

## Other Issues

- Washington County CHHA is currently the only CHHA in the County. As a public entity, CHHA staff and administrators assert that it is part of their mission to serve any patients in the County that need care. This necessitates travel to outlying areas of the County, which can be well over an hour to reach areas to the north and east of Hudson Falls, where the Department is located. The County has created an “outpost”—an office in the town of Salem where CHHA nurses can check in and pick up and park County cars to reduce travel time. Given the geography of the County, with outlying areas having fewer patients, concerns have been expressed that a private operator would not serve all the patients who would need home care.
- The Department constantly needs to adjust to the changing episodic payer structure, with changes in numbers of visits expected and amount per episode.

<sup>10</sup> Source: 2009 Medicaid Cost Report

- Change to managed care and increased copays appears to have resulted, at least in the short run, in some reluctance by patients to accept care.
- Aggressive and competent administration:
  - Denials. The administrator in charge of home care services aggressively pursues any denied claims and is often successful in overcoming the initial denials and securing payment for these claims.
  - Efficiencies and cost savings have been implemented in recent years. Laptops are used by nurses in the field, cutting down on the time needed for charting. The clinical software used by nurses links with the financial software used by the Department's billers, which has reduced the need for any duplicate data entry and has expedited revenue generation.
  - Overtime costs have been reduced by hiring staff to fill functions that were previously filled by on-call staff, and by negotiating with the nurses' union to increase the number of weekends for which nurses are paid a 10% differential as opposed to time and a half.
- One way that revenue could be maximized is through the program being more aggressive about collecting unpaid copayments and payments from self-pay patients. For self-pays, an income assessment is completed but the information is not verified. Patients are placed on a sliding scale payment schedule. The Department produces three follow-up letters for unpaid amounts; however, after that there is no further follow-up and no threat of further actions such as use of a collection agency. The CHHA has outstanding copayments of about \$62,000 for 2008 and 2010, and has written off nearly \$74,000 for services provided between 2005 and 2007.
- There is a perception that for CHHA the patient satisfaction rate is high and that staff are dedicated and caring.

## Long-Term Home Health Care Program

The Long Term Home Health Care Program (LTHHCP), also known as the Nursing Home Without Walls, provides in-home services to patients who are eligible for admission to a skilled nursing facility but are able to and prefer to stay home.

## Service Volume

Between 2005 and 2009, the LTHHCP had an average census of 63 patients and made an average of more than 8,000 annual visits (Tables 39 and 40), providing services such as skilled nursing, home health aides, and personal care. However, the unduplicated census declined from a high of 71 in 2005 to 52 in 2009, though with a slight uptick year to date from 51 to 54 at the end of September. Of more concern is that the number of visits dropped from more than 10,000 in 2005 to less than 6,500 in 2009. Furthermore, this has been compounded in 2010 by a further substantial drop in the number of visits from the first three quarters of 2009 compared to the same time period in 2010. About 1,100 fewer visits were made during this period in 2010 than in 2009—a 22% reduction. As noted in more detail below, these declining numbers may be in part a function of competition from a state nursing home diversion program.

**Table 39: LTHHCP Unduplicated Census, 2005-2009**

	2005	2006	2007	2008	2009	5 Year Average
<b>Number of Patients</b>	71	67	60	64	52	63

LTHHCP Cost Report, Schedule B-2

**Table 40: LTHHCP Total Visits, 2005-2009**

	2005	2006	2007	2008	2009	5 Year Average	Percent of Total
<b>Nursing General</b>	2,231	1,852	1,710	1,491	1,502	1,757	21%
<b>Physical Therapy</b>	533	806	736	856	742	735	9%
<b>Speech Pathology</b>	13	7	7	0	0	5	0%
<b>Occupational Therapy</b>	17	18	46	158	53	58	1%
<b>Home Health Aide</b>	2,235	2,345	712	1,815	1,750	1,771	21%
<b>Personal Care</b>	4,260	3,049	3,818	2,063	1,404	2,919	35%
<b>Medical Social Service</b>	296	271	269	497	509	368	4%
<b>Nutrition</b>	428	232	327	380	227	319	4%
<b>Respiratory Pathology</b>	315	346	352	301	253	313	4%
<b>Total</b>	<b>10,328</b>	<b>8,926</b>	<b>7,977</b>	<b>7,561</b>	<b>6,440</b>	<b>8,246</b>	<b>100%</b>

LTHHCP Cost Report, Schedule B-2

About 35% of visits are typically for personal care services, 21% are general nursing visits, and another 21% are visits by home health aides.

As shown in Table 41, the majority of referrals to the LTHHCP are made by hospitals (59%). The second largest referral source is nursing homes, accounting for 14% of referrals.

Table 41: Long Term Home Health Care Program Referrals, 2005-2010

	2005	2006	2007	2008	2009	2010 (as of 10/31/10)	2005-2009 Total	Percent of Total
Hospital	23	15	19	24	17	18	116	59%
Physician		2	5		1	2	10	5%
Self/Family/Friend	1	1	1	3	1		7	4%
Other Agency		1			3	3	7	4%
Other CHHA	7		3	3	2	2	17	9%
Other Comm Agency		2	4	3	1	1	11	6%
Nursing Home	6	4	6	4	3	4	27	14%
<b>Total</b>	<b>37</b>	<b>25</b>	<b>38</b>	<b>37</b>	<b>28</b>	<b>30</b>	<b>195</b>	<b>100%</b>

Source: Washington County Public Health

## Staffing

The LTHHCP currently employs six home health aides, two full-time and one part-time or on-call RN, one social worker and one clerk. In the proposed budget for 2011, the supervisory position has been eliminated, one home health aide has been eliminated and an LPN position has been added. All but one of the current staff is a Washington County resident.

Table 42: LTHHCP Staffing, 2006-2011

	2006	2007	2008	2009	2010	2011 (Budgeted)
Clerical	1	2	2	2	1	1
Supervision	1	1	1	1	1	
RN On Call/PT/PD		1	1	1	1	1
RN Full Time	2	2	2	2	2	2
LPN						1
Home Health Aide	4	7	7	6	6	5
MSW			1	1	1	1
<b>Total</b>	<b>8</b>	<b>13</b>	<b>14</b>	<b>13</b>	<b>12</b>	<b>11</b>

Source: Washington County Public Health

## Financial Analysis

The LTHHCP has seen consistent financial losses over a five year period, with a total loss of more than \$380,000 between 2005 and 2009—an average of about \$76,000 per year (see Table 43 below). Not surprisingly, given the substantial reduction in the numbers of visits to date in 2010, the revenues associated with the program are also down significantly for the first three quarters of 2010—a 15% reduction of about \$74,500 from the same time in 2009.

Table 43: LTHHCP Revenues and Expenses, 2005-2009

	2005	2006	2007	2008	2009	5 Year Total	5 Year Average
Operating Revenue	\$ 601,761	\$ 587,100	\$ 533,286	\$ 598,167	\$ 476,048	\$ 2,796,362	\$ 559,272
Total Patient Service Revenue	\$ 572,216	\$ 495,910	\$ 453,659	\$ 520,075	\$ 476,048	\$ 2,517,908	\$ 503,582
Other Operating Revenues	\$ 29,545	\$ 91,190	\$ 79,627	\$ 78,092	\$ -	\$ 278,454	\$ 55,691
Operating Expense	\$ 696,966	\$ 657,875	\$ 700,734	\$ 669,632	\$ 600,898	\$ 3,326,105	\$ 665,221
Personal Services - Salaries & Wages	\$ 358,892	\$ 308,426	\$ 348,697	\$ 331,020	\$ 298,486	\$ 1,645,521	\$ 329,104
Personal Services - Employee Benefits	\$ 145,476	\$ 127,231	\$ 141,631	\$ 140,829	\$ 115,277	\$ 670,444	\$ 134,089
Personal Services - Contracted/Purchased Services	\$ 90,980	\$ 108,264	\$ 100,411	\$ 100,152	\$ 79,768	\$ 479,575	\$ 95,915
Other than personal services	\$ 101,618	\$ 113,954	\$ 109,995	\$ 97,631	\$ 107,367	\$ 530,565	\$ 106,113
Operating Expenses Over Operating Revenues	\$ (95,205)	\$ (70,775)	\$ (167,448)	\$ (71,465)	\$ (124,850)	\$ (529,743)	\$ (105,949)
Non-Operating Revenues	\$ 33,462	\$ -	\$ 29,241	\$ -	\$ 86,125	\$ 148,828	\$ 29,766
State Aid	\$ -	\$ -	\$ -	\$ -	\$ 54,436	\$ 54,436	\$ 10,887
Other	\$ -	\$ -	\$ 29,241	\$ -	\$ 31,689	\$ 60,930	\$ 12,186
Indirect services provided by County	\$ 33,462	\$ -	\$ -	\$ -	\$ -	\$ 33,462	\$ 6,692
Total Revenues	\$ 635,223	\$ 587,100	\$ 562,527	\$ 598,167	\$ 562,173	\$ 2,945,190	\$ 589,038
Total Expenses	\$ 696,966	\$ 657,875	\$ 700,734	\$ 669,632	\$ 600,898	\$ 3,326,105	\$ 665,221
Excess of Total Revenue over Total Expenses	\$ (61,743)	\$ (70,775)	\$ (138,207)	\$ (71,465)	\$ (38,725)	\$ (380,915)	\$ (76,183)

LTHHCP Cost Report, Schedule G

## Expenses

The largest expenses in the LTHHCP are employee related. Salaries and benefits have averaged more than \$463,000 from 2005 to 2009. Benefit levels, on average, are about 41% of salary amounts.

Table 44: LTHHCP Employee Salaries and Benefits, 2005-2009

	2005	2006	2007	2008	2009	5 Year Total	5 Year Average
Administrative	\$ 157,035	\$ 138,597	\$ 176,497	\$ 182,969	\$ 162,247	\$ 817,345	\$ 163,469
Unidentified to special function	\$ -	\$ -	\$ -	\$ -	\$ 1,655	\$ 1,655	\$ 331
Patient Assessment	\$ 6,805	\$ 6,327	\$ 10,079	\$ 7,998	\$ 93,560	\$ 124,769	\$ 24,954
Nursing General	\$ 126,509	\$ 130,187	\$ 129,594	\$ 105,801	\$ 744	\$ 492,835	\$ 98,567
Physical Therapy	\$ 65	\$ -	\$ -	\$ 2,107	\$ -	\$ 2,172	\$ 434
Occupational Therapy	\$ -	\$ -	\$ -	\$ -	\$ 62,272	\$ 62,272	\$ 12,454
Home Health Aide	\$ 62,306	\$ 65,736	\$ 25,331	\$ 57,775	\$ -	\$ 211,148	\$ 42,230
Housekeeper	\$ -	\$ -	\$ -	\$ -	\$ 51,023	\$ 51,023	\$ 10,205
Personal Care	\$ 136,257	\$ 90,777	\$ 132,990	\$ 68,441	\$ 40,125	\$ 468,590	\$ 93,718
Medical Social Service	\$ 15,391	\$ 4,033	\$ 15,837	\$ 44,080	\$ -	\$ 79,341	\$ 15,868
Telehealth Services	\$ -	\$ -	\$ -	\$ 2,678	\$ 2,047	\$ 4,725	\$ 945
Total	\$ 504,368	\$ 435,657	\$ 490,328	\$ 471,849	\$ 413,673	\$ 2,315,875	\$ 463,175

LTHHCP Cost Report, Schedules A-1 and A-2

## Issues and Concerns

- As indicated above, the LTHHCP service has recently been experiencing competition from the State's Nursing Home Diversion program, operated locally by Fort Hudson. Funding for these services is slightly different; the Diversion program has an annual spending cap, whereas the LTHHCP is intended to cost no more than 75% of what nursing home care for the patient would cost. The Diversion program's annual cap provides greater flexibility for some patients.

- Currently the program has only Medicaid patients. The program could also accept patients with long-term care insurance. However, program administrators have not had time to date to market the program to such insurance carriers.

## Hospice

The mission of the Washington County hospice is: “To dedicate ourselves to listening with heart to the life experiences of our patients and their loved ones. With deep compassion, gentle humor, and caring professional support, guide them towards a peaceful acceptance of their lives and losses together as we journey their end of life path.”<sup>11</sup> Washington County Public Health took the hospice service over when Mary McLellan, a local hospital, closed.

## Service Volume

The program has served an average of 162 patients per year, with numbers varying considerably from year to year (Table 45). As shown in Table 46, it has provided an average of 7,300 service days per year.

**Table 45: Number of Patients, Hospice, 2005-2009**

	2005	2006	2007	2008	2009	5 Year Average
<b>Unduplicated Census</b>	151	158	129	191	182	162

Source: Medicare Cost Report

**Table 46: Hospice Days, 2005-2009**

	2005	2006	2007	2008	2009	5 Year Average
<b>Hospice Days</b>	4,989	6,695	6,535	9,693	8,588	7,300

Source: Medicare Cost Report

The number of patients in the hospice program was down by 27 (minus 18%, from 150 to 123) between January and September of 2010 compared to the same period in 2009, and down by almost 2,400 service days during that same period (a 34% reduction). The number of visits is also down by more than 1,200 (-29%). The program has seen an increasing number of denials from payers—especially for conditions such as congestive heart failure and chronic obstructive pulmonary disease, which has led to some hesitancy to take on cases. Denials may not be processed until well after a case has been opened, so a denial can mean a retroactive loss of revenue. Even cases that are opened may be closed earlier than in the past, rather

<sup>11</sup> [http://www.co.washington.ny.us/Departments/Publth/ph\\_hospice.htm](http://www.co.washington.ny.us/Departments/Publth/ph_hospice.htm)

than remaining in the program until death. The average length of stay in the program has declined by 20% in 2010 compared to last year, an average of nine fewer days in the program per patient this year.

On a perhaps somewhat more encouraging note, the number of active cases has increased recently. From a high of an active census of 41 in the past, the active census had declined to as few as 15 or so in the past year, before rebounding in the past month or two to as many as 24 active cases.

## Staffing

The hospice program is currently staffed by 12 employees and has been budgeted for 11 positions in the 2011 budget. Seven of the 12 current employees (58%) are Washington County residents.

**Table 47: Hospice Staffing, 2006-2011**

	2006	2007	2008	2009	2010	2011 (Budgeted)
<b>Assist. Director</b>	1					
<b>Clerical</b>	4	4	4	5	5	5
<b>Supervision</b>	1	1	1	1	1	1
<b>RN On Call/PT/PD</b>	1	1	1	1	1	1
<b>RN Full Time</b>	2	3	3	3	2	2
<b>Medical Director</b>	1	1	1	1		
<b>LPN</b>	1			1	1	
<b>Home Health Aide</b>	1	1	1	1	1	1
<b>MSW</b>	1	1	1	1	1	1
<b>Total</b>	<b>13</b>	<b>12</b>	<b>12</b>	<b>14</b>	<b>12</b>	<b>11</b>

Source: Washington County Public Health

## Revenue and Expenses

As shown below in Table 48, revenue for the Hospice program has averaged about \$1 million for the past 5 years, with expenses exceeding revenues by an average of about \$162,000 per year. Salaries and benefits account for nearly half of expenses, with benefits at about 41% the amount of salaries.

The Hospice program almost broke even in 2008, when its number of patients and total hospice service days peaked. Although expenditures declined in 2009, revenues declined by a greater amount, leading to an increased “deficit.” Through the first nine months of 2010, revenues have declined further—by more than \$400,000 compared to the same period last year, a decline of 38%. The revenue picture is further clouded by the decision by the state to remove the Hospice program from State aid eligibility, which in the past could have helped offset up to 36% of program losses through revenues from the State. That is no longer possible.

Table 48: Revenue and Expenses, Hospice, 2005-2009

	2005	2006	2007	2008	2009	5 Year Total	5 Year Average
<b>Revenue</b>	\$ 712,423	\$ 872,756	\$ 866,419	\$ 1,413,437	\$ 1,206,647	\$ 5,071,682	\$1,014,336
<b>Expenses</b>							
<b>Salaries</b>	\$ 370,880	\$ 411,780	\$ 384,638	\$ 415,778	\$ 444,488	\$ 2,027,564	\$ 405,513
<b>Benefits</b>	\$ 150,335	\$ 169,868	\$ 156,228	\$ 176,890	\$ 171,665	\$ 824,986	\$ 164,997
<b>Transportation</b>	\$ -	\$ 12,900	\$ 11,198	\$ 16,640	\$ 22,677	\$ 63,415	\$ 12,683
<b>Contracted Services</b>	\$ 277,445	\$ 141,039	\$ 82,408	\$ 383,570	\$ 216,256	\$ 1,100,718	\$ 220,144
<b>Other</b>	\$ -	\$ 140,282	\$ 121,131	\$ 154,225	\$ 187,757	\$ 603,395	\$ 120,679
<b>Allocated Costs</b>	\$ 222,254	\$ 242,215	\$ 215,026	\$ 289,559	\$ 292,605	\$ 1,261,659	\$ 252,332
<b>Total Expenses</b>	\$ 1,020,914	\$ 1,118,084	\$ 970,629	\$ 1,436,662	\$ 1,335,448	\$ 5,881,737	\$1,176,347
<b>Revenue over Expenses</b>	\$ (308,491)	\$ (245,328)	\$ (104,210)	\$ (23,225)	\$ (128,801)	\$ (810,055)	\$ (162,011)

Source: Medicaid Cost Report

Hospice services are billed per day; in 2009 in-home care was billed at \$132.54 per day, and inpatient care at \$592.77 per day.

### Other Issues

- When the County took over the hospice program, the Board of Supervisors reportedly were under the impression that the program would have a net operating gain each year. When the program showed an operating loss, some expected that the program's affiliated non-profit organization, Friends of Hospice, would cover the losses. However, the role of Friends of Hospice has been disputed and for the last several years the group has not covered losses, though it does conduct fundraisers and sometimes subsidizes care for individual cases.
- As with CHHA services, the department does not have an effective way to collect unpaid bills from self-pay patients. Nearly \$45,000 in unpaid amounts for services provided between 2005 and 2007 have been written off.
- The loss of State aid will further exacerbate the financial circumstances of the Hospice program in the future.

## CONCLUSIONS AND NEXT STEPS

This Phase 1 report has accomplished its objective of describing “What is,” the current profile of the Pleasant Valley Nursing Home, Adult Home and Adult Day Care program, as well as the CHHA, Long Term Home Health Care Program and Hospice program. The report provides what the County requested in Phase 1, and the County could decide to end the project at this point and that it has enough information to make decisions going forward. Or it may decide that more information is needed to flesh out various options before it makes any far-reaching future decisions.

All of the examined facilities and programs offer vital services needed in Washington County. All have recognizable strengths that can be built on should the County decide to continue in the future to offer one or more of the programs and services. At the same time, each facility and program has limitations and challenges, both internal and external. Not the least of the challenges, of course, is the financial challenge of finding ways to at least break even financially without requiring taxpayer support. At this point, only the CHHA appears to be doing that with regularity, and even it is facing challenges in being able to continue to do that in the future.

The County should have sufficient information from this report to begin to develop a Request for Proposals, or more than one RFP, should it decide to put one or more of its facilities and programs on the market. On the other hand, the Phase 1 assessment has identified potential opportunities to make changes that could potentially save money and/or increase revenues that could reduce the deficit operations of most if not all of the component programs and facilities. These involve both internal changes and various potential combinations of internal and external options that could potentially be developed further as part of Phase 2, should the County choose to authorize an extension of this process. What became clear as part of the Phase 1 process was that options and decisions made about any number of possible scenarios also have implications for others, and that to act unilaterally on any one option might lead to unintended consequences related to other alternatives.

The County has a clear choice to make. On the one hand, core information needed to begin the development of an RFP process is in place, should the County decide to act at this point. On the other hand, the advantage of potentially extending the project to explore options in more detail is that the pros and cons, implications, feasibility, likelihood of success, and assessment of various cross-option implications could be explored in further detail before the County makes any irrevocable decisions. CGR looks forward to seeing the County use this information either way in its decision-making process, and to the possibility of assisting the County further should we be requested to do so. Let the debate begin.