

The Future of the DuPage County
Convalescent Center
Options for Consideration

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DuPage County Board

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Executive Summary

Like many counties across the United States that continue to operate publicly-owned skilled nursing/long-term care facilities, DuPage County is currently engaged in a process of assessing a range of options to ensure the continued financial sustainability related to the operation of its 368-bed DuPage County Convalescent Center (DPCC), located in Wheaton, IL.

The County's goal is to preserve the Center's historic mission while improving its financial sustainability in a challenging healthcare and long-term care environment. CGR (Center for Governmental Research) was engaged by the County to assess these issues and provide an objective third-party perspective concerning the Center's current operation while developing a menu of options regarding the optimal operation and management of the Convalescent Center, both in the short run and for the foreseeable future.

DuPage County has remained committed and devoted for more than a century to the mission of DPCC: to provide high-quality care to County residents regardless of income level, with particular concern for low-income and high-need residents less likely to be served by other nursing homes (for-profit and not-for-profit) located throughout DuPage and surrounding counties. The question is how best to sustain this commitment in the future, given changing financial realities and other changes in the health-care and long-term-care environment.

Methodology

During the six-month study process, CGR interviewed and received information from approximately 200 separate individuals, in addition to receiving more than 400 completed surveys from Convalescent Center residents, family members, volunteers and staff members. These were supplemented by detailed analyses of numerous data and reports, assessments of state and national trends, and comparisons of DPCC with other nursing homes in DuPage County and statewide.

Overview of Convalescent Center

The Convalescent Center contains 368 certified beds, with 353 of those currently operational, offering a combination of long-term care and short-term rehabilitation services. The facility spans four separate but interconnected buildings, which were built in four primary stages, from the 1960s to the mid-1990s. The Center operates at somewhat of a disadvantage compared to many of its competitors because of its older, more institutional look and feel. However, it has been well maintained over the years, with a solid infrastructure and periodic renovations to maintain an attractive look and feel for an older facility.

The facility currently employs about 500 staff members, about 375 of whom are full-time. The facility's budget for 2016 is just over \$37 million. Additionally, DPCC is supported by close to 400 community volunteers, who in 2014 contributed over 31,000 hours of service.

Framing the Discussion: The Environmental Context

A number of factors help shape the context within which the DuPage County Convalescent Center exists. These factors affect both the current operations and financial condition of the nursing home, as well as the viability of options which may be available to DPCC and DuPage County in the future. Some of these environmental factors can be controlled or influenced by the County and/or DPCC, while others are at least in part beyond the ability of the Convalescent Center to control directly.

For example, it is likely that the need for the types of services provided by the Convalescent Center will increase in the future, as demographic changes will result in almost 35,000 more county residents 75 and older in 2025 than existed in 2010. Many of these will be low-income seniors with high levels of medical and behavioral needs and issues that other nursing homes in the county have historically been reluctant, and in many cases unwilling, to serve.

Yet as the needs for service increase, so do the net costs of serving Convalescent Center residents. Despite effective management efforts to limit the expenditures of operating the facility, rising health care and pension costs, over which the Center has little direct control, have continued to increase rapidly, at rates consistent with other public facilities throughout the state but higher than among DPCC's for-profit and not-for-profit competitors. DPCC and other public nursing homes also face other difficult financial realities, including that the vast majority of residents of county nursing homes—typically higher proportions than in most of their competitors—ultimately wind up on Medicaid, and Medicaid reimbursement rates fall far short of covering the actual costs of the care provided for residents of the homes. It is also likely that some other nursing homes will continue to serve portions of this population with initial payer sources other than Medicaid, and then look to the Convalescent Center to assume the responsibility once those other payer sources are exhausted.

These current realities are not unique to DuPage County. As difficult as these realities are for counties to face in their own right, they become even more difficult to address when exacerbated by the current economy, significant recent declines in Medicaid reimbursement levels, and the uncertainty about future long-term-care reimbursement and funding streams from state and federal governments—declines and uncertainties which make rational financial planning for the future of nursing facilities increasingly difficult. The pending expansion of managed care and related financial realities further exacerbate the future financial uncertainties of operating the Convalescent Center.

And yet, balanced against these fiscal realities is the County's continuing commitment to the mission of the Convalescent Center and its residents. It is a commitment many are reluctant to walk away from, even under difficult financial circumstances, and even though the operation of a public nursing home is not a mandated County service. As the DuPage County Board seeks to think strategically about the future of the Convalescent Center, the tradeoffs involved in balancing the historic commitment with changing fiscal realities—and potential opportunities to reduce costs and increase revenues—become central to ensuring a sustainable future strategy and plan of action for continued delivery of quality

nursing home care to its residents, and most particularly to low-income residents of the county.

Occupancy Rates and Revenue Implications

Occupancy rates have been fairly consistent at the Convalescent Center over recent years, but for most of 2015, the average daily census averaged about 10 fewer occupied beds than in 2014, with most of the decline in short-term rehab beds, which are the most financially-lucrative for any nursing facility. Filling those beds at 2014 levels would generate additional revenues of between \$780,000 and \$1.5 million, depending on the mix of Medicaid and Medicare residents.

Historically, three-quarters of all resident care days at the Convalescent Center have been paid for by Medicaid—fully 20 percentage points higher than the median in all other nursing homes in DuPage County, all of which are operated by for-profit or not-for-profit providers. Medicaid payments to DPCC fall short by \$77 for each resident day of meeting full costs of serving those residents. *At a loss of \$77 per resident day, those differences make it virtually impossible for DPCC to operate without other funding subsidies, unless there are significant changes in the facility's cost structure and/or other sources of offsetting revenues.*

One potential source of offsetting revenues would be increased proportions of resident days paid for by higher Medicare reimbursement rates, but over the past five years, only 7 percent of all DPCC resident days have been paid for by Medicare. By contrast, in other nursing homes within the county, that proportion has been almost three times as high—19 percent. (However, it should be noted that admissions policies that may be employed by other facilities to generate additional revenue may not always be consistent with the principles guiding a publicly-funded safety-net facility.) Medicare revenues at DPCC have declined by almost 30 percent since 2011. DPCC's number of Private Pay residents increased in recent years, but began to decline in 2015. Taken together, to the extent that the Convalescent Center can find ways to approach in future years its historic highs of Medicare and Private Pay residents, and to fill empty beds more rapidly, it could have the effect of generating in excess of an additional \$1 million to \$2 million over revenues generated in 2015.

Staffing and Perceived Quality of Care

As part of an industry-wide pattern by no means unique to DPCC, the facility is experiencing a large number of vacancies at each nursing staffing level, but particularly among CNAs, where about one in every five approved positions have been vacant recently. One result has been significant increases in recent years in costs of overtime and expensive contract agency staff. With the facility serving a high-acuity population with high levels of medical and behavioral needs, imposing reductions in existing staffing levels among nurses and CNAs as a means of reducing operating costs does not seem to be wise, and could be a threat to the future quality of care available to high-acuity DPCC residents. There may, however, be opportunities over time to create different

configurations of staff, and additional use of per diem/registry staff in lieu of contract agency nurses and CNAs, that could help reduce overall costs while still maintaining quality of care for residents.

Support services staff—including housekeeping, laundry and dining services—not only provide services to facility residents, but also provide additional services to selected agencies outside DPCC. Additional opportunities to provide services which could enhance revenues for DPCC could become available in the future, subject to County approval. A variety of other community life and quality assurance services are provided efficiently across the facility.

Although concerns were expressed by staff on various issues—consistent with previous survey findings—survey responses from residents, resident family members and volunteers were consistently positive about the overall level of services and quality of care provided throughout the facility. The Center's most recent Overall Quality of Care rating is 4 stars out of a potential 5.

Finances

The Convalescent Center's operating expenses have only increased slightly over the last several years. Between 2011 and 2014, the Convalescent Center's operating expenses grew by just over \$560,000, or 1.5 percent.

Meanwhile, revenues, which are heavily dependent upon Medicaid reimbursement rates, have not been able to keep pace, resulting in DPCC structural deficits in the range of \$5 million to \$7 million from 2011 through 2014. This deficit is partially offset by an annual subsidy from DuPage County, which was recently increased from \$2.4 million in 2014 to \$3 million in 2015. The County also supports the Convalescent Center through various administrative services provided directly by the County. This includes support from the County's Human Resources, IT, Facilities, Security, and Finance departments. Most of these expenses are included as non-cash items in the Convalescent Center's financial reports, and together represent an in-kind contribution from the County to the Convalescent Center worth more than \$3 million per year.

Primary drivers of the modest increased costs at the Convalescent Center are health and pension costs, over which the nursing home has little direct control, and nursing staff expenses, largely because of increased reliance on part-time, on-call and contract agency staff. Given these trends, along with the ratio of short-term rehab to long-term care beds and the high percentage of Medicaid-funded care days at the facility, it appears unlikely that the Convalescent Center will be able to generate sufficient revenue in future years to avoid an ongoing operating deficit that will necessitate the need for continued financial support from the County, unless there are significant shifts in the payer mix and census/occupancy rate that generate more revenues.

Potential Options for Future Consideration

A number of issues and opportunities are presented for the County's consideration to build on the strengths of the Convalescent Center, to improve how resources are used throughout the facility, to reduce or reallocate costs more efficiently, and to expand revenues in the future. These opportunities offer the potential to reduce future annual DPCC deficits, though some level of County subsidy is likely to continue to be needed.

Each option has merit, and each has potential drawbacks. The options are offered in the belief that various combinations of the potential opportunities can help strengthen the operations of DPCC going forward, and have the potential to ensure the future viability and sustainability of the services available to future generations of county residents. The options are briefly summarized under the following broad categories:

Potential to reduce costs and maximize effective use of staff

A number of possible options are presented to, among other things, change staffing mixes and allocations over time, create staffing efficiencies and adjustments, and reduce costs of overtime and contract agency staff by expanding the use of per diems/registry staff for that purpose. **Likely Implications:** CGR sees little opportunity for the County to save significant amounts of money by making substantial reductions in staffing at DPCC. Instead, it would seem important to consider doing what is necessary to fill as many vacant positions as possible—positions already approved and included within the budgeted allocations. Beyond that, there appear to be only limited opportunities for major cost-savings across the Convalescent Center. The study has identified the potential for perhaps \$300,000 to \$350,000 in actual annual cost reductions that could occur within the next year or two under certain scenarios, with additional savings possible as other longer-term changes occur.

Potential to increase revenues

The major opportunity to expand revenues involves a variety of actions designed to increase the daily census/occupancy rate, to change the payer mix of residents so that higher proportions of resident days are covered by Medicare and Private Pay, to admit higher proportions of referrals, and to reduce the length of time beds remain empty before being re-occupied. In addition, DPCC's Support Services has the potential to create and expand a variety of services to agencies outside DPCC, consistent with their existing operations. **Likely Implications:** As noted earlier, by approaching historic highs of Medicare and Private Pay resident days, and by reducing the time beds are empty, it is possible that additional revenues of \$1.5 million to \$2 million could be generated annually in future years. However, private sector facilities are seeking the same population, and care would need to be taken to make sure that changes in the patient mix would not be at the expense of reducing service to the low-income population DPCC has historically been committed to serving. In addition, if approval were given for Support Services to pursue additional services to outside agencies, it seems reasonable that the unit has the potential to generate annual net revenues in the vicinity of a quarter of a million dollars within two to three years of approval to proceed.

Potential of hiring a management consultant

In some cases, counties have found it helpful to hire a management consultant with experience managing and operating nursing homes to provide guidance and a fresh outside perspective to help sort through various issues, either on a short-term or longer-term basis. Should the County choose to pursue such a contractual arrangement, it would presumably explore its options through an RFP process. Under such a scenario, the County would presumably continue to operate the Convalescent Center with County employees and administration who would work closely with, and with the overall guidance of, the consultant to help address key issues. **Likely Implications:** Such an option may not be needed or worth the cost to DPCC, but a number of issues raised in this report are complex and may be amenable to guidance and support from an outsider with hands-on experience dealing with such issues in a variety of other nursing home settings, working under whatever guidelines the County Board would choose to set. As one example, with the issue of managed care looming, DPCC and the County might benefit from consulting with an outside management firm with managed care experience to help DPCC maximize its opportunities and minimize its risks.

Potential of new or expanded services in vacant space at DPCC

Three floors in the South building of the DPCC complex have remained vacant for a number of years. Several ideas have surfaced during this process for use of some or all of the vacant space, in ways that could add or strengthen services and potentially also provide revenues for DPCC. These options include the creation of a multi-specialty clinic, the creation of a short-term rehab wing, the creation of a child care center, and the development of an adult day services program. **Likely Implications:** Some options appear more viable than others, but at least two or three seem to have sufficient merit and feasibility to be worthy of consideration by DPCC and DuPage County. These would appear to offer the opportunity to enhance services to DPCC residents and other residents of the county, offer the potential for sharing the costs of renovating valuable space, and create the potential opportunity for creating lease revenues for DPCC.

Potential for new construction or major renovation of existing space

Given the older, more institutional nature of the DPCC facility, some have advocated for the construction of a totally new nursing facility. Others have suggested that, building on the sound maintenance and ongoing renovations to the existing facility, consideration should be given to making significant renovations in the resident rooms and common areas of at least the largest floors in the current facility—to make the nursing home more livable, with more of a homelike feel, to remain competitive and meet expectations of future residents and their family members. **Likely Implications:** It seems likely that if the County continues to maintain ownership of DPCC, it will need to make an investment in its future—either to build new or substantially renovate and upgrade the existing facility. Building a new facility may help attract higher proportions of Private Pay and Medicare residents, but that result would need to be squared against the historic stated mission to serve those with fewer resources. If the choice is renovation, very preliminary and somewhat outdated estimates put the costs of renovating the existing 224 beds in the

North building at about \$13 million, not including new furnishings or some common areas, but including some work that has since been done subsequent to the development of those estimates. New estimates would need to be obtained before any decisions are made.

Potential for partnerships and collaboration

A number of potential partnerships and collaborative efforts have been identified for County consideration, including some referenced above in the context of shared use of currently-vacant space. Other partnerships might include such things as contractual agreements between DPCC Support Services and outside agencies for direct provision of services, contracting with a management consultant, partnerships with community-based agencies to help provide services to DPCC residents with disabilities and behavioral health concerns, partnerships involving the possible creation of permanent supportive housing facilities in the county, and a collaborative effort to develop a strategic countywide plan for the creation of a network of community-based long-term-care services for seniors needing community support short of institutional care. **Likely Implications:** A number of possible collaborative partnerships referenced in the report have the potential to be of mutual benefit to DPCC, the County, and various agencies and those they serve. Each would need careful vetting, but several have the potential to enhance DPCC revenues, as well as improving services and the environment for residents.

Potential for tax levy dedicated to DPCC

A number of counties owning nursing homes have tax levies dedicated to support operations of those facilities. At one point through the mid-1990s, DuPage County had such a dedicated levy. Even with potential cost savings and revenue enhancements identified in this study, it is likely that the County will continue to be called upon to provide annual subsidies to balance the DPCC budget. The reinstatement of a dedicated tax levy would ensure the availability of the needed subsidy, while eliminating the need to depend on the County General Fund. Proposed amounts of the levy have ranged from the \$3 million needed to cover the current amount of the annual County subsidy to as much as \$12 million, which could cover the current subsidy, plus the costs of indirect services provided by County agencies to DPCC, a long-term capital fund, and the creation of a DPCC fund balance. Suggestions have been made by some to expand such a dedicated levy to also include funds set aside for the development and maintenance of a county long-term-care plan and services for seniors and/or support for transportation services for seniors and possibly people with disabilities. **Likely Implications:** There is clear precedent for the creation of such a dedicated tax levy, but any new levy would require passage of a referendum. Any such levy would likely generate about \$1 million for every \$3 per household per year. As an example, estimates indicate that a \$12 million levy would be equivalent to roughly \$36 per average homeowner per year, or about \$3 per month.

Potential for changes in ownership and operation of DPCC

If the County should choose to no longer be responsible for the ownership and operation of the Convalescent Center, it could explore several possibilities. The most likely of these would seem to be (1) to sell the bed license for the facility to another operator who would administer the facility, while the County would continue to own the land and facility and would rent or lease them to the new operator, or (2) the County would sell the facility to another owner who would assume full costs and responsibilities of operating the facility, or at some point could decide to convert the facility into some other use. Sale would presumably be undertaken through the introduction of an RFP process. **Likely Implications:** Should the County opt for either of these options, once any sale of licenses or of the overall facility is complete, the County would be removing itself from any future ability to control the mission of DPCC or the fate of its current or potential future residents or employees. It would save money each year, but would in effect be altering the historic commitment to service and to the low-income and “hard to place” population that has been the hallmark of the Convalescent Center’s mission over the years. Terms of the RFP process and potential sale would be important to craft carefully to protect residents, mission of the facility and employees as much as possible in the future.

Conclusions

CGR was not asked by the County to make specific recommendations, but rather to outline an array of options for the County’s consideration regarding the future of the Convalescent Center. We believe that, as outlined above, a number of feasible, practical options exist for County and DPCC action, either individually or in various combinations, that offer viable opportunities for a sustainable model of operations for the facility well into the future.

Acknowledgements

A project of this scope can only be accomplished with the cooperation and support of many people too numerous to mention. Throughout the process of completing this study, people we approached were unfailingly generous with their time and insights.

We are particularly grateful to Jennifer Ulmer, Administrator of the DuPage County Convalescent Center, and to Thomas Cuculich, County Chief of Staff. They were our initial contacts on this project, and from the beginning have provided guidance, access to data and staff, and helpful insights and suggestions—while at the same time respecting the integrity of the process and our need to be objective in our analyses. They were consistently helpful throughout the process, but that helpfulness never crossed the fine line into attempting to influence our findings or suggest that certain topics were off limits. We appreciate that they respected the process and understood that only in so doing would the County and DPCC receive the objective assessment of the facility's future sustainability that we had been asked to provide.

Beyond Jennifer and Tom, we received support, guidance and valuable insights at several points throughout the study from an excellent project Steering Committee. Our meetings with them at strategic points during the project were invariably valuable, as the group's observations, questions and suggestions were consistently helpful in shaping next steps throughout our process, including key issues to pursue further and key people with whom to follow up. Thanks to each member of the Committee: Jennifer Ulmer; Tom Cuculich; Robert Larsen, Chair of the County Board's Health and Human Services Committee; Sheryl Markay, County Deputy Chief of Staff; Paul Rafac, County Chief Financial Officer; Mary Keating, County Director of Community Services; Joan Olson, County Communications Manager; Paul Padron, DPCC Foundation Board Member; Phyliss Royster, DPCC Director of Nursing; and Mark Delorio, DPCC Director of Support Services. In addition to the value of the overall group meetings, each person on the Steering Committee made singular contributions and valuable comments at various points throughout the process. We are grateful.

We met with approximately 200 individuals throughout the study, representing all staffing levels and functions within the Convalescent Center, many key functions within County Government, and knowledgeable people in other nursing homes, other counties, other health care facilities, and at state and national levels. We also received completed surveys from more than 400 DPCC residents, family members, volunteers and staff members. Many others through emails and phone calls supplied important information and insights upon request. This study would not have been possible without the time, cooperation and thoughtful observations of these scores of people. To everyone with whom we met, and from whom we received information, our grateful thanks and appreciation!

Staff Team

Don Pryor, Pete Nabozny and Erika Rosenberg carried out all field work associated with this project, and were responsible for writing this report. Spencer Gurley-Green also provided valuable assistance in analyzing survey data and made other important contributions throughout the process.

Table of Contents

Executive Summary.....	i
I. Introduction and Context	1
Brief Overview of Convalescent Center	2
Framing the Debate and Weighing Options for the Future of the Convalescent Center	2
Methodology	4
Project Steering Committee	4
Interviews and Focus Group Discussions	4
Town Hall Meeting with Residents, Family Members and Volunteers.....	5
Surveys of Four DPCC Constituency Groups	5
Discussions with State and Other County Stakeholders	6
DPCC Data Collection and Analysis	6
Comparisons with Other Nursing Homes	6
A Final Perspective on our Analytic Approach	6
Report Format.....	7
II. The Environmental Context	8
Demographic Changes: County Senior Population Growing	8
Long-Term Care Planning and Community-Based Services.....	10
Uncertainty of State Funding	10
The Impact of Managed Care	12
The Impact of Employee Benefit Costs.....	13
DPCC's Competition.....	13
III. Baseline Findings: Current Operations of the Convalescent Center.....	15
Summary Overview of the Center	15
Physical Plant Overview	15
Bed Distribution.....	16
Physical Improvements and Capital Upgrades	17
Census and Occupancy Rates	18
Referrals and Admissions.....	20
Short-Term Subacute Referrals Resulting in Admissions	22
Long-Term Care Referrals and Admissions	23

Process Underway to Strengthen Referral and Admission Process.....	23
Residents with High Needs.....	23
Residents by Payer Source.....	25
Admissions by Payer Source	26
Total Resident Care Days by Payer Source.....	26
The Importance of the MDS Process for Increasing Revenues	28
Residents Needing Therapy	29
Alliance Rehab Contract	30
In-House Physical Rehab Services	30
Restorative Nursing Rehab Services	31
Core Services and Staffing Patterns.....	32
2015 DuPage Convalescent Center Overall Organization Chart	33
Nursing Services Organizational Chart	34
Support Services Organizational Chart.....	35
Nursing Services	36
Staffing Gaps, but Emphasis on High Proportions of RN Nurses	36
High Levels of Vacancies	37
Resident-to-Staff Ratio	38
Absence/Attendance Issues	38
Expanded Use of Overtime and Contract Agency Staff	40
Expand Use of Per Diem Staff?	41
Salary and Wages	42
Support Services.....	43
Housekeeping.....	44
Laundry.....	45
Dining Services.....	46
Community Life and Quality Assurance Services.....	46
Community Life.....	47
Quality Assurance.....	48
Facilities Management and Security	48
Staff Departures: Timing and Reasons for Leaving	49
Disciplinary Complaints.....	50

Quality of Care.....	51
Internal Issues Raised by Staff	52
Stakeholder Survey Findings	54
Resident Survey.....	54
Family Survey	56
Volunteer Survey.....	58
Staff Survey	60
Comparisons with Other Nursing Homes.....	64
Experience of Other Counties with Public Nursing Homes	65
Lake County	65
McHenry County	67
Will County.....	68
IV. Convalescent Center Financial Analysis	70
Overview of Revenue and Expenditures.....	70
Significant Trends in Operating Revenue.....	71
Patient Care Day Revenue	71
Other Revenue Sources	75
Expenditure Trends.....	75
Fiscal Year 2016 Budget Outlook.....	77
Conclusion	78
V. Potential Options for Future Consideration	79
Criteria for Assessing Viability of Options	80
Potential Internal Operational Changes to Reduce Costs and Increase Revenues	80
Potential to Reduce Costs and Maximize Effective Use of Staff	81
Potential to Change RN/LPN Mix Over Time	82
Potential Staff Efficiencies and Adjustments.....	82
Potential Reductions in Overtime: Expanded Use of Per Diems.....	85
Potential Reduction in “High Need” Admissions	86
Potential for More Aggressive Recruiting and Retention of Employees	87
Potential to Improve Organizational Culture	88
Potential to Eliminate Non-Reimbursed Cleaning Services for County Buildings.....	88

Summary of Likely Implications of Potential Options to Reduce Costs and Maximize Effective Use of Staff	89
Potential to Increase Revenues	89
Potential to Limit Impact of Medicaid Reimbursement Rate Reduction	89
Potential to Improve Occupancy and Payer Mix of Residents	90
Potential to Get to “Yes” Quicker and More Frequently in Admissions Decisions	92
Potential to Expand Entrepreneurial Opportunities and Revenues from Support Services	92
Potential to Increase Revenues through MDS and Electronic Health Records	93
Other Potential Opportunities.....	94
Summary of Likely Implications of Potential Options to Increase Revenues ...	94
Potential of Hiring a Management Consultant.....	95
Potential of New or Expanded Services in Vacant Space at DPCC.....	96
Potential for Creation of Multi-Specialty Clinic	97
Potential for Creation of a Short-Term Rehab Wing.....	98
Potential for Creation of a Child Care Center	98
Potential to Develop Adult Day Services Program	99
Potential Creation of Sheltered Living Facility	99
Summary of Likely Implications of Potential Options for Using Vacant Space at DPCC	100
Potential for New Construction or Major Renovation of Existing Space.....	100
Potential to Build New DPCC Facility	100
Potential to Renovate Existing DPCC Facility	102
Likely Implications for Building New or Renovation of Existing Structure.....	102
Potential for Partnerships and Collaboration.....	103
Potential for Local Partnerships	103
Potential for Partnerships with Other Counties	104
Likely Implications of Partnerships	105
Potential for Tax Levy Dedicated to DPCC	105
Potential for Changes in Ownership and Operation of DPCC.....	106
Potential Option to Privatize and Lease the Facility	106
Potential Option to Sell the Facility.....	107
Summary Implications of Divestment.....	109

Conclusions 109

I. Introduction and Context

Like many counties across the United States that continue to operate publicly-owned skilled nursing/long-term care facilities, DuPage County is currently engaged in a process of assessing a range of options concerning the future viability, practical feasibility and financial sustainability of continuing to own and operate its 368-bed Convalescent Center, located in Wheaton, IL.

DuPage County has remained committed for more than a century to the mission of the DuPage County Convalescent Center “to provide quality long-term and rehabilitation services to DuPage County residents in a professional and cost effective manner.” The County and the Convalescent Center (also referred to throughout this report as the Center and DPCC) have been committed and devoted to the provision of high quality care to county residents regardless of income level, with particular concern for low-income residents less likely to be served by other nursing homes (for-profit and not-for-profit) located throughout DuPage and surrounding counties.

Against this distinguished history and County commitment to the Center and especially its low-income residents, DuPage County must weigh the following: Given the current economy, the net costs to the County of operating the Convalescent Center (about \$3 million a year in direct County subsidies, plus about an additional \$3 million in indirect costs of services provided by County agencies to DPCC), and the changing nature of and ongoing uncertainty concerning the level of state and federal funding support the Convalescent Center can count on to help cover operating costs in the future, DuPage County seeks to assess its options concerning the future operation, management and ownership of the Convalescent Center.

CGR (Center for Governmental Research) was engaged by the County to provide an objective third-party perspective concerning the future of the Center by conducting a study, as outlined in the County’s Request for Proposals, to “develop a menu of options regarding the optimal operation and management of the DuPage Convalescent Center” and to “develop a strategy and plan of action for continued delivery of quality care and services to residents of the facility.”

It is important to understand that this study is not intended to be a detailed management study of every aspect of the Convalescent Center. Rather, CGR was engaged to assemble objective data about the County-owned facility and raise core issues and opportunities for the County’s deliberations. This report provides important background information concerning issues affecting the future of the facility, outlines internal and external environmental and policy implications impacting DPCC, and reviews a spectrum of options for the County to consider moving forward.

The goal of the Convalescent Center project from the beginning was to create an objective and comprehensive foundation upon which DuPage County could strategically position itself to respond to current and future conditions affecting the long-term care environment, and to answer this core question: What options should DuPage County

consider to establish a sustainable future strategy and plan of action for continued delivery of quality nursing home care to its residents, and most particularly to low-income residents of the county?

Brief Overview of Convalescent Center

The Convalescent Center is located in the town of Wheaton, the County seat and geographical center of DuPage County—the second largest county in Illinois, with a current population of more than 930,000 residents.

The Convalescent Center contains 368 certified beds, with 353 of those currently operational, offering a combination of long-term care and short-term rehabilitation services. The facility spans four separate but interconnected buildings, which were built in four primary stages, from the 1960s to the mid-1990s. The overall facility is considerably older than many of its nursing home competitors, but has been well maintained over the years, with a solid infrastructure and periodic renovations to maintain an attractive look and feel for an older facility.

The facility currently employs about 500 staff members, about 375 of whom are full-time. About 400 volunteers provide additional support for DPCC, contributing more than 31,000 hours of service in 2014. The facility's budget for 2016 is just over \$37 million.

Framing the Debate and Weighing Options for the Future of the Convalescent Center

Although this study and the concerns about the future of the Convalescent Center have been largely precipitated by financial concerns, the issues in reality are more complex. A number of factors, including DuPage County's historic commitment to DPCC, intermingle with the financial issues, and simultaneously both complicate and help inform the process of determining the future of the facility.

Public nursing homes face difficult financial realities unique to the public sector. The vast majority of residents of county nursing homes—typically higher proportions than in most of their competitors—ultimately wind up on Medicaid, and Medicaid reimbursement rates fall far short of covering the actual costs of the care provided for residents of the homes. In addition, employee benefit costs are typically considerably higher in public nursing homes than in their for-profit and not-for-profit competitors.

These current realities are not unique to DuPage County, and difficult as they are for counties to face in their own right, become even more difficult to address when exacerbated by the current economy, significant recent declines in Medicaid reimbursement levels, and the uncertainty of future long-term-care reimbursement and funding streams from state and federal governments—declines and uncertainties which make rational financial planning for the future of nursing facilities increasingly difficult.

And yet, balanced against these fiscal realities is the County's continuing commitment to the mission of the Convalescent Center and its residents—a commitment many are reluctant to walk away from, even under difficult financial circumstances, and even though the operation of a public nursing home is not a mandated County service. As the DuPage County Board seeks to think strategically about the future of the Convalescent Center, the tradeoffs involved in balancing the historic commitment with changing fiscal realities become central to some of the analyses undertaken in this report.

As part of the debate about the future of the Center, and the level of County financial support for the facility, issues arise concerning what should be the County's priorities in spending its finite resources. For example, what level of resources should be devoted to support seniors, compared to such other priorities as public safety, transportation, and economic development for the county and region? And of those resources devoted to seniors, to what extent should they be devoted to the operation of a nursing home, as compared to other lower levels of care, such as various community-based services? And if there is a desire to support institutional care, should the County be the provider of a service that others in the private sector can and do also provide?

Some argue that while DPCC is needed and must be sustained, it is not necessarily the role of the County to own and operate the facility, and that a private operator may be able to institute efficiencies and various modifications that would reduce costs and improve services. Others argue that there may be a reduction in quality of care if such a transfer of ownership were to occur. Moreover, if a key part of the mission of the Convalescent Center has been to admit people whom other nursing homes are reluctant to accept, what would happen to such individuals under new ownership?

Other issues also enter into the discussion: For example, adequacy of staffing levels and how those staff are deployed; impact of staffing on quality of care offered to residents; DPCC referral and admissions patterns; characteristics of residents, including acuity levels, behavioral issues and the mix of Medicaid, Medicare and private pay residents, all of which have important financial/reimbursement implications for the facility; competition from an array of often-newer nearby nursing homes; and many other issues affecting the operation and future sustainability of the Convalescent Center.

These and other related issues, in addition to the core financial concerns and prospects for the future, are at the heart of the discussion about the future of DPCC, and are addressed throughout this report. The report attempts to point out, and help reconcile, the tradeoffs inherent in the conflicts between the historic commitment to the mission of DPCC, recent financial realities, and future financial uncertainties, as well as opportunities.

CGR believes that the primary focus of this report is on educating the public and DuPage County stakeholders and decision-makers on the context within which the County nursing home operates, including the special features, challenges and opportunities of operating a public nursing facility. *And beyond that baseline reality of current and historical operations, this report is designed ultimately to provide guidance—a roadmap or*

blueprint—to help DuPage County make the most informed and cost effective decisions possible about the future of the Convalescent Center—balancing the legitimate needs and concerns of various important constituent/ stakeholder groups, including residents of the facility, its employees, and DuPage County residents/taxpayers.

Methodology

CGR’s approach to this study focused on an objective assessment of the Convalescent Center operations and of the strengths, limitations, feasibility, costs, future sustainability, and related implications of a number of potential options for the future operation of the facility.

We had no preconceived predisposition or bias as to the ultimate outcome of this process, and had as our primary concern simply using objective information and understanding of relevant issues to facilitate a process that would result in informed decisions that are ultimately in the best future interest of DuPage County.

To inform the study, CGR gathered and analyzed data regarding the current and historic status and operations of the Convalescent Center; the changing role of public nursing homes; changing demographics and their implications for the need for and availability of long-term care services; policy, reimbursement and oversight changes at the local, state and federal levels; and implications for the community of various decisions the County might make with regard to its skilled nursing facility.

Our data collection and analyses consisted of the following main components, starting in August 2015:

Project Steering Committee

We worked closely throughout the project with a 10-person Steering Committee appointed by DuPage County, representing the County Board, key County officials, key DPCC leadership, and a representative from the DPCC Foundation Board. During the course of the project, we met four times in person with the Steering Committee, which played a crucial role throughout the project in providing overall oversight, ensuring that the County’s goals and timeline for the study were met; helping facilitate contacts with key staff and ensuring access to key data; providing liaison as needed with County officials and Board members; providing guidance on various aspects of the project methodology; reviewing and commenting on potential alternative options suggested by CGR; and reviewing and offering insights concerning draft materials as requested.

Interviews and Focus Group Discussions

CGR conducted confidential individual and small group interviews and town hall meeting discussions with almost 200 different County and DPCC employees and community stakeholders.

Several of these individuals were interviewed more than once. Interviews included key positions within the County government, community stakeholders, and staff members representing all functions, levels, shifts and floors of the DPCC facility. All discussions were confidential, with promises that no one would be quoted, and that information would be presented in such a way that no one would be able to determine the source of any information or observations presented in the report.

It was not possible to meet with each staff member as part of the study, but interviews included a representative cross-section of all functions and levels of staff, thus ensuring a wide range of perspectives. Additional opportunities for input were provided through three staff town hall meetings, and making CGR staff contact information readily available to all staff, several of whom took advantage of the opportunity to call or email us with comments and suggestions. Additional DPCC staff perspectives were received via the survey process described below.

These interviews and group discussions gave CGR insights into the operations of the Convalescent Center, interrelationships across DPCC staff and between DPCC staff and other aspects of County government, and strengths and limitations of current operations within the Center, while also providing a number of helpful suggestions for operational and structural improvements with the potential to help make the nursing facility more efficient and financially viable. Many of these discussions were also helpful in framing alternative future options and their potential implications if implemented.

Each of these conversations yielded helpful insights, and helped shape issues addressed throughout this report. Although we promised that each interview would be confidential, and therefore cannot attribute specific comments or suggestions to individuals, we are grateful for the helpful observations and ideas that surfaced in these discussions.

Town Hall Meeting with Residents, Family Members and Volunteers

In addition to the extensive staff discussions, CGR worked with the DPCC administration to schedule a 1.5-to 2-hour town hall meeting open to all residents, family members and volunteers who provide various services at DPCC. CGR staff facilitated the discussion, and the town hall provided an opportunity for key stakeholders from all three groups to share their views and insights on a wide range of topics related to numerous aspects of life and services provided at the Convalescent Center. No administrators or staff members were invited to this meeting, to ensure that participants would feel free to be as candid as possible in their comments, and the wide diversity of comments offered, both positive and negative, suggested that this goal was met. About 75 participated in the town hall discussion, with good representation from each of the three groups.

Surveys of Four DPCC Constituency Groups

To further supplement the information obtained in interviews, focus groups and town hall discussions, CGR provided an additional opportunity for input into the process. We

developed surveys that were distributed to the four primary constituencies within DPCC: staff, residents, family members and volunteers. The surveys asked for respondents to provide ratings of various aspects of DPCC functions and services, as well as offering opportunities for responses to a handful of open-ended questions. Several of the survey questions were asked of each group, to enable cross-group comparisons to be made, while other questions were unique to the particular constituency group. Copies of the surveys are included in the appendix.

More than 400 completed surveys were received, with roughly 100 from each of the four constituency groups. Such a strong level of survey participation reflects the high degree of interest in the study, and a high level of concern about and commitment to DPCC and its future.

Discussions with State and Other County Stakeholders

In addition to the information gathered from DuPage County, DPCC and other local stakeholders, we also conducted interviews with representatives from six other counties with histories of owning and operating public nursing homes, and with representatives of various state government agencies and statewide associations knowledgeable about nursing homes and long-term care.

DPCC Data Collection and Analysis

CGR reviewed and analyzed extensive background materials including annual reports, audited financial statements, internal financial documents and breakdowns, cost reports, organizational charts, staffing needs and patterns, referral and admission profiles, occupancy data, data on payer sources, demographic trends and projections, facility plans, and numerous other types of information compiled for the purpose of this study. Where possible, historic trends were compared to provide perspective to current data.

Comparisons with Other Nursing Homes

As part of the data collection and analysis process, we compared DPCC on selected measures with the 20 other county-owned nursing homes in Illinois, and with 34 other nursing homes (for-profit and not-for-profit) located within DuPage County.

A Final Perspective on our Analytic Approach

The CGR team's findings and final judgments and conclusions were shaped by the composite of all the information gathered from the above components throughout the study. It is important to note that, even though this report includes invaluable information obtained in part from our many helpful interviews and discussions during the project, no single interview carried undue weight in our process. We needed to hear about specific issues from multiple sources, and/or to have information obtained in interviews independently verified from other data or our independent observations, in order for those issues to surface in this report. In other words, isolated comments are not included in any of our analyses or issues raised throughout the report.

Report Format

This document presents a wide range of information in an effort to provide sufficient background as the core foundation for the County to use as it weighs its options going forward. The information is grouped in the following chapters:

- **Chapter II: The Environmental Context**
- **Chapter III: Review of Current Operations of the Convalescent Center**
- **Chapter IV: Fiscal Analyses**
- **Chapter V: Potential Options for County Consideration**

II. The Environmental Context

A number of factors help shape the context within which the DuPage County Convalescent Center exists, and affect both the current operations and financial condition of the nursing home, as well as the viability of options which may be available to DPCC and DuPage County in the future. Some of these factors in the surrounding environment are able to be controlled or influenced by the County and/or DPCC, but most are not unique to DuPage County, and most are at least in part beyond the ability of the Convalescent Center to control directly.

Together and individually, these factors should be taken into consideration in reviewing the remaining chapters of this report. This chapter provides an overview of the big picture trends impacting the Convalescent Center overall operations, current and future.

Demographic Changes: County Senior Population Growing

Similar to other parts of the state and nation, the population in DuPage County is getting older and living longer. As indicated in the table below, the total population for DuPage County is projected to grow modestly by about 4 percent between 2010 and 2025. But during that same period, the 65+ population is projected to almost double (+89 percent), to more than 200,000 residents by 2025—an increase of more than 95,000 in 15 years. By 2025, more than one of every five county residents is projected to be 65 or older, compared to just under 12 percent in 2010. The explosive growth rate among seniors in DuPage County is projected to outpace both the state and national growth rates for this population between now and 2025.

DuPage County Population Projections, 2010-2025

Age Group	2010	2015	2020	2025	% Change '10-'25
Overall	917,942	927,150	939,015	950,948	3.6%
25 to 64	506,304	501,011	494,798	480,714	-5.0%
65+	107,097	133,227	165,821	202,607	89.2%
75+	48,994	53,479	64,600	83,777	71.0%
85+	16,040	17,667	18,601	20,342	26.8%

The baby boomer generation will begin to reach the age of 75 in 2021. Among the 75 and older group—the most significant subgroup in projecting the overall need for long-term care—demographers anticipate an increase in DuPage County of about 71 percent between 2010 and 2025—with almost 35,000 more than existed in 2010. By 2025, those

75+ are expected to represent about 9 percent of the county's population, compared to just over 5 percent in 2010.

The 85 and older population—those most likely to need institutional care at that stage of their lives—is projected to increase by almost 27 percent between 2010 and 2025, to a total of more than 20,000 residents—more than 4,300 additional 85+ residents by 2025 than existed five years ago in 2010. Those numbers will become significantly larger in the years following 2025.

Projections are of course only that—projections—and can change dramatically as unforeseen events and realities intrude. But even so, it is realistic to assume that the number of elderly residents of the county will almost certainly be dramatically higher for the foreseeable future, and these increasing numbers will have significant implications for long-term-care services needed for older citizens in the future.

It is worth noting that not only will there likely be a much larger proportion of older people in the population, but they will also live longer and in many cases healthier lives, but in some cases with limited financial resources. Although the poverty rate among those 65-74 is a relatively low 4 percent, for those 75 and older, the rate increases to just under 7 percent. With the number of 75+ seniors growing rapidly, even if the proportion of those in poverty simply remains constant, the total numbers of low-income seniors who make up much of the target population focus of DPCC will continue to increase.

That probability takes on added significance in light of the fact that of 34 non-DPCC nursing homes in DuPage County, most serve fewer poor residents than does DPCC, including about 1/3 that explicitly restrict the numbers of Medicaid recipients they will admit—five facilities which take no Medicaid recipients at the time of admission, and six others that place limits on the number of Medicaid beds (based on the DuPage County Community Services Long Term Care Facilities 2014 Directory).

As the older population expands—particularly in the segments of the population most likely to need some level of institutional care at some point in their aging process—analyses published by the Illinois Department of Health's Health Facilities and Services Review Board indicate an overall shortage through 2018 ("additional beds needed") across all DuPage County nursing facilities of 136 beds, compared with projected need. This documented shortfall of beds seems likely to increase as the older population continues to expand beyond 2018, and is exacerbated by restrictions associated with many of the existing beds on admitting Medicaid residents, thereby underscoring the value of the Convalescent Center as an important component of the nursing home infrastructure in DuPage County.

It should also be noted that, even though the overall DuPage County population between the ages of 25 and 64 is declining, a disproportionate share of the DPCC resident population is between those ages, with 22 percent in 2014 (and more than a third of all male DPCC residents). Many of the residents in this younger age range have suffered debilitating accidents, and many exhibit various physical disabilities

and types of behavior that require considerable staff attention. Many of these younger residents have few other viable residential options, and because of their ages, often remain residents at the facility for many more years than the typical nursing home resident.

Long-Term Care Planning and Community-Based Services

Research and federal and state policies suggest that there will be increasing demands for community-based services to support the growing proportions of residents wishing to age in place, delaying institutional care as long as possible. This suggests that there will be a growing need for expanding not only such institutional care resources as nursing homes and assisted living and supportive living facilities, but also such community-based resources as home care, personal care, home-delivered meals, case management, respite care, and adult day care programs.

But the concept of expanded use of community-based services as desirable alternatives to institutional care only works if the needed array of services is in place to make that possible. At this point that appears to be only partially the case in DuPage County. Furthermore, despite policies promoting expansion of such community-based services, to date the levels of available funding have not been sufficient to support the policies.

DuPage County has conducted analyses of gaps in senior and long-term-care services, but does not at this point have a specific Long-Term Care Plan in place. The DuPage Federation on Human Services Reform and the DuPage Health Coalition are currently spearheading an effort, with County government participation, to develop community-wide strategies for long-term care and developing partnerships for services to seniors and their caregivers. The need to develop such a comprehensive long-term-care plan for the County is likely to become more and more important in the context of an expanding older population and the changing needs and demands for various levels of long-term care.

Uncertainty of State Funding

The future of State and to some extent federal funding for long-term care in general, and nursing facilities in particular, is highly uncertain at best, and should probably most realistically be thought of as trending downward (although how much, and at what points in time, remain highly speculative, even among “experts” in the field). That reality of uncertainty—perhaps even more than the known recent levels of County contributions to the operation of the Convalescent Center—is what makes the decision-making roles of DPCC administrators and County policymakers so difficult around the issue of the future funding of the DPCC facility.

Illinois already ranks at or near the bottom of states in terms of Medicaid payments to long-term-care facilities, and is currently considering significantly deeper cuts in Medicaid reimbursement rates, as outlined in the Governor’s proposed budget. With the continuing

inability of State officials to agree on a FY 2016 budget, several months into the fiscal year, the level of the actual percentage reduction in rates is yet to be determined. And reimbursement rates for future years remain even more a mystery.

Discussions CGR has had with knowledgeable officials of State agencies and statewide associations yields no clear guidance as to how this issue will be resolved, but there appears to be a cautious consensus that there will be a compromise at some point of something less than the 9.5 percent reduction DPCC has budgeted for. The consensus in these discussions is also that DPCC and DuPage County have been wise to budget conservatively by assuming such a drastic level of rate reduction, a “worst-case” scenario that most think will ultimately be resolved at a proportionate reduction somewhere between the 9.5 percent level and a level of about a 2 percent reduction offered by Democratic leaders in the State legislature.

On a more positive note for 2016 and subsequent years, there appears to be little doubt that the supplemental Medicaid payments available only to public nursing facilities through Intergovernmental Transfer (IGT) funds will continue. In some other states, the future of these payments remains more uncertain, and payments have not always been made on a regular scheduled basis. In Illinois, by contrast, payments have been made consistently in recent years, with no indication that this will change. For DuPage County, payments in recent years have been received quarterly on a routine basis, ranging between about \$2.6 million and \$2.8 million a year. Given the way the formula works, if basic Medicaid reimbursement rates are reduced as anticipated, the reductions would be partially offset by increases in the IGT payments received by the County.

Although in some states there is a sense that policymakers at the state level are not particularly supportive of public nursing homes, the officials with whom we have spoken do not seem to have that sense about Illinois. Despite likely budget reductions, there does not seem to be a sense that State officials are singling out county nursing homes or advocating for their demise or replacement by other providers.

On the other hand, there does not appear to be any unified advocacy effort that speaks consistently on behalf of county nursing homes. At one point there was a statewide association of county nursing facilities, but it has withered away for lack of financial subsidies to underwrite staff support. Statewide associations such as LeadingAge Illinois speak for a variety of nursing homes, but their primary membership consists of not-for-profit facilities, with only about a dozen public nursing home members. So even though public and not-for-profit interests often intersect, there is currently no singular strong voice in Springfield advocating consistently and forcefully on behalf of the interests of county facilities such as DPCC. DuPage County appears to have strong connections at the State level which can translate into support for DPCC and perhaps indirectly also for other county nursing homes, but support for public facilities may be more robust in the future if a more united voice were to arise on their behalf.

The Impact of Managed Care

One of the major unknowns, and greatest perceived threats, concerning the future of all nursing homes, and perhaps particularly county-owned facilities, is the pending expansion of managed long-term care. As an alternative to the current reimbursement model, managed care is designed to negotiate set prices for a range of services, and nursing home providers fear that the reimbursement levels will fall short of current levels, even as their costs continue to rise. But nothing is yet certain as to the future of these approaches across the state. As one leading authority at a statewide agency observed: “Who knows at what level nursing homes will be included in this process, and what the financial impact will be.” Successful implementation partly depends on having sufficient managed care companies engaged in a region, and having a network of service providers sufficient to respond to the needs.

Currently, DuPage County is one of 21 counties across Illinois that are part of a demonstration managed care program, Medicare-Medicaid Alignment Initiative (MMAI), which is being tested for dual-eligible Medicaid and Medicare recipients. The managed care rollout across the state has been slow and inconsistent, with frustrations and finger-pointing from both the managed care and provider perspectives. In the region including DuPage County, six managed care organizations (MCOs) have been established, although one may be closing. Thus far DPCC has affiliated with two of the regional MCOs, with relatively few direct referrals to DPCC resulting to date. Residents at the facility who have been given the option to enroll in the managed care demonstration project have thus far tended for the most part to opt out, choosing to remain with their more traditional coverage.

And while many believe that significant expansion of the managed care model will lead to major reductions in revenues for nursing homes, others are not so sure, and expect something closer to “a wash,” with little or no net reduction in revenues—depending on market conditions, the ability of nursing homes to negotiate favorable rates with the MCOs, and what levels of quality care are provided and how facilities perform on quality measures going forward. Under the current reimbursement system, quality of care measures have not played a predominant role in setting reimbursement rates, but an explicit focus on such metrics under managed care is likely to place a greater burden on nursing homes to demonstrate high quality of care in the future.

Uncertainties notwithstanding, there seems to be little real doubt that managed care is on the horizon, and eventually will become a key player in how nursing homes are funded and conduct their business. The question is how soon, and with what impact. This may be an area where experience and relationships with MCOs/insurance companies, and skills in negotiating rates and conditions, may be critical to the ability of nursing homes such as DPCC to survive and thrive in the future. The possibility of hiring an outside consultant with experience in such negotiations may be an investment that would pay dividends for DPCC and the County as managed care expands.

The Impact of Employee Benefit Costs

Similar to the rest of the public sector across the state and nation, the Convalescent Center has experienced substantially increased costs as a result of increasing health insurance, pension costs and other benefits for its employees. From 2010 to 2014, DPCC total wages rose by less than 1 percent, while health care and pension costs rose by nearly 22 percent over the same time period.

The 2016 Convalescent Center budget projects that for every \$1 in salary the average DPCC employee receives, an additional 44 cents in benefit costs is incurred by the Center, up from 33 cents for every dollar earned in 2010. These non-salary personnel expenses have increased each year since at least 2010, and while they include other costs such as the employer's share of social security payments, tuition reimbursement, and other benefit payments, the main drivers of the increase have been health care and pension obligations.

While both private and nonprofit nursing homes have also experienced significant increases in employee costs, especially as it relates to costs for health insurance, public nursing homes have been disproportionately impacted. The benefits provided to public sector employees trend higher than in the private sector and include pension contributions not typically offered by their private counterparts. *As a result, no matter how efficiently the Convalescent Center is operated, and no matter how effective it and other county nursing homes are in controlling costs, they each face built-in benefit costs that they cannot control by themselves, given decisions approved over the years by decision-makers at the State and County levels.*

DPCC's Competition

As noted earlier, there are 34 nursing homes in DuPage County in addition to DPCC—a mixture of for-profit and not-for-profit facilities. Many of these are newer facilities with less of an “institutional” feel to them than the older DPCC facility. Some offer higher proportions of single-bed rooms, especially for short-term rehabilitation residents, than are currently available at DPCC.

Clearly there is considerable competition for nursing home residents in the county and region. This is increasingly the case for the highly-lucrative short-term rehab market, which is becoming increasingly saturated, particularly with the increase in facilities offering more single rooms and amenities such as free TV and phones, which are often highly desired and even demanded by many potential residents. The competition may become even more pronounced with the pending purchase by Northwestern Medical/Central DuPage Hospital of the Marianjoy nursing facility, with its dedicated single-room short-term rehab beds. With the majority of referrals to DPCC historically having come from Central DuPage Hospital, this referral source may be affected going

forward by CDH's new affiliation with Marianjoy. At this point, DPCC is struggling to find ways to keep pace with this competition, including developing potential partnerships, as discussed in more detail later in the report.

On the other hand, it should be noted that DPCC appears to have less competition for low-income and "hard to place" residents, which many of their competitors are less likely to admit as residents, as noted in more detail in the next chapter.

III. Baseline Findings: Current Operations of the Convalescent Center

Given the environmental context described above, this chapter describes the DPCC baseline: the “what is”—a description of important aspects and features of the Convalescent Center and its operations as it currently exists, along with some historic perspective. The premise underlying the presentation of information is that decision-makers and the public need to have an understanding of how the facility operates, in order to understand and evaluate the opportunities and challenges that the various potential options for the future must address (outlined in Chapter V).

Summary Overview of the Center

As noted in a previous chapter, the DuPage County Convalescent Center is a certified 368-bed facility, with 353 of those beds currently in operation. It is the only publicly-owned nursing home in DuPage County. DPCC provides 24/7 nursing and medical care, as well as physical, occupational and speech therapy. Its 2016 budget is just over \$37 million, most of which covers wages and benefits to support a staff of just over 500 County employees, including about 375 full-time staff.

The vast majority of services to Convalescent Center residents are provided by the County employees, though a few services are outsourced in whole or in part. Medical services are provided by non-employee physicians, as are dental, podiatry, psychology, psychiatry and podiatry services as needed. Although most residents receive various levels of rehabilitation therapy from DPCC staff, more extensive levels of physical, occupational and speech therapy, including short-term rehabilitation services, are provided on a contract basis with Alliance Rehab, under the overall supervision of DPCC staff.

Physical Plant Overview

As noted earlier, the current Convalescent Center has evolved and expanded over a roughly 50-year period. Beginning in the early to mid-1960s, when the Center and South buildings were constructed, the facility expanded in 1975 with the addition of the largest concentration of current beds in the North building, with the final addition, the East building, added in 1995. The four buildings, though built separately, are all interconnected to form a single seamless facility.

Bed Distribution

As indicated in the table below, the Center's beds are distributed across eight separate units spread across the four buildings. The total number of beds in operation has gone through two significant changes since the end of 2013, reflecting changes in the distribution and use of beds on the 1 East unit between short-term rehabilitation and long-term care beds, and between private and double-occupancy rooms.

Unit	Beds in Operation at DPCC		
	Current (as of 8/1/15)	12/1/13 - 7/31/15	Prior to 12/1/13
1N	56	56	56
2N	56	56	56
3N	56	56	56
4N	56	56	56
3C	16	16	16
2S	20	20	20
2E	50	50	50
1E*	43	28	50
Total	353	338	360

* Post-Acute Unit History	
Current	18 beds dedicated to short-term post-acute; 25 long-term care beds
12/1/13 – 7/31/15	28 beds dedicated to short-term post-acute, all private
Prior to 12/1/13	50 beds dedicated to short-term post-acute, mix of semi-private and private

Thus, of the 353 beds currently in operation, 335 are considered long-term care beds, with 18 beds dedicated to short-term post-acute rehab residents. Long-term care beds can also be used if needed for short-term rehab purposes, as available.

Although the Convalescent Center facility dates back more than 50 years, the vast majority of its residents are housed in the two most-recently-built structures. Almost two-thirds (224) of the 353 active beds are in four units in the North building, completed in 1975, and 93 (just over a quarter) are in the East building opened in 1995.

Out of a total of 200 resident rooms across the four buildings, about a quarter are designated as single-bed, private rooms, with between two and eight private rooms on each wing (with the exception of 13 designated on 1 East). Other than five 3-bed rooms, the remainder are configured as two-bed, semi-private rooms.

It should be noted that the small number of beds in the Center building reflects the fact that much of the space in that building is used for offices, cafeteria, recreation, kitchen and various community uses, and the small number of beds in the South building reflects

the fact that three floors in that building have been vacant for a number of years (at one point, well over 125 beds in that building were certified and in operation, at a time when the facility was certified for more than 500 nursing facility beds). More will be said about the configuration and use of beds later in the report.

The Convalescent Center operates at somewhat of a disadvantage compared to many of its competitors because of its older, more institutional look and feel. The large majority of semi-private rooms and the fact that most of those involve sharing a toilet, with sinks typically separated from the bathrooms—coupled with inefficiencies in size and functionality and design of many of the common areas—create barriers to the ability to provide the type of homelike environment DPCC leadership would prefer to offer throughout the facility.

Physical Improvements and Capital Upgrades

Despite such structural limitations that are largely a function of the initial building designs that are consistent with most nursing homes built in the years when DPCC was constructed, the County and Convalescent Center officials have done much to create as pleasant a look and feel to the facility as possible. With capital funding support from the County, supplemented by federal grants and grants from the Convalescent Center Foundation, a number of aesthetic improvements have been made over the years to the resident rooms and common areas of the facility. These improvements have created a more homelike appearance and atmosphere than exists in many other facilities of similar age and structure.

For example, in recent years, significant renovations have been made to upgrade lighting, painting of rooms and common areas, other upgrades to various common areas throughout the facility, and adding vanities in rooms. In addition, the overall facility has been well maintained, with consistent annual capital investments in things like a new roof, annual tuckpointing updates, window replacements, elevator repairs, and other basic maintenance upgrades that have helped enhance the functionality and ambience of the facility. In addition, the County was able to make use of a federal bond program in recent years to significantly expand and upgrade the capacity of the DPCC kitchen, thus improving the efficiency of the dining services component of the facility, while also creating the potential for expanded entrepreneurial opportunities for that function to create additional revenues for DPCC in the future, should the County be interested.

A current 10-year capital plan for the DPCC facility anticipates capital investments of almost \$3.2 million over the four years between 2016 and 2019, followed by current estimates of an additional \$4.5 million between 2020 and 2024. These include basic maintenance tasks such as continuing tuckpointing, caulking repairs, electrical work, handrail replacements, window replacements, elevator repairs, HVAC upgrades, and the like.

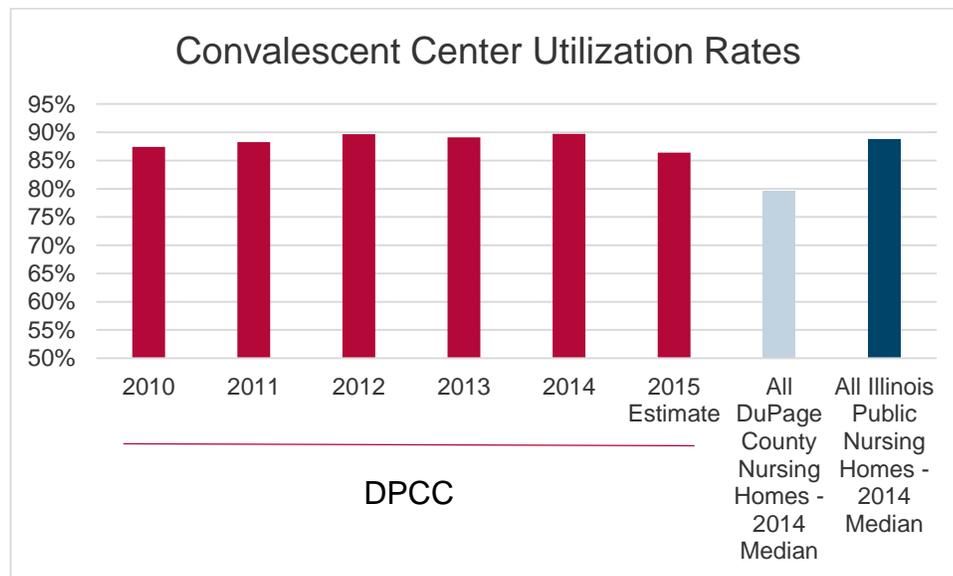
Major improvements and renovations of living quarters and common areas are not included in such totals, and would cost several million additional dollars across the facility,

should the County choose to make such an investment (discussed among options in the last chapter of the report).

The Convalescent Center receives a partial return to help offset the costs of its capital renovations investment over the years, built into its basic Medicaid daily reimbursement rate. The rate includes three components: the largest of which (56%) is for nursing, followed by support services (37%), with the smallest component (7%) covering capital costs. As of October 1, 2015, the capital portion of the Medicaid reimbursement rate was \$12.98, out of a total daily rate of \$181.68.

Census and Occupancy Rates

Daily census and occupancy rates are obviously a critical factor in determining the financial viability of any nursing home. On the most basic level, unfilled beds represent lost revenue to the facility. As indicated in the graph below, occupancy rates have been fairly consistent at the Convalescent Center over the past several years, and compare favorably to other nursing facilities in DuPage County, but there remain significant numbers of unfilled beds that represent opportunities to expand revenues in the future.



Occupancy rates shown in the graph above are consistently based on the 360 licensed beds that were in operation through 2013. Using that denominator, rates for the past five years have typically averaged between 87 percent and just under 90 percent, with a decline to closer to 86 percent in 2015 to date. If only the reduced number of 338 beds in operation in 2014 and the first two-thirds of 2015 are used as the basis for determining the occupancy rate, the rates were closer to 95 percent in 2014 and about 92 percent thus far in 2015. Over the years, occupancy rates at DPCC have been consistent with the median rates in 2014 for all public nursing homes in the state, and have typically exceeded by about 10 percentage points the 2014 median rates for all nursing homes in DuPage County.

However, occupancy rates as reflected in the average daily census of beds filled have declined significantly in 2015, as indicated in the graph below.

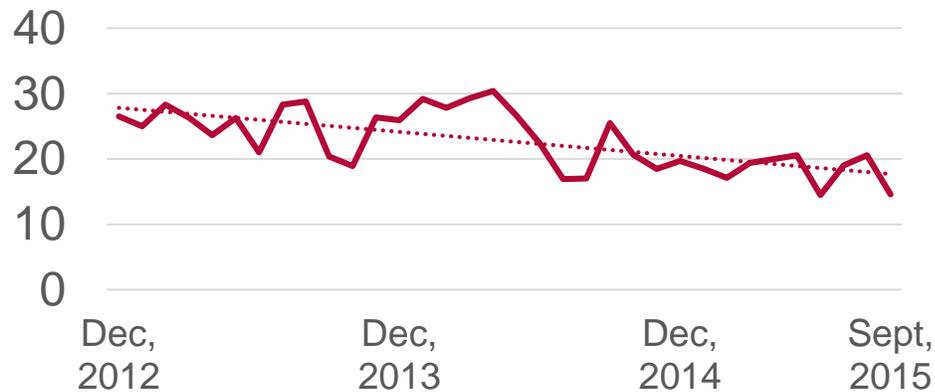
	Total Patient Days					Avg Daily Census		
	2013	2014	2015	2015 Goal	Y-T-D	2013	2014	2015
Dec	10010	9954	9615	10164	-3.41%	323	321	310
Jan	9871	10104	9674	10164	-4.26%	318	326	312
Feb	9018	9127	8681	9180	-4.89%	322	326	310
Mar	9971	10174	9582	10164	-5.82%	322	328	309
Apr	9641	9736	9222	9836	-5.28%	321	325	307
May	9858	9936	9690	10164	-2.48%	318	321	313
Jun	9243	9506	9177	9836	-3.46%	319	317	306
Jul	9751	9745	9728	10164	-0.17%	315	314	314
Aug	9890	9860	9805	10164	-0.56%	319	318	316
Sep	9513	9720	9408	9836	-3.21%	317	324	314
Oct	9720	9801	-	10164	-	314	316	-
Nov	9525	9335	-	9836	-	318	311	-
YTD	116,001	116,998	94,582*	119,669		319	321	311

- Totals through September, with two months yet to be added.

Using DPCC's fiscal year of December through November, total patient days month-to-month have been consistently lower in 2015 than in previous years. The average daily census through September 2015 averaged 10 fewer occupied beds than in all of 2014.

Most of the reduction in daily census over the past year has been attributable to declines in the number of occupied short-term rehabilitation beds. While the predominant number of long-term-care beds (all but 18 under the current bed configuration) has remained consistently occupied year to year at around the 95 percent level, the number of occupied short-term rehab beds has steadily declined in recent years, from an average daily census of about 30 beds as recently as 2012, to the mid-20s in 2013 and 2014, to 18 in 2015 through September.

Short-Term Rehabilitation Unit Average Monthly Census



If one assumes that ways can be found going forward to restore the average daily census from 2015's 311 to 2014's total of 321, and that the number of occupied short-term rehab beds within those totals could be restored from this year's 18 to 25, occupied bed revenues could be increased year over year by about \$1,510,000. This is based on the assumption that each of seven additional short-term rehab residents would be reimbursed at the average Medicare daily rate of about \$500, and the remaining three additional long-term care residents would be reimbursed at the 2015 Medicaid daily reimbursement rate of about \$213, including base reimbursement rate plus enhanced IGT rate.

Even if the daily census could be restored to last year's level of 321 with only additional long-term-care residents at the daily Medicaid rates, with no increase in short-term rehab residents, that would translate into additional revenues of about \$777,000 over 2015 resident reimbursements (compared with the \$1,510,000 figure with short-term rehab increases included). Either way, taking steps to fill greater proportions of the facility's beds should be and is a priority for DPCC, as discussed further throughout the report.

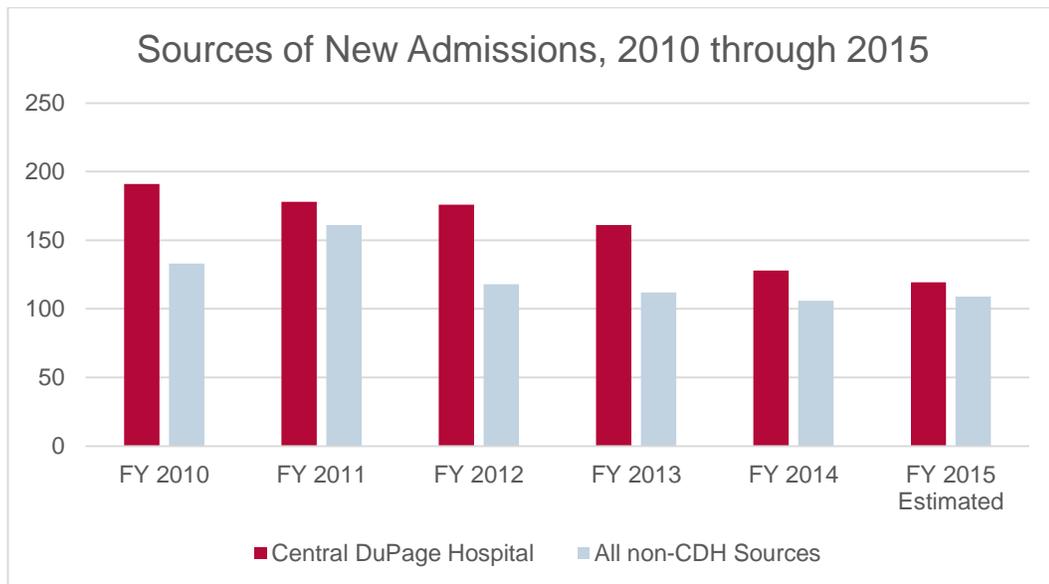
Referrals and Admissions

Occupancy rates and average daily census are functions of separate factors such as length of stay and numbers of admissions. Total annual admissions have declined each year between 2011 and 2014, from 339 in 2011 to 234 in 2014 (a 31 percent decline), before leveling off through the early fall months in 2015. It was not unusual for the Convalescent Center to average in the vicinity of 25 to 30 monthly admissions, or more, in many months, through 2013. Such numbers became more rare toward the latter part of 2014. For five months spanning the latter portion of 2014 and early 2015, admissions shrank to an average of just over 14 per month, before increasing to an average of about 21 monthly admissions in the most recent eight months through October 2015. These

declines coincided in part with staffing vacancies, inexperienced staff and administrative reorganizations within the DPCC Admissions office—issues which now appear to be stabilizing.

Perhaps of more concern than the overall decline in numbers is the fact that the vast majority of the reductions were in the financially most lucrative short-term rehab unit, with residents typically reimbursed at high Medicare rates during their relatively short stays. Between 2012 and the fall of 2015, the number of long-term-care admissions averaged between 40 and 45 per year, with an increase to more than 60 by the fall of 2015. But during that same period, short-term admissions were on pace to decline by about one-third through 2015, based on data through October. From 2012 through 2014, more than 80 percent of all admissions each year were for short-term subacute rehabilitation. Thus far in 2015, that proportion has shrunk to 69 percent.

The declines in admissions have been most pronounced from Central DuPage Hospital (CDH), which has consistently been the predominant source of referrals to the Convalescent Center over the years. In several years, it has been the referral source for almost 60 percent of all admissions to DPCC, but in the past two years, the proportion has dropped to less than 55 percent. As indicated in the graph below, the total number of annual admissions based on referrals from CDH to DPCC has declined by more than one-third since 2010.



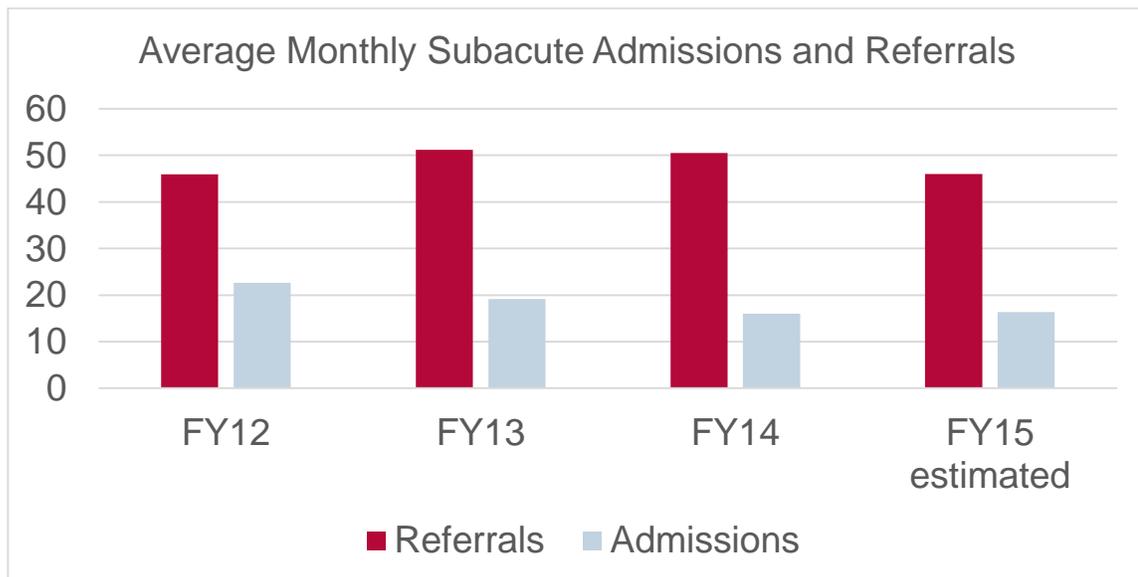
While admissions from the most frequent additional referral sources—Marianjoy, Edward and Good Samaritan Hospitals—have remained relatively consistent at about 10 to 15 per year, and admissions from private home settings have bounced back and forth between about 25 and 40 per year, admissions from other nursing homes have been reduced by more than half from their recent peak of 33 in 2010. With the pending

finalization of the purchase of Marianjoy by Central DuPage Hospital and its parent Northwestern Medical network of facilities, there is at least the potential for even fewer referrals to DPCC in the future from both CDH and Marianjoy, unless some agreements and potential partnerships can be worked out between these entities— possibilities discussed in more detail in the final chapter.

Overall, since 2010, about 81 percent of all admissions to the Convalescent Center have come from hospitals, including about 6 percent from acute rehabilitation hospitals such as Marianjoy. Another 11 percent have entered DPCC directly from their private home settings, and 8 percent have been referred from other nursing homes.

Short-Term Subacute Referrals Resulting in Admissions

The short-term rehabilitation admissions referenced above have reflected declining proportions of total short-term referrals to DPCC. As indicated in the graph below, total numbers of short-term subacute referrals have remained relatively constant since 2012, with an average of roughly 46 to 50 referrals per month. However, during that period, short-term admissions have declined from an average of about 23 per month to about 16 short-term admissions—from admitting about half of all short-term referrals to admitting only about 35 percent of all referrals in the past two years.



Of those referred to but not admitted by the Convalescent Center, the number who chose another facility for one reason or another has more than doubled in the last four years, from 68 in 2012 to 137 in the first 11 months of 2015. But most of the referrals that did not result in admissions were based on rejections by DPCC for a number of reasons related to not meeting a variety of financial and health and behavioral criteria. In 2012, DPCC declined to accept about one-third of all referrals; by 2014, that proportion had grown to more than 45 percent, dropping back to about 40 percent in the first 11 months of 2015.

DPCC administration and Admissions staff are in the process of prioritizing new ways of making it easier for the facility and prospective residents to get to a “Yes” decision about admissions more frequently, thereby reducing both the numbers of persons who choose another facility of their own volition and the numbers of cases in which DPCC declines to admit an applicant for financial or health/behavioral reasons.

Of the primary sources of referrals and admissions mentioned in the previous section, over the past few years DPCC has admitted just under half of all referrals received from Central DuPage Hospital, and has admitted more than half of the referrals from Marianjoy. On the other hand, it has admitted only about one-third of all referrals from Good Samaritan, and only about one of every five referrals from Edward Hospital. These data may suggest the need for different types of admissions approaches in the future related to different referral sources.

Long-Term Care Referrals and Admissions

Convalescent Center admissions staff have typically not maintained as much information on sources of referrals for long-term care admissions as has been maintained for short-term admissions. But other data that have been maintained are instructive.

Data for the past three years indicate that, for the average long-term care resident, the admission process took more than 100 days from initial application to the actual date of admission. Furthermore, the beds ultimately occupied by the newly-admitted residents had been open for an average of about 50 days per bed. If DPCC were able to measurably reduce either or both of those averages, the implications for increased revenues could be significant.

For example, assuming recent years’ average of about 45 long-term-care admissions per year, at an average of 50 days during which the bed of each of these new admits was open prior to admission (representing an average annual total of 2,250 days)—with an average reimbursement (mixture of private pay and Medicaid rates) of \$225 per resident day—these empty beds have resulted in about \$506,000 in lost revenues on an annual basis. *If these empty bed days could be cut in half for each admission, DPCC could realize additional revenues of about \$253,000 per year.*

Process Underway to Strengthen Referral and Admission Process

DPCC is currently in the process of carefully monitoring and reassessing all aspects of its approaches related to the referral, review and admissions decision-making process.

Residents with High Needs

Anecdotally, but consistently in discussions with staff across all levels and functions at DPCC, there is strong agreement that increasing proportions of residents have increasingly greater needs that must be addressed, making it steadily more and more difficult over the years for DPCC staff to effectively serve and meet the needs of residents in the facility.

Staff at all levels consistently report that significantly greater proportions of residents have higher levels of acuity and medical needs, have more frequent and complex behavioral problems, and are increasingly demanding—thereby creating more stresses and demands on staff, whose levels, while continually meeting or exceeding state standards, have not expanded to meet the reported growing needs and expectations of residents (see further discussion of staffing in a subsequent section of the report).

Historical data from the facility to document such anecdotal reports of these increasing needs were not available, but a number of indicators and comparisons with other facilities are available to offer corroboration in support of the staff claims and stories. Among the available supporting data:

- CGR only had access to two years of data on acuity levels, as measured by the facility's Medicaid case mix index (CMI), but during that time, the facility overall CMI rose from 1.0265 in January 2014 to 1.228 as of October 2015. The aggregate CMI score for the facility is based on the sum of individual resident acuity scores measuring levels of health/illness, based on clinical status, functional impairments and various other characteristics and needs as identified in a standardized assessment tool. Higher facility CMI scores indicate higher composite resident sickness/acuity levels. Furthermore, 87 percent of DPCC's Medicaid residents score in the high Resource Utilization Group (RUG) categories, reflecting high levels of resident medical conditions and skilled care needs.
- Comparative data available from the Illinois Department of Public Health suggests that DPCC houses a higher proportion of residents with a primary diagnosis of Alzheimer's/dementia than do most other nursing facilities in DuPage County: 16 percent in DPCC, compared with a median of 6 percent of residents in all DuPage County nursing homes. Moreover, information from DPCC suggests that, beyond primary diagnoses, closer to two-thirds of all Convalescent Center residents have some dementia symptoms.
- About three-quarters of DPCC residents have some type of mental illness diagnosis, including 8 percent as the primary diagnosis. These rates significantly exceed the comparable rates in most other nursing homes in the county.
- DPCC houses a disproportionately high share of residents under the age of 65. More than one of every five residents (22 percent) of the Convalescent Center is under 65—a higher proportion than in any other public nursing facility in the state, and more than three times the median of 6 percent of residents in all DuPage County nursing homes. The proportion is even higher among male residents: more than a third of all males in DPCC are under 65. (It should be noted, however, that this overall 22 percent proportion was higher in the past; the 2009 Blue Ribbon Panel Report on the Convalescent Center states the share of residents under 65 at that time at 30 percent.)

The significance of these variations in proportions of younger residents has to do with the added behavioral concerns presented by many of them. Those knowledgeable about nursing homes in general, and about DPCC in particular, suggest that the large proportion of younger residents is typically associated with higher care needs, more disruptive behavior, higher proportions with various disabilities, and greater likelihood of social, behavioral and substance abuse issues. And, as younger residents, they are likely to remain residents for many years, with their accompanying higher demands on staff time. Furthermore, the issues represented by these younger residents, and the staff time required to address them, are often inadequately captured by activities and levels of care recorded in assessments that help determine facility reimbursement rates.

These are only a few among a number of examples of the Convalescent Center's historical willingness to accept what are often referred to as the "hard to place" residents that represent the "safety net" function of many public nursing homes. DPCC is perceived by many, including competitors, as providing this "safety net" function by serving "hard to place" residents that for-profit and non-profit homes are often more reluctant to admit. Data cited earlier in the report indicate that about one-third of DPCC's competitors in the county place restrictions on admitting Medicaid recipients, and the above data, along with anecdotal observations offered in interviews with both local and statewide stakeholders representing a wide range of perspectives and providers, strongly support the conclusion that *many of the current and likely future residents of the Convalescent Center would be less likely to be admitted to most other nursing facilities in the county.*

Residents by Payer Source

The ability of the DPCC facility to meet the various needs of its residents is, of course, dependent to a great extent on the reimbursement it receives for each day of resident occupancy. Reimbursement rates per resident day vary considerably by payer source, ranging from the most lucrative Medicare rate to the lowest daily rate paid by Medicaid. Typical rates are as follows:

- Medicare: An average of about \$500 per day
- Private pay: Currently about \$270 per day, expected to increase by 4 percent in 2016
- Insurance: An average of \$600 per day
- Medicaid: \$181.68 as of October 1, 2015; 2016 budget assumes a reduction to \$163.15 per resident day (supplemented by an enhanced IGT payment).

Admissions by Payer Source

Because traditionally more than 80 percent of all admissions have been for short-term rehab residents, most of which are covered by Medicare, the vast majority of DPCC residents receive Medicare reimbursement at the time of admission. From 2010 through early fall of 2015, about 1,600 new DPCC admissions occurred; of those, the following proportions were covered by the four primary payer sources:

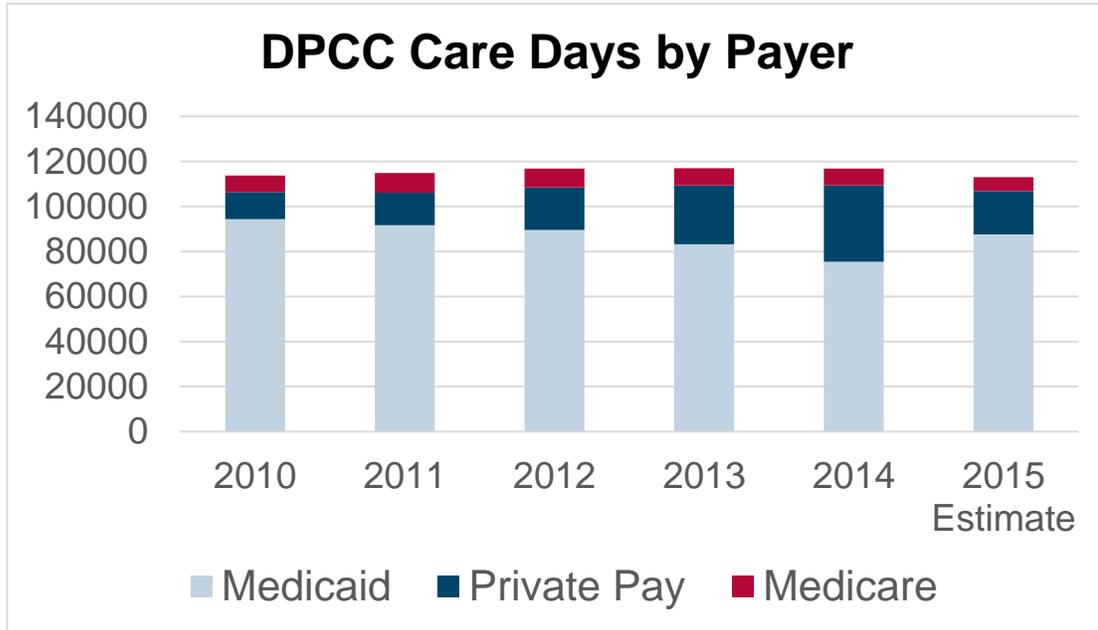
- Medicare: 71.4 percent
- Medicaid: 11.6 percent
- Insurance: 8.6 percent
- Private pay: 8.4 percent

The proportion of Medicare admissions has remained consistent from year to year. The proportions of Insurance and private pay admissions have tended to increase slowly since 2010. Only Medicaid admissions have changed significantly over the years.

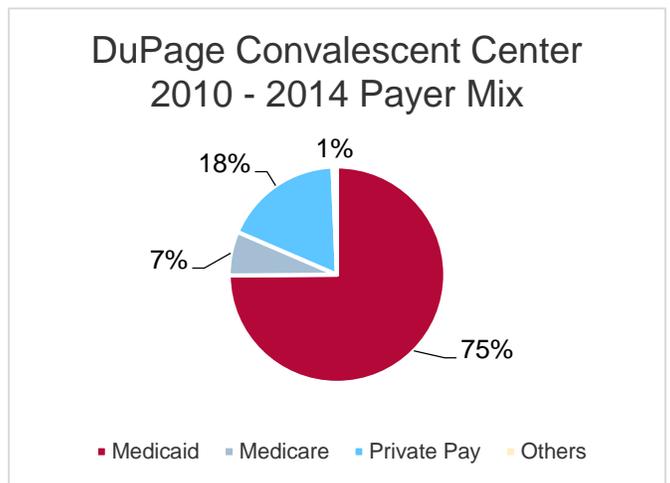
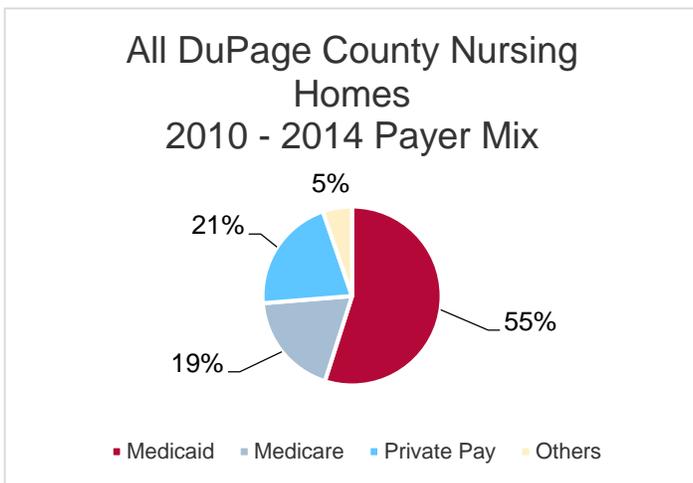
Despite the primary historic focus of DPCC on serving low-income residents of the county, the proportion of Medicaid residents at admission has declined over the past few years, from about 15 percent of all intakes in 2010 and 2011 to about 7 percent in 2015 to date. These payer source proportions subsequently change dramatically over time—as most residents who remain in the facility beyond the short-term rehab residents transition at some point to Medicaid (see next section). But these admission data suggest that DPCC—whether consciously or subconsciously (or because of changes in the economic circumstances of those referred to the facility)—in recent years has been accepting somewhat higher proportions of persons who are able, at least at the time of admission, to cover their daily resident costs at a higher level than is true for those who enter with only Medicaid reimbursement coverage from day one.

Total Resident Care Days by Payer Source

Some of those who initially are admitted for short-term subacute rehab services wind up needing to transition post-rehab to long-term care in the facility. When that happens, their reimbursement payer source typically changes, to private pay, insurance, or Medicaid, or perhaps some combination of all of these at some point, depending on their economic circumstances and how long they remain in nursing care. Beyond that, those who are admitted initially on Medicaid virtually never change their payer status, while the majority of those who enter covered by some combination of private resources or insurance ultimately convert to Medicaid coverage after their other resources have been depleted. Thus, factoring in all resident care days—both long-term care and short-term rehab—the proportions of days covered by Medicaid, Medicare and private pay (both of the latter including also some private insurance reimbursement) look very different than do the payer source patterns at admission, as indicated in the graph below.



From 2010 through 2014, total private pay resident days increased steadily from an average of 33 residents per day in 2010 to triple that, 93 per day in 2014, before falling back in 2015 to date. During that same period, Medicaid resident days declined from 259 to 207, before increasing again in 2015 to date. The extent to which DPCC can serve more private pay residents on an ongoing basis, while at the same time meeting the County’s historic mission to serve the low-income population, helps the facility reduce the need for County subsidies, as *for each Medicaid resident day, DPCC loses about \$77—representing the difference between the costs of operating the facility and the daily Medicaid reimbursement rate (including the IGT supplement)*. The financial implications of that daily shortfall become clearer in the graph below, which reflects the proportions of resident days paid for over the past five years by the primary payer sources.



In the five years from 2010-2014, three-quarters of all resident care days at the Convalescent Center were paid for by Medicaid—fully 20 percentage points higher than in all other DuPage County nursing homes, all of which are operated by for-profit or not-for-profit providers. *At a loss of \$77 per resident day, those differences make it virtually impossible for DPCC to operate without other funding subsidies, unless there are significant changes in the facility’s cost structure and/or other sources of offsetting revenues.* But even with such revenue shortfalls, it is still preferable for as many beds to be occupied as possible, even at Medicaid reimbursement levels, in order to increase revenues and distribute the facility’s fixed costs across as many full beds as possible.

One potential source of closing the financial gap through offsetting revenues would be increased proportions of resident days paid for by higher Medicare reimbursement rates, but over the past five years, only 7 percent of all DPCC resident days have been paid for by Medicare. By contrast, in all other nursing homes within the county, that proportion has been almost three times as high—19 percent. DPCC’s number of Private Pay residents has been increasing in recent years, as noted above, but even here, DPCC’s overall 18 percent over the past five years trails the 21 percent total in all nursing homes in the county. The bottom line financial implications of these resident-care-day data and trends are spelled out in more detail in Chapter IV.

Nursing homes do not have full control over whom they admit. They are dependent upon referral sources such as hospital discharge planners, geography, perceptions, and many other variables over which they do not have total control. This may be more true for public facilities than others, given the mission focus of facilities such as DPCC.

Nonetheless, there may be opportunities within this overall context to market more aggressively on a selected basis among physicians, hospitals, other nursing homes, and others who work closely with seniors across the community, such that the Convalescent Center increases the odds of attracting more lucrative private pay and/or Medicare residents, without undermining its historic commitments to serve low-income and harder-to-place individuals. For example, are there ways to build on recent trends and expand the numbers of private pay residents in the future? Are there ways to attract more Medicare residents? Can higher proportions of referrals to the DPCC facility actually wind up as admitted residents? There may be opportunities to change the payer mix in future years in ways that maximize the revenue-generating potential going forward, while at the same time adhering to the facility’s historic mission. Solutions will not be easy, but opportunities may exist. This issue will be addressed in more detail, with potential implications outlined, in Chapter V.

The Importance of the MDS Process for Increasing Revenues

It is perhaps worth noting in this context the importance of the MDS process in maximizing revenues, regardless of payer type. The MDS (Minimum Data Set) initiative is the federally-mandated process for the clinical assessment of all residents in Medicare or

Medicaid certified nursing homes. All residents, regardless of payment type, are included in the MDS process; it is what documents and generates reimbursement for the DPCC facility.

This critical function is administered by four Registered Nurses/MDS Coordinators who work with all staff and units to ensure patient assessments and activities are fully documented, are on an established schedule, and in keeping with the changing rules and regulations for reimbursement.

Ongoing training and orientation of staff providing care to properly document the range and levels of care is paramount to capturing revenue for DPCC. When shifts are understaffed by call-ins or other factors (see below), and when outside contract agency staff are engaged to help fill in the staffing gaps, accurately capturing revenue for the facility becomes all the more difficult. We heard concerns expressed about potential loss of necessary information about working with residents on activities of daily living (ADLs), which can have major implications for lost revenue generation.

There is no question that how the MDS process is implemented, and how its importance is communicated to staff through on-going training and support, directly impacts the rate of reimbursement for the facility. Full implementation of electronic medical records throughout all staff serving residents (the process is continuing) should help to capture more of these reimbursable activities while they are occurring. Maintaining a full complement of in-house staff on all shifts will be important to balance the continuing demands for providing quality care with the demands of accurately documenting the care provided to ensure sufficient revenue.

Residents Needing Therapy

As indicated above, one of the important sources of revenue for the Convalescent Center is the short-term subacute rehab residents and the primarily Medicare revenues they generate. In response to the declining numbers of rehab residents and resulting empty beds, as referenced above, DPCC has made decisions in recent years to reduce the number of designated rehab beds from 50 prior to the end of 2013 to 28 through July 2015 to the current total of 18. That latter number itself is somewhat flexible, as the facility has the ability to absorb into non-rehab beds additional rehab residents as needed, and even to continue to reconfigure the numbers of designated rehab beds in the future, as needs and demands dictate.

Debates continue within DPCC leadership as to whether to (a) continue with the reduced numbers of rehab beds, thereby in effect bowing to the recent trends and the increased competition and saturation of new, often single-room rehab beds in other nursing facilities in the county—or, alternatively, (b) to more aggressively seek to market and recruit short-term rehab residents, and to reconfigure the facility's beds accordingly, including creating more, rather than fewer, single-room beds to attract residents.

At this point, there is insufficient data to begin to provide definitive answers to the question of which direction makes most sense: Whether the reduction in short-term beds makes it easier to fill a higher proportion of the newly long-term-care beds—with sufficient revenues generated to offset the loss of Medicare dollars for the short-term beds that were previously filled—or whether the longer-term care demand is not sufficient to offset the loss of Medicare revenues, in which case more aggressive efforts to attract rehab patients may be needed. The data on occupancy and revenues pre- and post-July 31 bed reconfiguration will need to continue to be tracked and analyzed closely to help determine the most appropriate approach going forward, both in terms of the impact on revenues, and also the ability to attract more long-term-care residents who may not have been admitted in the past, when more beds were dedicated to short-term residents. This issue will be addressed in more detail in Chapter V.

Beyond residents receiving short-term therapy services, another two-thirds or so of the residents receive other less-intensive long-term-care physical therapy on an ongoing basis.

Therapy services are provided by a combination of outsourced services via a contract with Alliance Rehab and in-house DPCC employees.

Alliance Rehab Contract

Alliance Rehab staff provide a mixture of occupational, physical and speech therapy. Between 2009 and 2012, Alliance typically served more than 500 Medicare A patients per year (including some duplicate counts from month to month), providing an average of more than 8,000 “Medicare days” of service per year. In 2013 and 2014, the number of such patients dipped into the 480s, and the days of service dropped below 8,000, to about 7,500 in 2014, as the number of rehab residents in the facility declined. Residents receiving services per day have averaged between 15 and 17 each month during the past two years for Medicare A patients (primarily short-term rehab) and between 16 and 19 for Medicare B (primarily long-term-care residents).

The Alliance Rehab staff also provide a variety of rehab and wellness services on an outpatient basis. Since 2012, outpatient services have been provided to about 45 community residents per year in the DPCC facility. In addition, each month an average of about a dozen employees and another 35 or 40 community “wellness members” take advantage of the fitness services provided by Alliance staff

In-House Physical Rehab Services

In addition to those receiving high-intensity, focused short-term rehab services (and some long-term residents also receiving intensive rehab services) via the Alliance contractual arrangement, DPCC also provides an internal Physical Rehab unit made up of a physical therapist and eight Physical Rehab Aides on the County payroll who provide a range of therapy services for long-term-care residents. These services primarily focus on helping residents stay fit and maintain a high quality of life via range of motion and other activities

that are provided in the facility's fitness gym, physical rehab gym, and on the residents' floors, including at bedside, depending on need and mobility of the residents.

Over the past several years, this unit has typically served an active caseload of around 250 residents or more at any given time, including provision of direct rehab services for most, as well as additional assessments, wheelchair consultations and other services for some residents who are not actively receiving direct therapy treatment. . Some of those may be referred to more intensive services provided by Alliance as needed, but for the most part, these residents have all their therapy needs met by the in-house physical rehab therapy staff. Over the past three years, typically about 140-145 of those active at any given time are scheduled for services each day, with about 100 of those actually receiving services. Scheduled frequency of rehab services for residents ranges from twice a week to five times a week, depending on resident needs, mobility and ability to benefit from the services. Recent staffing shortages have reduced the numbers being served somewhat during parts of this year, but the goal is to maintain full staffing and provide therapy services for as many residents as can profit from them.

Although these physical rehab services provided to the majority of residents do not receive separate reimbursement, as do the Alliance more intensive rehab services, DPCC officials believe that they significantly enhance the quality of life of residents, and contribute to the quality measures that compare DPCC to other nursing facilities. They also believe that the rehab program contributes to lowering the facility's re-hospitalization rate, which is typically lower (better) than the federal benchmark rate.

Moreover, the DPCC physical rehab program appears to be distinct in comparison with other nursing homes in the county. Few if any of the other facilities appear to offer such an extensive rehab program that reaches the large majority of its residents. It would appear that this program is a relatively unknown jewel in comparison with DPCC's competitors, and could be more heavily marketed among the amenities that help set DPCC apart from its competition.

Restorative Nursing Rehab Services

In addition to the distinctive Physical Rehab services provided to residents of the Convalescent Center, a separate unit of specially-trained CNA rehab aides offers further therapy support for all residents throughout the facility. This unit of nine CNAs includes a CNA assigned during the day shift to each unit of the facility, as well as one person with lead responsibility for dealing with all fall-related episodes that occur throughout the building, including follow-up treatment and developing corrective actions as needed.

The core CNA restorative nursing rehab unit focuses on working with all residents to help them maintain core functions and activities of daily living, with particular focus on ambulatory activities. As such, the unit does not provide the broader range of therapy services provided by Alliance or in-house Physical Rehab staff, but rather supplements the efforts of regular floor nurses and CNAs by offering additional support such as walking assistance that would otherwise typically fall through the cracks, given other CNA

staff priorities and assignments. The rehab CNAs also play a key role in providing assessments for new residents on each floor.

While at first glance this staffing unit may seem somewhat redundant as a second in-house rehab unit, in fact its role is quite diverse, as the CNAs provide services beyond just the unit's valuable rehab support function. In addition to the specialized therapy support services, these rehab aides also provide data entry support to other staff on the floor, help train and support other staff, and supply backup coverage if there is a shortage of CNAs on a given unit. In addition, these rehab CNAs often serve as unofficial "head CNAs" on each floor, and are often the "go to" CNAs nurses on the floor are most likely to approach with special requests or when emergencies arise that require immediate attention.

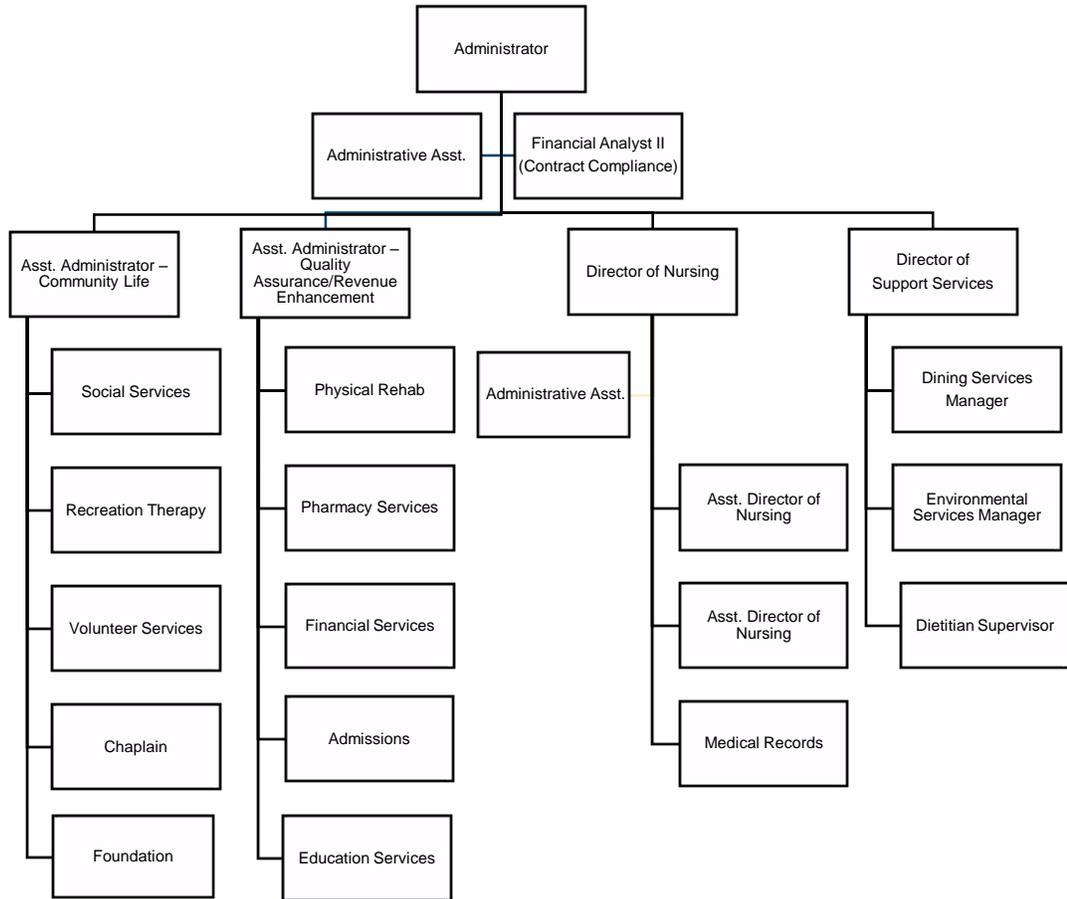
Core Services and Staffing Patterns

The DuPage County Convalescent Center currently employs about 500 staff members, roughly 375 of whom are full-time employees. These overall totals, and the distribution of staff across various functional units, have remained relatively constant in recent years, with few changes in the numbers of approved positions. More than 80 percent of the positions are in the functional areas of Nursing and Support Services, which includes dining services, housekeeping and laundry.

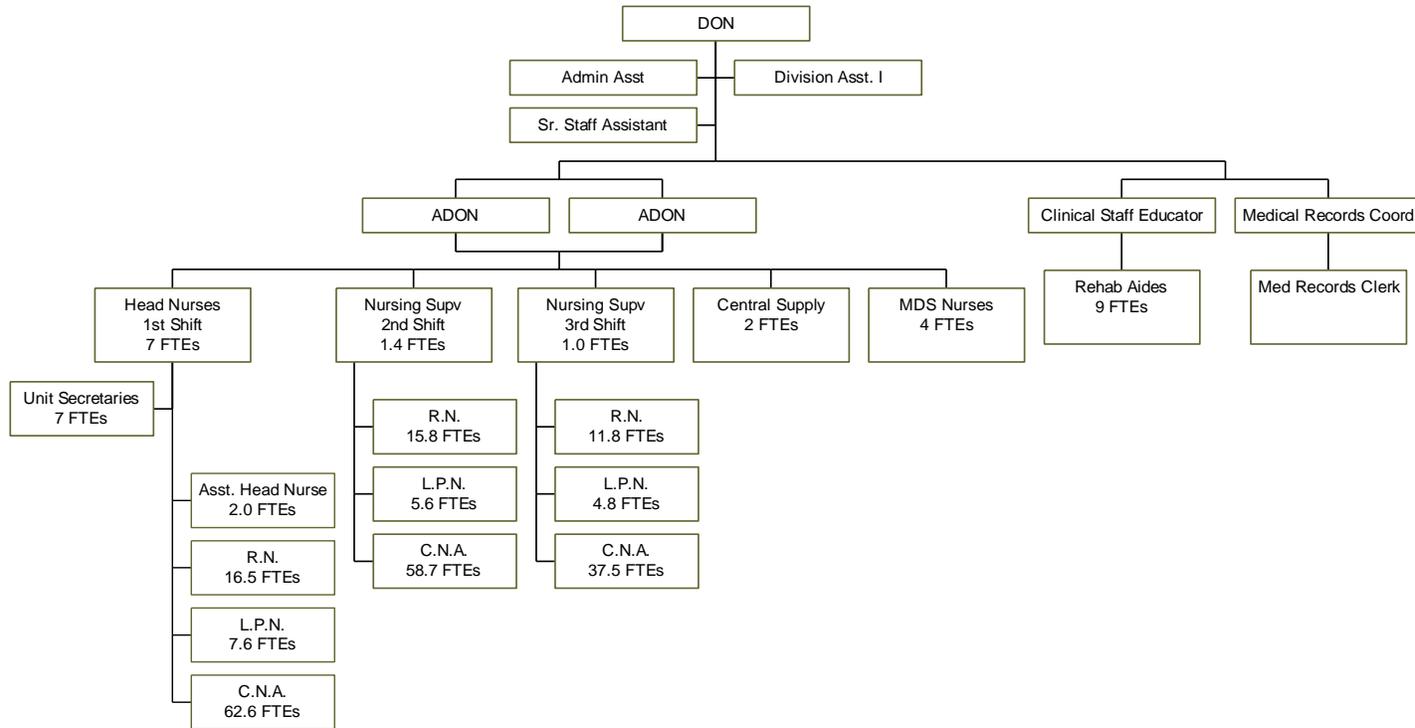
As indicated in the following organizational charts, the DPCC Administrator has four persons directly reporting to her:

- The Director of Nursing, with two Assistant DONs under her;
- The Director of Support Services, with a Dining Services Manager, Environmental Services Manager (including housekeeping and laundry services), and Dietician Supervisor reporting to him;
- Two Assistant Administrators—one with responsibility for Community Life (including Social Services, Recreation Therapy, Volunteer Services, Chaplain and DPCC Foundation), and the other overseeing Quality Assurance/Revenue Enhancement (including Physical Rehab, Pharmacy Services, Financial Services, Admissions and Education Services).

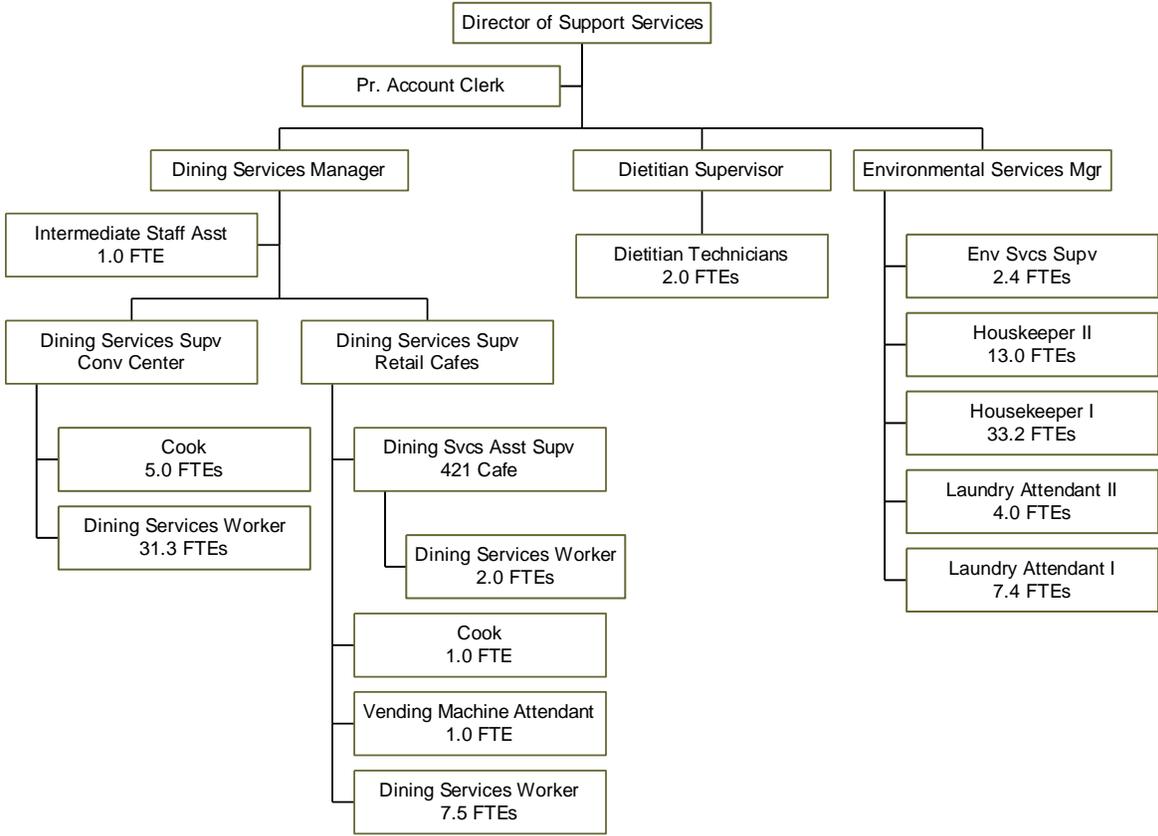
2015 DuPage Convalescent Center Overall Organization Chart



Nursing Services Organizational Chart



Support Services Organizational Chart



Nursing Services

The majority of all DPCC positions are devoted to nursing services. As of January 2015, as indicated in the following chart, there were 264 approved nursing positions—178 of which (two-thirds) were full-time, 56 part-time, and 30 temporary/per diem.

Approved Positions (effective 1/23/2015)										
	RN			LPN			CNA			
	F/T	P/T	Temp	F/T	P/T	Temp	F/T	P/T	Temp	
1st Shift	11	8	5	6	2	4	51	15	7	
		64 hrs 40 hrs						64 hrs 48 hrs		
		5	3					13	2	
2nd Shift	11	6	7	4	2	0	50	12	2	
							80 hrs 75 hrs	64 hrs 48 hrs		
							49	1	8	4
3rd Shift	8	4	3	4	1	1	33	6	1	
		64 hrs 48 hrs					80 hrs 75 hrs	64 hrs 48 hrs		
		3	1				32	1	5	1

Vacancies/Overfills (Effective 9/25/15)									
	RN			LPN			CNA		
	F/T	P/T	Temp	F/T	P/T	Temp	F/T	P/T	Temp
1st Shift	0	-4	-1	0	0	-2	-5	-6	-1
2nd Shift	-2	-2	-4	-1	0	0	-8	-5	0
3rd Shift	0	1	-2	0	-1	0	-11	0	-1

Staffing Gaps, but Emphasis on High Proportions of RN Nurses

Not surprisingly, about two-thirds of the approved nursing positions are CNAs (Certified Nursing Assistants), which is consistent with staffing guidelines established in the Illinois Administrative Code, Part 300, pertaining to Skilled Nursing Facilities, Direct Care Staffing. Perhaps more surprising is the fact that DPCC has so many more authorized Registered Nurse (RN) positions, compared to Licensed Practical Nurses (LPNs). The state guidelines suggest a ratio of 2.5 LPNs for every RN. Instead, the ratio in DPCC is more than reversed: 65 approved higher-level RN positions (including full-time, part-time and temporary) compared to 24 LPNs. Statewide comparisons in 2014, using FTE positions actually working (as opposed to approved positions), showed an even greater ratio of 3.7 RNs for every LPN position in DPCC—compared to the median ratio of 1.8 in all nursing facilities in the county, and compared to 0.8 among other public nursing homes across the state. In order to help ensure the highest quality of care within the DPCC facility, County officials appear to have made a conscious decision to provide its residents with a higher level of nursing care than is either required or typical of most other nursing facilities locally or statewide.

However, based on an internal analysis of productive nursing and CNA hours needed to meet service needs—conducted by DPCC in 2012 and updated by CGR to reflect slightly different numbers of current approved positions—even if all of the approved positions were filled, the internal analysis (which appears accurate, but was not independently confirmed by CGR) suggests that there should ideally be additional positions added to fully meet the needs of the increasingly “hard to place” residents described above. The internal analyses, updated to reflect current approved positions, suggest that ideally two additional FTE nursing positions would be approved on the first shift, and two to three on each of the second and third shifts. Among CNAs, the analyses suggest the need for approving about seven additional FTEs for each of the first two shifts, and about four for the third shift. It is important to emphasize that this analysis is now several years out of date and should be updated before any actions should be considered; and even if such shortages exist, the existing staffing levels nonetheless meet or exceed state standards, as noted above.

Whether or not such increases can realistically be accommodated within budget constraints, at the very least the message seems to be clear that *imposing reductions in existing staffing levels among nurses and CNAs as a means of reducing operating costs does not seem to be wise, and could be a threat to the future quality of care available to high-acuity DPCC residents*. That said, however, there may be opportunities over time to create different configurations of staff—such as changing the mix of RNs and LPNs, changing ratios of supervising staff to direct-service staff, and similar types of reallocations of staff resources—that can help reduce overall costs while still maintaining quality of care for residents. This issue is addressed in more detail in Chapter V.

High Levels of Vacancies

A continuing concern for DPCC, and consistent with industry-wide trends, is the large number of vacancies shown in the previous graph at each staffing level, but particularly among CNAs, where about one in every five approved positions have been vacant recently, including one-third of the approved positions on the third shift (11pm – 7am).

Turnover and resulting vacancies have increased significantly, especially among CNAs in the past year. Turnover rates among CNAs have typically been higher than among either RNs or LPNs, but they have been especially high in 2015, with as many staff departures (47) through August as for the entire years in 2013 and 2014. And, although the turnover rates are consistently lower among nurses than among CNAs, the number of RN departures through August (13) had also reached or exceeded the corresponding yearly totals in previous years.

The bottom line is that, through vacancies, turnover and routine attrition, there are currently fewer CNAs and nurses actually on the floor providing direct services to residents than was the case just two years ago. This is most pronounced among CNAs, where in a typical month in 2015, there were about 20 fewer CNAs on the payroll actually available to provide services than in comparable months in 2013. The number of active

employed LPNs actively providing services in 2015 was down in most months by three or four compared to two years ago. RNs were down by one to two per month, on average.

As suggested above, literature and conversations with knowledgeable people both locally and statewide suggest that *this pattern is by no means unique to DPCC*, and that it is very difficult at this point to recruit replacements among nurses and CNAs in nursing homes. This appears to be part of a statewide pattern. Nurses and CNAs appear to prefer work in hospitals and other settings, compared with the perception of more stressful working conditions in nursing homes. This pattern is likely to be exacerbated in attempting to hire in a public nursing facility with a history of accepting higher-acuity residents with more difficult issues needing to be addressed, as emphasized earlier, without sufficient offsetting incentives (see discussion below concerning salaries and benefits).

In order to continue to thrive as an institution and to offer high levels of quality care in the future, DPCC and the County will need to continue to explore ways of creating incentives to attract and retain nurses and CNAs. Our interviews with staff and staff survey results, described in detail later in this report, do suggest there are a number of ways management and staff could work together to improve retention of staff by improving the work climate and culture and strengthening teamwork and an increased sense of mutual responsibility and ownership throughout the facility. DPCC may receive helpful support and specific suggestions of ways to address the hiring and retention of nurses and CNAs, as the issue is currently being actively addressed by LeadingAge Illinois, the statewide association of providers advocating for high-quality care for seniors.

Resident-to-Staff Ratio

It is worth noting that despite all these concerns about staffing levels, statewide comparisons indicate that DPCC offers a richer staff-to-resident ratio than do most other statewide public facilities or most other nursing homes of any type in DuPage County. That is, even though (and maybe partly because) there are many hard-to-serve residents at DPCC, the average DPCC nurse and CNA is responsible for fewer residents than is true in most other nursing homes in the county. Although this may not be a major selling point in recruiting staff who prefer working in a hospital, it may be worth emphasizing with candidates considering other nursing homes.

Absence/Attendance Issues

Difficulties in filling critical nursing and CNA positions are exacerbated by persistent levels of absenteeism and the challenges posed by staff members calling in absent before a shift begins. These “call-ins,” often at the last minute, occur when a staff member scheduled to work calls in sick or uses personal time to not come into work on the intended previously-scheduled day. These unplanned absences leave the facility little advance notice to find replacement staff.

In order to ascertain the extent to which call-ins represent a practical ongoing problem for DPCC, CGR worked with nursing leadership and staff to track the extent to which call-ins occurred, by shift and by floor, during two months of the past year (June and October). In both months, use of call-ins was somewhat more predominant among CNAs than among nurses: 5.6 percent of all scheduled individual CNA shifts vs. 3.1 percent of nursing shifts in June, and 6.6 percent CNAs and 4.7 percent nurses in October. Thus, across the two months, about one in every 17 scheduled CNA shifts resulted in a call-in, and about one in every 25 scheduled nursing shifts.

In both months, nursing call-ins were somewhat more likely to occur on day shifts than either of the other two. They were more frequent during the day among CNAs in June (about one in every 11 scheduled daytime shifts), but in October, a similar proportion of call-ins occurred during the night shift. Perhaps surprisingly, CNA call-ins were somewhat more likely on weekdays than weekends (7 percent vs. 5 percent), with no difference among nurses.

By floor/unit, there was no clear consistent pattern of call-ins from month to month, though nurses on 2E were somewhat more likely than those on other floors to call in, particularly in October. CNA call-ins occurred on about one of every six scheduled individual shifts on 1E in October (and almost 30 percent of the scheduled night shifts), but in June call-ins had only occurred in 6 percent of all scheduled CNA shifts on that unit, and only 8 percent of the scheduled night shifts. Thus there did not appear to be, at least in these two months, any clear repeating patterns of call-ins at particular times or in particular locations.

While calling in sick is to be expected when appropriate (and encouraged both for the health of the employee or sick family member and for protecting the residents from exposure to illness), there are concerns that call-ins are being abused and occurring when illness is not the root cause.

Call-ins place organizational, fiscal and staff emotional stress on the facility. The practical implication of call-ins is that fewer nursing and CNA staff must tend to the same number of residents, which has implications for quality of care. Working “short” also places strain on staff who do show up. Working short places increased burdens and wear on staff in physically and emotionally demanding jobs. Signs of “burn out” in turn may cause an overworked staff member to call-in the next day, and the cycle of unplanned gaps in staffing continues.

Although the analyses indicated that the problem of call-ins is perhaps not as great as suggested by some of the interview comments we received, it remains a significant enough concern to warrant continued attention to limit the impact on morale and stress levels, and to reduce the need for costly overtime and use of contract agency staff to fill resulting gaps in coverage.

Expanded Use of Overtime and Contract Agency Staff

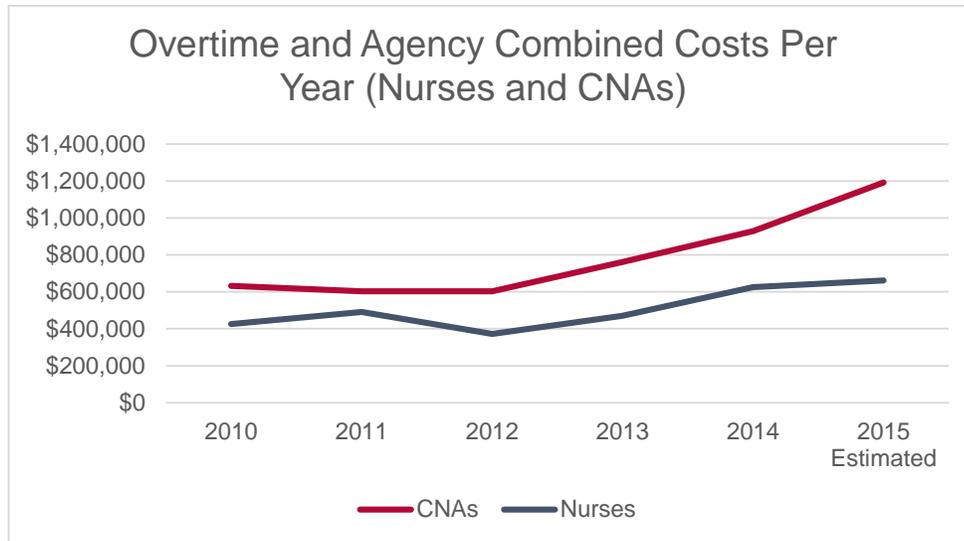
With the increased number of employee departures and resulting vacancies, combined with periodic call-in absences, DPCC has needed to expend increased amounts of resources in the past three years on overtime and use of contract agency staff (both CNAs and nurses) to fill staff shortages on various shifts and floors. Prior to 2013, there had been little or no need to use contract agency staff, as need for additional staff to fill staffing gaps could be addressed through the use of overtime with existing staff and/or use of temporary/per diem staff. Beginning in 2013, the staffing gaps were beginning to be large enough that arrangements were made to add contract agency staff support as backups when needed.

The use of agency staff has not been without conflict and stress. In numerous interviews and focus group conversations, and observations from staff, residents and family members during our survey process, frequent comments referenced the variable and perceived unreliable, inconsistent quality of care provided by agency staff, leading to frustrations and stresses among residents, family members, and employees who must work in collaboration with the agency staff. Concerns were also expressed about how effectively and consistently information about services provided is entered by agency staff into the computers and forms needed to track activities for quality monitoring and reimbursement purposes.

Partly in response to these concerns, DPCC has begun relying less in 2015 on agency staff for LPN and RN support, but continues to remain reliant on contract agency support for a significant amount of CNA staff coverage, as indicated below.

Annual Agency Hours	2013	2014	2015 Estimated
CNAs	1891	9015	8492
Nurses	497	2745	979

The combination of overtime and agency costs, after remaining consistently around \$1 million a year through 2012, has expanded rapidly in the past three years, as shown below. The added costs of overtime and contract agency backup support have been particularly pronounced among CNAs, with combined overtime and agency costs essentially doubling between 2012 and projected 2015. Overtime hours continue to increase for both nurses and CNAs; by contrast, use of contract agency staff has declined significantly among nurses in 2015, while dropping off slightly among CNAs.



Declining agency use in 2015 may indeed have been part of a conscious intent to respond to expressed concerns related to use of agency staff, but in part this may also have simply reflected the fact that the primary contract agency used up to this point by DPCC has been unable to meet many of the requests made of them for coverage. In response, DPCC is making plans for 2016 to contract with two additional staffing agencies in hopes of filling all staffing shortages not able to be met by voluntary overtime provided by existing staff.

However, one of the new agencies charges more per hour than the existing agency and, in general, the use of agencies is more costly than paying overtime to existing DPCC staff. Using average hourly rates of the three contract agencies, and applying them to coverage for an 8-hour stint on the first shift (7am to 3pm), average agency coverage for a CNA shift would cost DPCC about \$20 more than covering that same shift by paying an existing CNA overtime. The differential is greater for LPNs and RNs: About \$46 more for an agency LPN on an 8-hour first shift, and about \$72 more for an RN.

Expand Use of Per Diem Staff?

A better option from a financial perspective, if it can be implemented at an expanded level, may be to cover higher proportions of staffing shortages through use of temporary/per diem staff, also known as registry staff. As shown below, expanded use of registry staff would yield significant savings over time, as coverage of each 8-hour shift would be slightly less expensive than paying regular staff overtime rates for CNAs and LPNs, and significantly less expensive than RN overtime rates. And, if it were possible to eliminate the need for extensive use of contract agency staff via expanded use of per diem/registry staff, savings would be even more substantial: About \$26 less per first shift for CNAs, about \$50 per shift for LPNs, and \$125 per shift for RNs.

Cost Differentials to cover a 8-hour shift				
	DPPC Reg	DPCC OT*	DPCC Registry	Agency**
CNA - 1st Shift	\$109.44	\$164.16	\$157.84	\$184.00
CNA - 2nd Shift	\$117.44	\$172.16	\$165.84	\$185.33
CNA - 3rd Shift	\$117.44	\$172.16	\$165.84	\$186.67
LPN - 1st Shift	\$180.80	\$271.20	\$266.88	\$317.33
LPN - 2nd Shift	\$192.00	\$282.40	\$278.08	\$319.33
LPN - 3rd Shift	\$198.80	\$289.20	\$284.88	\$321.33
RN - 1st Shift	\$228.96	\$343.44	\$290.64	\$416.00
RN - 2nd Shift	\$240.16	\$354.64	\$301.84	\$418.67
RN - 3rd Shift	\$246.96	\$361.44	\$308.64	\$421.33

* If an OT bonus is offered it would add \$50 to the CNA cost and \$100 to the LPN and RN cost

** Represents an average of the 3 agencies rates

To create such savings, the current pool of temporary/registry nurses and CNAs would need to be expanded. Currently 10 CNA per diem positions are approved in the DPCC budget, nine of which are filled. Given the potential savings possible with so many CNA vacancies and coverage shortages, expanding the pool of available registry CNAs seems worth considering. Among nurses, 20 per diem positions are currently approved (15 RNs and five LPNs). Of these, 11 are currently filled, with unfilled/vacant positions on each shift.

More aggressive efforts to recruit nurses interested in per diem assignments, including nurses who retire from DPCC or other area facilities, may prove to be extremely beneficial in creating a more stable pool of backup resources that could become more reliable and acceptable to staff and residents than agency staff, as well as being significantly more cost effective, as long as they are used as alternatives to contract agency staff and not full-time employees, and as long as they are subject to certain restrictions on numbers of hours worked on an annual basis.

Salary and Wages

Among the concerns frequently expressed in conversations with nursing and CNA staff was the perceived inadequacy of wages, especially among CNAs. Placed in the context of the perception that the job of caring for residents, many with significant physical and behavioral issues, is increasingly demanding and stressful, both physically and mentally, many staff feel that they are expected to do too much, for relatively low pay. This concern is underscored for many by the absence of pay raises in recent years, and cost of living adjustments are not viewed as an adequate substitute for real raises.

Salary concerns are partially offset by the more generous employee benefits available to public employees, benefits which are especially important to more tenured, longer-term staff who are in the best position to benefit from them, and who in many cases are influenced to remain at DPCC in part to take full advantage of the benefits available to them. By contrast, the value of the benefits package often has less impact in attracting and retaining younger and lower-paid staff, many of whom are less likely to benefit immediately from, or see the longer-term values of, the benefits package. They are typically more focused on the immediate benefit of an increased salary.

Regardless of the perceived and actual value of the salary levels available to DPCC nurses and CNAs, comparison data available from other nursing facilities suggests that DPCC is relatively competitive with other comparable facilities.

Based on partial information available for some comparable nursing facilities in the area, DPCC starting salaries for CNAs appear to be generally comparable with other facilities in the region, and average salaries for more experienced CNAs appear to be generally higher or in the upper end of the ranges of comparable facilities. Both starting salaries and overall average salaries for LPNs at DPCC appear roughly comparable with other facilities in DuPage and other nearby counties. Among RNs, starting salaries at DPCC appear roughly comparable to other nursing homes in the area, but more attention may need to be paid to keeping pace with salary levels among more experienced nurses.

These salary comparisons may not create sufficient advantages in recruiting or retaining staff to be sufficient to overcome other issues, or comparisons with hospitals or other options available to CNAs and nurses. To the extent that salary comparisons impact decisions to come to work and remain at DPCC, the fact that salaries are typically competitive, but not measurably higher than the competition, may mean that the hiring and retention capability of the Convalescent Center is not appreciably affected one way or the other by comparative salaries. It seems likely that salary levels, by themselves, are neither a major draw nor obstacle to working and remaining at DPCC, in comparison with other nursing homes in the area.

Support Services

Along with Nursing Services, the department within the Convalescent Center that has the most impact on the entire residency of the facility is Support Services, which includes dining services, housekeeping and laundry. In addition to affecting the lives of every resident on a daily basis, this department has the most employees within DPCC, other than nursing.

Housekeeping and Laundry make up the Environmental Services unit, both overseen by a Manager currently responsible for 74 approved positions: 61 in Housekeeping (40 full-time and 21 part-time), and 13 in Laundry (11 full-time and two part-time). The Dining Services Manager oversees 53 FTE positions, supplemented by the Dietician Supervisor and two technicians reporting to her.

Housekeeping

The housekeeping or cleaning unit is responsible for maintaining the cleanliness and sanitary conditions of all rooms and common areas throughout the Convalescent Center. In addition, staff from this unit provide cleaning services for the service areas of the cafeterias in two County buildings, 505 and 421 (cafeterias operated by Dining Services). (Cleaning in the dining areas of these cafeterias is provided by the County Facilities Management staff.) Housekeeping staff also provide all cleaning services in other County buildings on the west campus close to the Convalescent Center. The combined work of the housekeeping/cleaning unit is carried out over two shifts (7-3 and 3-11).

Value of Housekeeping Services to County

In addition to the intrinsic value of Housekeeping to the well-being of the residents of DPCC, current staff are adding additional value to DuPage County in terms of cleaning services provided in facilities outside the Convalescent Center. In 2016, Housekeeping is expected to generate revenues of about \$27,500 for cleaning services provided to the County's Emergency Telephone System Board (ETSB) and Animal Control, against costs of about \$14,000, thus yielding net positive revenues of about \$13,500 to DPCC coffers. In addition, DPCC officials calculate that the "free" cleaning services provided by Housekeeping staff to other County facilities are worth about \$72,000 annually in staff and supervisory costs and housekeeping chemicals and equipment. These "savings" to the County do not appear to receive any "credit" in the DPCC budget.

Thus in 2016, the DPCC financial statements should reflect the revenues generated by the two cleaning contracts referenced above. Although not reflected in those financial statements, County officials should also realize that an in-kind contribution of about \$72,000 will have been made, as it has in years past, to the County's financial well-being—for services that would otherwise need to have been provided by other County employees, or via an outside cleaning contract. This is not a large offset to the County's subsidy of DPCC, but it should nonetheless at least be acknowledged.

Overtime and Vacancies

Through investments in cost-effective equipment and other efficiencies, Housekeeping in recent years was able to reduce its staff by five employees, in effect transferring the positions to the nursing area, leaving Housekeeping with 74 approved positions. However, although employee departures within Housekeeping have been relatively low and lower than in the Nursing area, they have taken a toll in that there were increased numbers of departures in 2014, resulting in about a half dozen fewer active employees per month than in 2013. Although those totals generally stabilized or slightly increased month to month in 2015, our most recent data indicated that there are currently eight vacancies among the 74 approved/budgeted Housekeeping positions (two full-time and six part-time positions). All of this led to a doubling of overtime for the unit in 2014, before falling back toward earlier levels in 2015.

Future Opportunities

The Support Services department has been characterized by its entrepreneurial spirit in looking for new opportunities to expand services and generate opportunities. Housekeeping has been no exception. There have been some discussions of expanding its role in cleaning buildings on the County complex to potentially cleaning the Health Department's offices. The potential cost and revenue implications of such an arrangement have not been calculated, but it may be worth consideration as an opportunity to enhance the revenues of DPCC, if the services are provided on a contractual basis, as is currently occurring with Animal Control and ETSB.

Laundry

Laundry services are provided under the same overall Environmental Services Manager as is Housekeeping. To date all services have been provided during the first shift, though with somewhat staggered hours to get all cleaning and sorting activities accomplished in an efficient manner. The Laundry unit is responsible for washing, sorting and returning all facility and personal materials to the original floor. Cleaning includes all facility towels and linens and related materials, as well as personal clothing of the residents.

Value of Laundry Services to County

In addition to providing laundry services for the DPCC facility and its residents, and while maintaining consistent to slightly declining costs, the Laundry unit has recently taken on the responsibility, under contract, of providing laundry services for Animal Control and the Crisis Unit Center. Together, in 2016 these are expected to generate about \$25,000 in new revenues for the County, and specifically DPCC, with little or no additional costs, as the size of the materials to be washed is such that it can be accommodated by the washers and dryers and staff, with no additional staff needed. Not only does this represent net revenues for DPCC, but also reflects a savings to the County, which was previously contracting out the laundry services to a company outside DuPage County, at more money than under the contract with DPCC. Thus, Animal Control will save money, while keeping the reduced funds in-house.

Overtime and Vacancies

The Laundry staff have been a loyal, consistent group of employees, with little turnover over time. All 11 full-time and two part-time budgeted positions are filled, with no current vacancies within the unit. With little turnover or major patterns of absences, and the ability to cover for each other when absences do occur, there has been little need for overtime within the unit.

Future Opportunities

As with Housekeeping, there may be opportunities to build on the entrepreneurial spirit by creating new opportunities to take advantage of the existence of equipment which sits unused on the second shift to provide laundry services to other potential customers. Preliminary conversations have begun with other nearby long-term-care facilities concerning the possibility of doing their laundry for them at less cost than under their current arrangements, and with the potential to generate net revenues for DPCC.

Preliminary estimates suggest that these revenues, after costs, could be significant, should the facility be encouraged to pursue the opportunities. This issue will be discussed further in Chapter V.

Dining Services

The Dining Services unit provides all meals for all residents in the facility, preparing and distributing meals to the dining areas on all floors and units, as well as to the restaurant-style common resident dining area for those who choose to have their meals in that setting. In order to prepare, serve and clean up after three meals per day, staff operate on a cross-shift schedule, beginning for some as early as 5am and lasting for others as late as 8:30 or 9pm.

In addition to meeting the dining needs of the residents, Dining Services staff also operate cafeterias open to the public in the DPCC building, as well as in the County Administration Building 421 and the Courthouse Building 505.

Value of Dining Services to County

In addition to the basic services provided by Dining Services to all residents, cafeteria sales are projected by Support Services leadership to generate a net positive revenue of about \$125,000 for DPCC in 2016, after staffing and food/supplies costs are factored in.

Overtime and Vacancies

In 2013, Dining Services had a total of nine employee departures for the entire year. In 2014, departures tripled, and data through August suggest that the 2015 total was likely to fall slightly short of the 2014 total. At least partly in response to the increased vacancies, 2014 overtime costs increased over previous years, though remaining manageable. With the cumulative effect of increased departures over the past two years, Dining Services is operating with an average of about a half dozen fewer employees each month than was the case two years ago.

Future Opportunities

With its recently-renovated and expanded kitchen, Dining Services has a 24/7 capacity to not only meet the dining needs of all residents of DPCC, but also to explore other opportunities to serve the larger community. Should the County choose to consider additional opportunities to use the kitchen and staff to serve others outside DPCC, opportunities could be available on a contract basis to provide meals to such organizations as Home Delivered Meals, senior congregate living and the County jail, among others. The pros and cons of such opportunities will be discussed in more detail in Chapter V.

Community Life and Quality Assurance Services

Most of these services provided under the overall supervision of the two Assistant Administrators have either been discussed previously, or appear to need little discussion. Thus this section and the references to the services will be brief, not because these services are not worthy of discussion or important to the well-being of the facility—to the

contrary, they indeed are—but rather because few issues surfaced related to these services that are likely to have implications affecting the future viable operations and sustainability of the Convalescent Center.

The services referred to in this section are organized under the broad responsibilities of the Assistant Administrators, as outlined in the DPCC organization chart presented earlier.

Community Life

The Social Services unit focuses on meeting the social and emotional needs and concerns of the residents of DPCC, including significant amounts of interaction with family members. Staff also interact regularly with nursing/CNA, rehab, recreation therapy and volunteer services and chaplaincy staff, as well as with support services staff as needed. One of their key roles is to work with residents in helping to process complaints when they surface. They are also responsible to do regular, required clinical assessments that document resident needs and help ensure proper reimbursement of costs—this work has grown in recent years as more reporting has been required of long-term care residents. The staff in this unit coordinate care plan meetings for each resident, doctors' visits, and discharge planning (mainly for sub-acute rehab patients) as well. The unit is staffed by two clinical case managers and five social service coordinators. For the most part, staff are assigned to particular floors, in order to foster continuity of relationships with residents and family members. Staff have been relatively stable over time, and there is virtually no overtime within this unit.

Recreation Therapy is responsible for leading group and individual recreational activities, such as arts and crafts, sing-alongs, community outings, games, etc. As with the Social Services unit, staffing in this unit has been relatively stable over time, the budget has been stable, and there is virtually no overtime. Staff include a Manager, Supervisor, crafts coordinator, three aides, and seven recreation unit coordinators. As with Social Services staffing, staff are assigned to particular floors and units in order to establish ongoing relationships with residents. Although all work primarily during the day, it is routine in most cases for staff to also return some evenings for post-dinner group activities.

Volunteer Services has a Supervisor who oversees some 400 volunteers who provide a wide range of services to residents and family members. The Supervisor also oversees gift shops within the facility. The volunteers provide a strong base of support for DPCC, both in supporting internal activities and in providing advocacy on behalf of the facility in the larger community.

The Chaplain is widely viewed as providing both spiritual and practical support on many levels across DPCC. She works closely with staff at all levels, and is particularly helpful in coordinating with the Volunteer Supervisor to help organize and facilitate volunteer services. She is also seen by staff, residents, and families as a regular presence in the units, including during the overnight hours.

The Convalescent Center Foundation has proved to be of great value in raising funds on behalf of the Center, and helping provide leadership and funding support to make possible various activities and internal renovations that have enhanced the quality of life at DPCC and that would not otherwise have been possible. Funding for the Foundation Coordinator has previously been fully provided by DPCC, but in the future the Foundation will cover some costs of the position. The Foundation, which was founded in 1993, has a 12-member board, and recently established a multi-year development plan. This plan seeks to expand the Foundation's effort beyond an annual appeal, golf outing, and fall festival, and intends to seek out corporate support in the county and to hold different awareness-building events like a celebrity bartender fundraiser and an outdoor concert. The Foundation currently supports three positions in the Recreation Therapy Department, and funds a number of aesthetic enhancements to the Convalescent Center each year.

Quality Assurance

Activities and issues related to Physical Rehab, under the Manager of Rehabilitation Services, and Admissions, under the Senior Admissions Coordinator, have previously been discussed in some detail earlier in this chapter.

The Pharmacy Services unit provides services both internally to residents and on an outpatient basis to other members of the community. It is staffed and supervised by a Head Pharmacist, additional full-time and part-time pharmacists, and four pharmacy techs. Historically, the Pharmacy's revenues have typically exceeded expenses, thus contributing net revenues to DPCC's bottom line.

Financial Services is overseen by a Manager who is in effect the Chief Financial Officer for DPCC. Along with the Administrator, he is primarily responsible for developing and overseeing the budget for the facility. He also supervises a Principal Accounts Clerk, two Senior Account Clerks, and a Financial Services Supervisor/Medicaid Billing, with other Principal Account Clerks and Senior Account Clerks under her supervision.

Education Services is staffed by a Coordinator who is responsible for non-clinical staff education and training, working alongside the clinical staff educator who reports to the Director of Nursing.

Facilities Management and Security

Facilities Management (FM) is not a staffing unit under DPCC, but it is mentioned here because of its significant implications for the facility. As a unit under overall DuPage County government, it provides virtually all of the support DPCC needs to maintain its physical facility. All staffing related to the physical operations and maintenance of DPCC fall under the supervision and budget of Facilities Management, thereby saving the Convalescent Center the costs associated with providing these critical services. One FM manager and eight other staff under him provide full-time dedicated service to DPCC, although the services are not charged directly to the DPCC budget.

And, by lodging all these services under the County operation, greater efficiency is possible than if DPCC had to provide the services directly on its own. The Facilities Management staff who are dedicated fully to DPCC are able to share services with other staff, “borrow” staff as needed for particular activities and emergencies, share equipment and supplies, and create other ways of minimizing costs. Moreover, the Center is able to claim the value of the services provided by Facilities Management, as part of the cost allocations assigned to DPCC, as costs that factor into the reimbursement formula.

The 2014 cost allocations report that assigns values of services provided by County departments to each other indicates that Facilities Management provided services to DPCC worth \$1.7 million in that year.

Similarly, Security services are provided to DPCC through the County’s Security Division. A Security Officers on site at the facility constantly, 24 hours a day, seven days a week. This equates to 4.2 FTEs. To achieve this level of coverage, three full-time and two part-time officers are dedicated to the Convalescent Center. In addition, all other Security officers are also cross-trained to provide additional coverage for DPCC as needed.

As with Facilities Management, DPCC is able to claim the value of the Security services as part of its cost allocations, as costs that factor into the reimbursement formula for the facility. The 2014 cost allocations report indicates that Security provided services to DPCC worth just over \$260,000 in that year.

Staff Departures: Timing and Reasons for Leaving

As noted above, the extent of staff turnover has varied considerably over the years by functional area within the Convalescent Center. In order to determine overall patterns of employee departures across the facility, we requested the County Human Resources office to conduct an analysis for 2013 through mid-November 2015. HR was able to provide a comprehensive analysis by length of employment and stated reason for leaving.

Across all units of the Center, 393 individuals terminated employment for a wide variety of reasons during the almost three years tracked by the analysis. More than half (53 percent) left employment within a year of their hiring date, including 38 percent within six months, 26 percent within three months, 11 percent in the first month, and 25 individuals (6 percent) within the first two weeks. So it is often clear early in an employee’s tenure with DPCC whether or not it is going to work out, either from the employee or employer perspective. Reasons for leaving among those who leave early tend to include a mixture of persons terminated by DPCC for various performance-related reasons that became clear early in the employment experience, and persons who said they were dissatisfied with the job, or were listed simply as abandoning the job or for unstated personal reasons.

Those who left within the first 90 days of their hire were disproportionately CNAs, dining service workers, and housekeepers: 85 percent of all early departures fell into those three job categories, including just over half of all early departures who were CNAs, about a fifth who were dining service workers, and 9 percent housekeepers. It is worth noting that these are among the lower-level, lower-paid staff members in the facility.

A variety of performance-related reasons accounted for just over one-fifth of all departures, which were initiated by DPCC and/or the County. Stated reasons included: 9 percent of total departures were terminations for attendance/tardiness problems, 8 percent for poor performance, and 4 percent for violation of County rules. More than two-thirds of all those terminations occurred within a year, mostly within six months. Thus performance issues typically surfaced early in an employee's tenure, often leading to early termination. A question for consideration is whether other employees who subsequently manifest attendance and performance issues could have been identified earlier, and either terminated or counseled at an early stage to correct the problems before they became more serious and harder to deal with the longer the employment continued.

Disciplinary Complaints

In many of our discussions with employees, concerns were raised about complaints made by residents, and in some cases family members, about alleged inappropriate behavior by staff. Staff concerns often focused on their perceptions that most of the allegations prove ultimately to be unfounded, but that employees were, in their view, often treated as if they were guilty, even though subsequently vindicated. Documented data provide some support for these concerns and suggest the need for further clarification of policies with staff.

The concern remains among many employees that, with the heightened emphasis growing out of state surveys on reporting even questionable allegations, staff are unfairly singled out, often creating embarrassing suspicions. Given the state and DPCC policies in effect that require that an employee who "may be involved in an incident of resident abuse, neglect, or theft... be removed from the work site pending the results of the investigation," DPCC seems to have no choice about sending employees home. (See "Resident Abuse/Theft Prevention" DPCC policy, revised 8/2015, p. 3.) However, based on our interviews both with DPCC staff and with other nursing homes, there seems to be room for improvement in how DPCC communicates these policies to staff and frames them as a matter of not only protecting residents but also protecting staff members from the consequences of unfounded allegations and from increasing troubles with difficult residents.

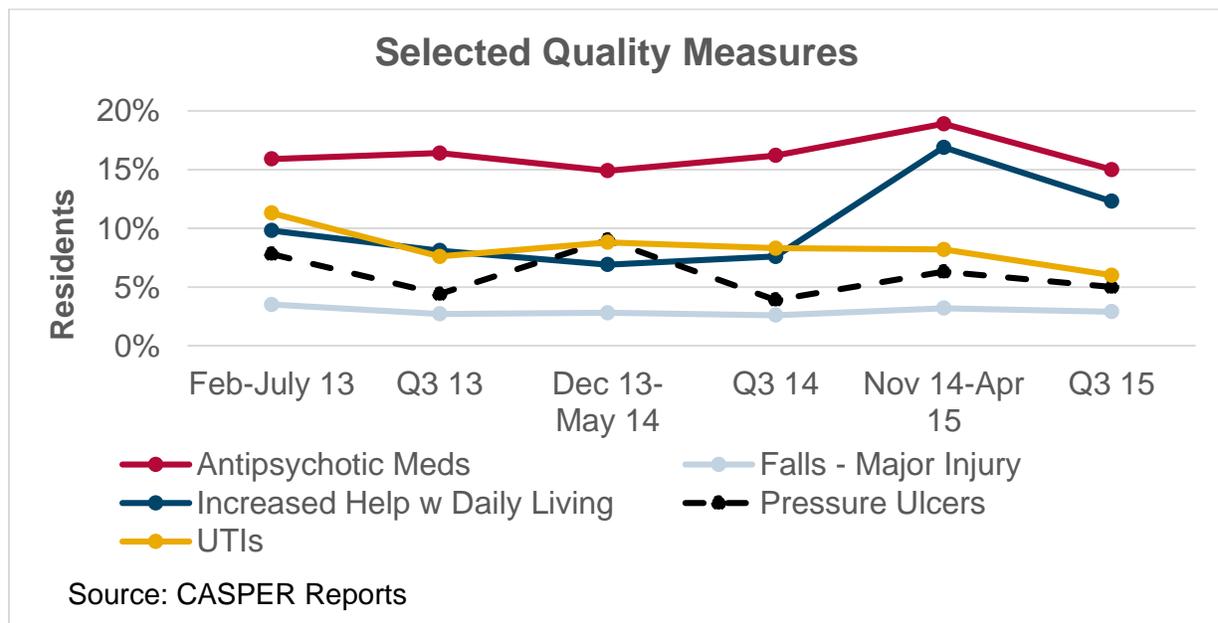
Given data indicating the very small proportion of investigations that result in substantiated charges, there would seem to also be improvements that could be made in communicating the results of investigations, and the fact that, in the overwhelming number of cases, employees are ultimately vindicated.

Quality of Care

Nursing home quality is assessed on several dimensions, including the results of state health inspections, staffing levels and quality measures. These inputs are used to generate star ratings (0-5 stars with 5 being the highest rating) in major categories and an overall star rating for the home. The ratings can help families and the public judge the quality of nursing homes and compare homes to one another, and they are made public through several sources, the key one being the online portal Nursing Home Compare provided by the Centers for Medicare and Medicaid Services (CMS).

Since 2010, the Convalescent Center's Nursing Home Compare Ratings have been largely stable in several key rating categories. It has generally received 4 out of 5 stars in overall Staffing, 5 stars in RN Staffing and 3 stars in Health Inspection. In the Quality Measures category, the Convalescent Center's rating has recently fallen from 3 to its current rating of 2, which is at least partly a function of changes in CMS's methodology for distilling quality measures data into a star rating. Due to these changes, CMS does not recommend comparing Quality Measures ratings since February 2015 with earlier ratings.

CGR examined the underlying data on Quality Measures for the last several years and found that overall, DPCC's incidence of indices such as falls resulting in major injuries, use of antipsychotic medications, urinary tract infections, pressure ulcers and residents needing increased help with daily living has not dramatically changed since early 2013. These are some of the 20 or so measures that are used in the calculation of the Quality Measures rating.



When we compare the Convalescent Center with comparison group homes in the state and nation on Quality Measures, we find that the Center is on par—better on some measures and worse on others. Specifically, the Convalescent Center had lower incidences of antipsychotic medications, falls with major injuries, residents needing increased help and pressure ulcers, but was higher, due to some degree to the nature of the needs of residents, on catheter insertions, use of physical restraints, residents with moderate or severe pain, and urinary tract infections. However, in many cases, these differences were small.

The decline in the Convalescent Center's Quality Measures rating had lowered its Overall Quality rating to 3 stars from 4 stars, but most recently that rating has reverted back to a 4.

Compared to three other large nursing homes in DuPage County with a relatively high share of residents receiving Medicaid (West Suburban Nursing and Rehabilitation Center in Bloomingdale, Wood Glen Nursing and Rehabilitation Center in West Chicago, and Meadowbrook Manor in Naperville), the Convalescent Center is on par or above in most categories except for Quality Measures:

- ∞ Overall star rating – DuPage most recent rating was a 4, with Meadowbrook having 3 stars; West Suburban and Wood Glen have 2.
- ∞ Health Inspections – DuPage has 3 stars; the other three facilities have 2.
- ∞ Staffing – DuPage has 4 stars, West Suburban and Meadowbrook have 2, and Wood Glen has 1.
- ∞ Quality Measures – DuPage has 2 stars, compared to 2 at West Suburban and 5 at both Wood Glen and Meadowbrook. But as noted above, cautions should be used in making any such comparisons with current data, until the issues raised about this measure have been addressed.

Internal Issues Raised by Staff

During the course of our numerous discussions with employees at all levels and within all key functions of the Convalescent Center, and with other key County employees knowledgeable about operations at the Center, a number of important issues surfaced with implications for the ongoing and future operations of the facility, and for its ability to sustain the provision of quality care in a cost effective manner going forward. The most important of these issues are summarized below. Some of these issues also surfaced in the survey findings discussed in the following section, and are generally consistent with the employee survey DPCC previously commissioned in 2014. Some are addressed further in the discussion of potential options for consideration in Chapter V.

Despite the overall quality of services associated with DPCC, and the generally positive survey responses from residents, family members and volunteers reported in the next section, there are concerns that will need to be addressed if the Center is to flourish and continue to meet the needs of County residents in the future. Many of these issues are

interrelated and impact on each other, and many are in the process of currently being addressed by DPCC Administration,

The perceived, and to some degree documented, increasing acuity levels and behavior issues of residents, along with their increasing demands of staff, as referenced earlier in the report, have contributed to high levels of stress among the employees who interact most directly with the residents and family members. The physical and mental demands and stresses of the job, combined with the perceptions among many staff that they are underpaid for the difficult jobs they do, have helped create concerns among many staff. The natural stresses of the job are often exacerbated by the fact that staff in various functions and units are not operating at optimal levels, due to staff vacancies, absences and frequent coverage of staff shortages by contract agency staff who too often are unfamiliar with staff and residents at DPCC, thus causing additional frustrations among both employees and residents.

Many employees on the front lines of direct service provision tend to believe that those at higher levels do not always fully understand and appreciate the complex and physically and emotionally draining jobs they are called upon to do, at wages they believe do not adequately compensate for the difficulty of their jobs. Even awareness that DPCC generally is competitive with other nearby nursing homes in salaries (and is far more generous in the package of benefits received by most employees, particularly those with more experience), does little to temper the frustrations most line staff feel with the combination of levels of job stress, remuneration and perceived lack of sufficient appreciation, particularly those at low-income levels providing a variety of direct services to residents of the facility.

Additional concerns raised by many staff members include a lack of a sense of teamwork in many DPCC units, and staff working on the evening and especially night (11-7) shifts feel particularly isolated and underappreciated. Most feel that the top administrators of the facility have little understanding of what they do and the difficulties they must address with few staff caring for large caseloads of residents. Staff expressed frustrations over and over about rarely seeing administrative/leadership representatives on the floors after 5 or 6 pm, unless there is a crisis or some special circumstances that demand their presence.

It is certainly fair to say that CGR heard not only critiques of various aspects of operations of DPCC, but also positive comments and suggestions for change to strengthen the culture and procedures within the facility. But there was the concern expressed that there is little or no similar opportunity on an ongoing basis, given the day-to-day pressures of the job and the perceived problems of getting access to top officials, to voice similar suggestions to key DPCC officials in the normal course of business.

Stakeholder Survey Findings

CGR and members of the Convalescent Center's leadership team collaborated to develop four different surveys for key Convalescent Center constituencies. Surveys were distributed in late October, 2015 to Convalescent Center staff, volunteers, residents, and family members of residents. Family members of residents, residents, and volunteers were given the opportunity to complete the survey either online or on paper, while staff completed the survey exclusively online. While individual questions varied on the four different surveys, all four asked questions that focused on certain themes.

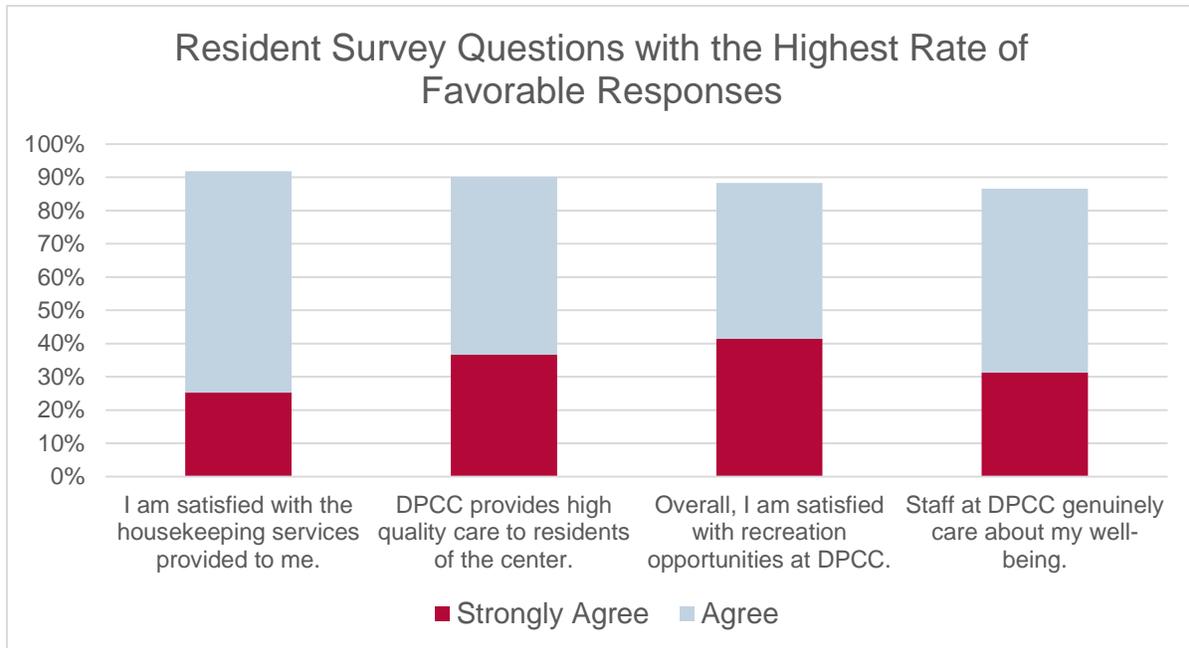
All four surveys attempted to gauge satisfaction with the overall operations of the Convalescent Center, and with major aspects of those operations (Staffing, Nursing, Food Service, etc.). The four different surveys also contained the same five open-ended questions:

- ∞ What are a few things DPCC is doing well?
- ∞ What are a few things DPCC could improve?
- ∞ Do you know of any opportunities to increase revenues that you think DPCC should pursue?
- ∞ What are a few opportunities to save costs or operate more efficiently that you think DPCC should pursue?
- ∞ Do you have any other thoughts or comments you'd like to share?

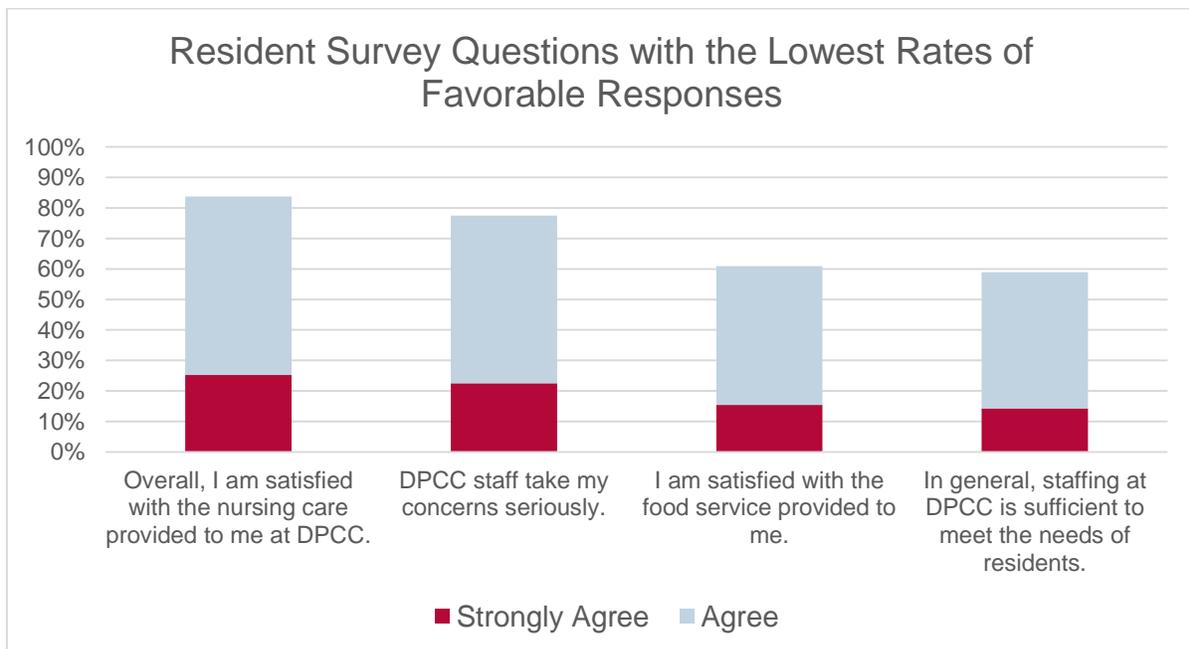
Resident Survey

Convalescent Center volunteers and recreation therapy staff administered paper surveys to those residents who were able and willing to complete it. Convalescent Center staff identified 149 residents who were able to complete the survey. Slightly more than 75% of those, or 112 residents, completed at least portions of the survey. Over three-quarters of respondents had lived at the Convalescent Center for less than six years. Slightly less than 18% of residents were under 60 years old, while another 20% were between 60 and 69 years old. The age group with the largest percentage of respondents was 80 to 89 years old, a cohort that represented 31% of all survey respondents.

Overall, a majority of respondents to the resident survey had favorable responses to most questions about the operations of the Convalescent Center. Over 90% of respondents expressed satisfaction with the overall quality of care provided to residents and specifically with the quality of housekeeping services.



The question with the lowest rate of favorable responses was “In general, staffing at DPCC is sufficient to meet the needs of residents.” Only 14% expressed strong agreement with that statement, while another 45% indicated some level of agreement. At 15% strong agreement and 45% agreement, a question that asked residents about the quality of food service had a similar rate of favorable responses. All other questions of residents had over 75% combined percentages of agreement and strong agreement.



Resident responses to the open-ended questions mostly echoed the sentiments in the previous two charts. Many residents spoke highly of their nurse/CNAs or housekeeping staff, while others highlighted the recreational events like the garden club, ceramics or other regular recreation programs. A few residents mentioned the high quality of food service or the ability of housekeeping staff to maintain their rooms.

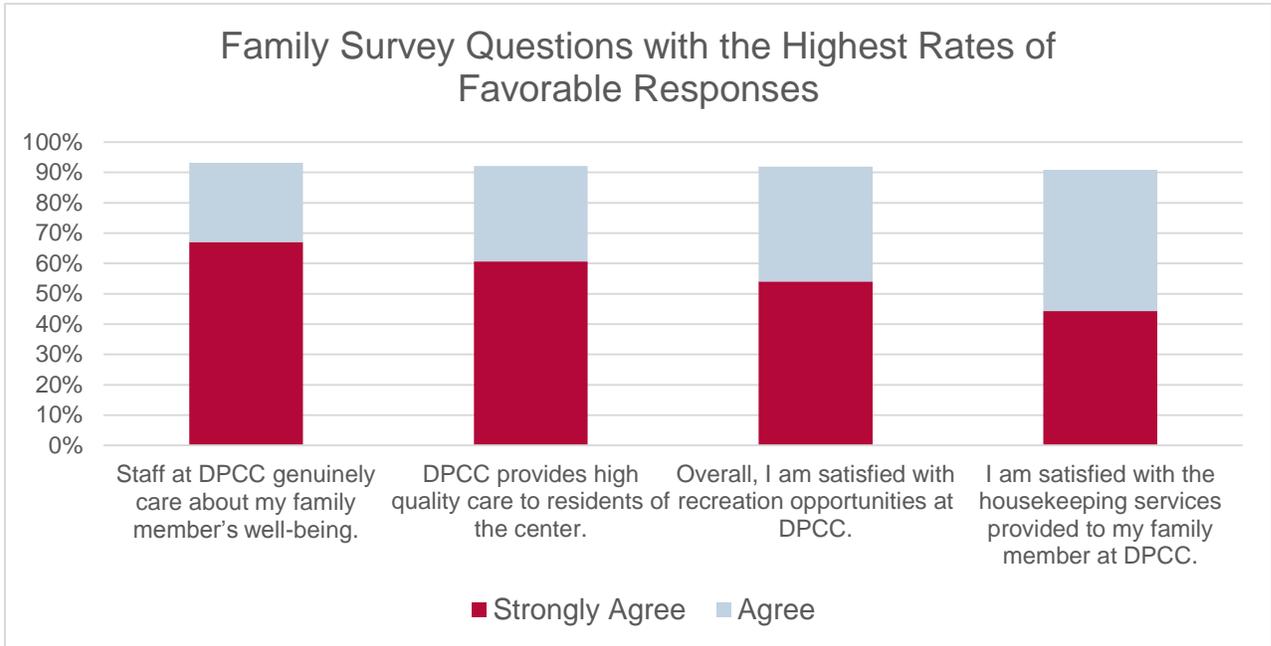
When asked about what DPCC could improve, many residents commented on what they perceived was inadequate staffing, or staff being too busy to respond promptly to call lights. A few mentioned the lack of consistent staff (too many floating staff or agency nurses) rather than an overall lack of staff. A number of residents stated that food service should be improved. Most other comments were extremely specific concerns to that particular resident.

Few residents offered suggestions about how to either reduce expenses or increase revenues, although a few suggested holding more fund raisers or increasing the foundation's activities.

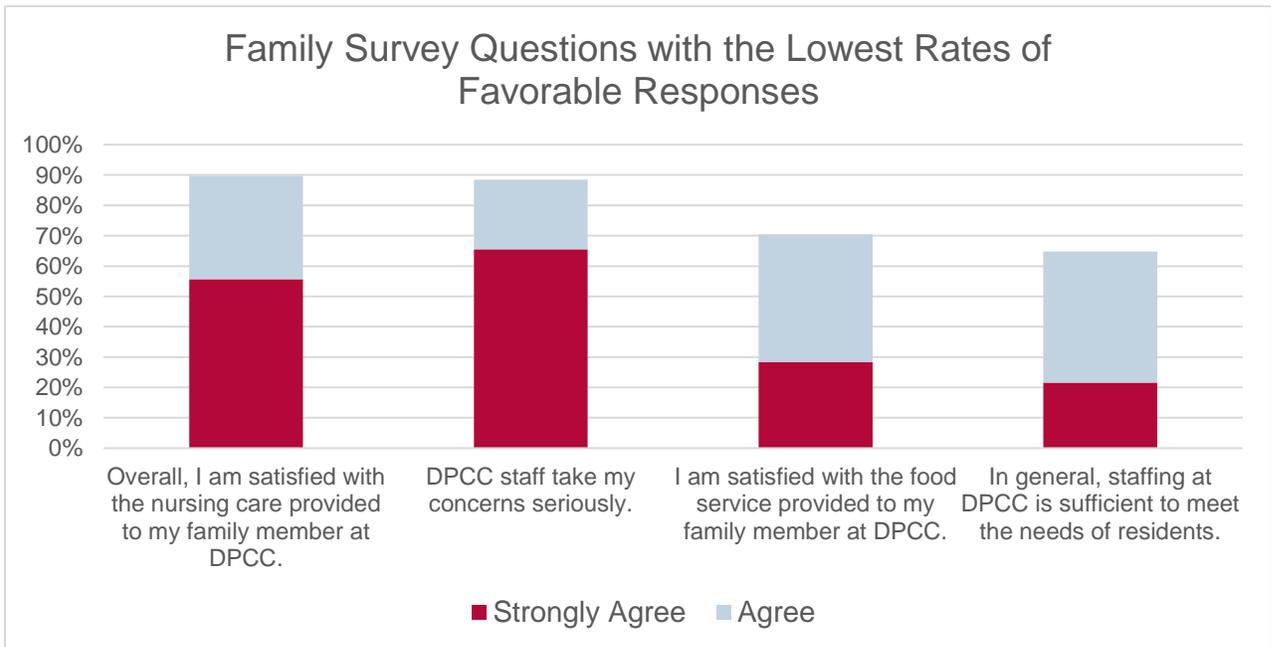
Family Survey

Families of Convalescent Center residents were mailed a letter containing a link to an online survey. Eight-nine family members responded to the survey. Family members were asked to respond to similar questions to those contained in the resident survey.

Family members who chose to respond to the survey were largely satisfied with most aspects of the Convalescent Center's operations. In particular, over 90% of respondents agreed or strongly agreed that DPCC staff genuinely care about their family member's well-being, and a similar percentage believe that residents receive high quality care at the Convalescent Center. Nearly equally high percentages viewed favorably the recreational, housekeeping, and nursing services the Convalescent Center provides to residents.



The only two questions that drew less than overwhelmingly favorable responses from family members of residents had to do with the quality of food service at DPCC and the sufficiency of staffing. The rates of agreement on these two questions were similar to the resident responses to the same questions, and while not overwhelmingly negative, do stand in contrast with the strongly positive responses to nearly all other questions posed.



When asked to name a few things the Convalescent Center was doing well, many family members pointed to the friendliness or helpfulness of staff, the rich array of recreational activities, and the sincere care that staff demonstrate for their family member.

Family members were also asked to comment on a few things DPCC could do to improve. Some respondents referenced specific concerns they've had with their family member's care, but most suggested either increasing the staffing or addressing certain operational issues like when to schedule family meetings, the need to improve food service, or reducing reliance on agency staff. Several different respondents mentioned that they have seen declining morale for the past several years.

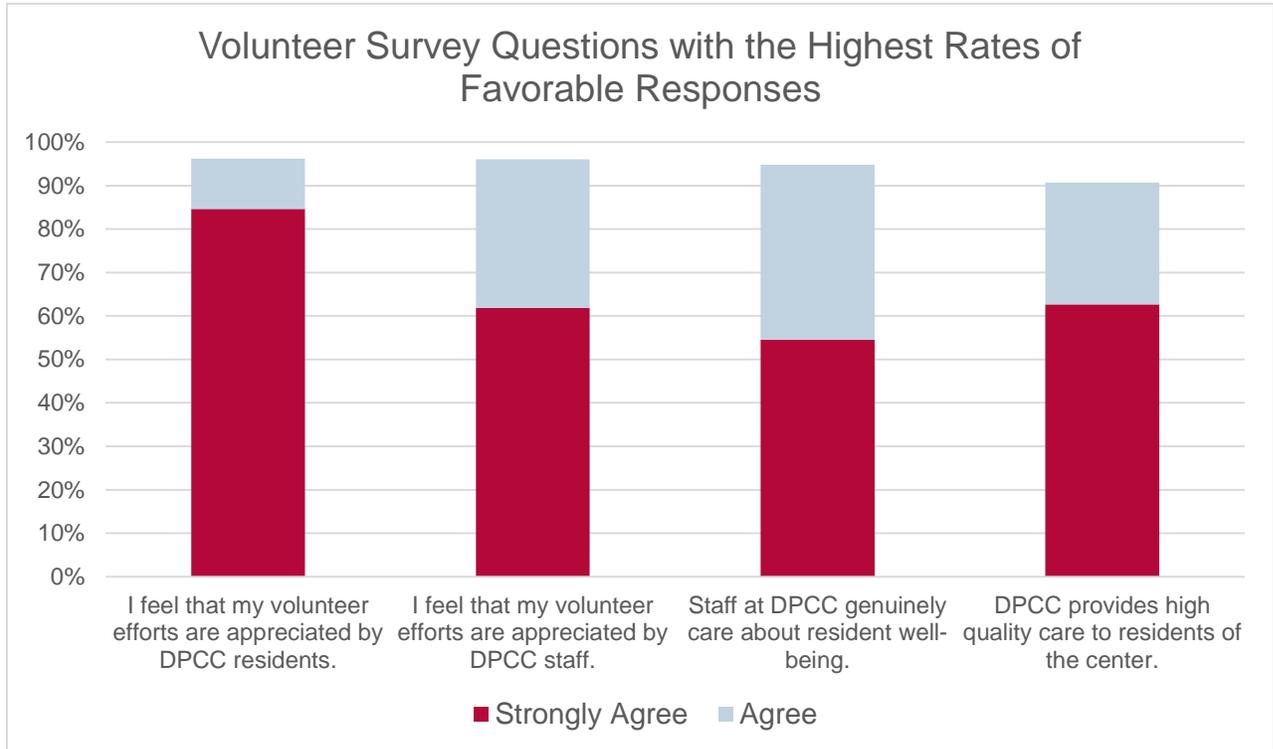
Many respondents to the family survey declined to offer suggestions for how to increase the Center's revenue. Those who did make suggestions either encouraged the Convalescent Center to engage in more fundraising operations, including seeking more grant funding, adding programs such as an adult day care service, or increasing taxes to fund the facility's operations.

Most respondents to the family survey also declined to suggest areas to reduce costs. One suggested renting out or leasing unused space, while a few others suggested some small energy savings approaches.

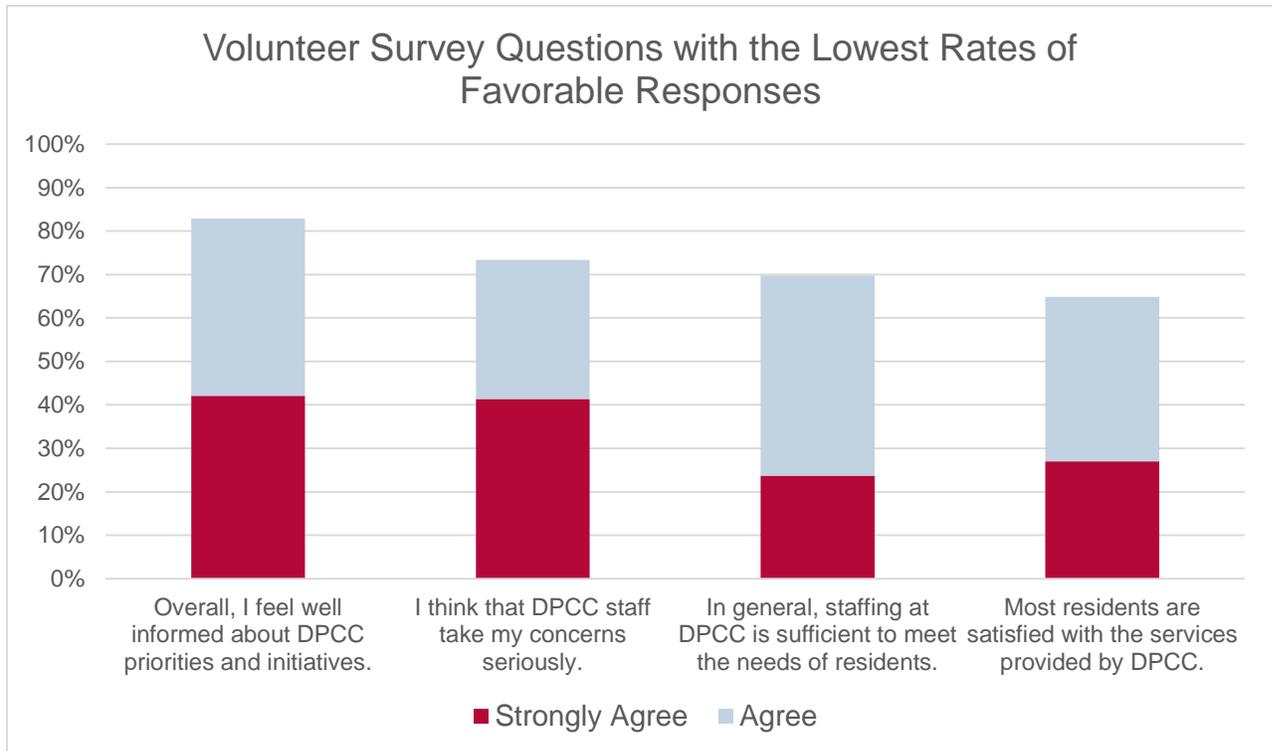
Volunteer Survey

DuPage County Convalescent Center volunteers were offered the opportunity to complete surveys either online or on paper, and 104 individuals chose to do so. The volunteers were asked some similar questions to those posed to staff, residents, or family members, but also a few that touched specifically on their experience as volunteers at the facility. Over a third of respondents had volunteered at the Convalescent Center for six or more years, and nearly 15% had been volunteering there for 16 or more years.

Respondents to the Volunteer survey were overwhelming positive in several key areas. Over 95% of respondents agreed or strongly agreed that residents appreciate their efforts as volunteers, the same percentage that believed that their efforts were appreciated by staff. A similarly high percentage of volunteers believe that DPCC staff genuinely care about resident well-being, and over 90% of respondent volunteers believe DPCC provides high quality care to residents.



While respondents to the volunteer survey were generally favorable about most aspects of the facility's operations, there were a few questions that elicited less overwhelmingly positive responses. Slightly fewer than two-thirds of respondents agreed with the statement that most residents are satisfied with the services provided by DPCC, and only 70% agreed that staffing at DPCC is sufficient to meet the needs of residents.



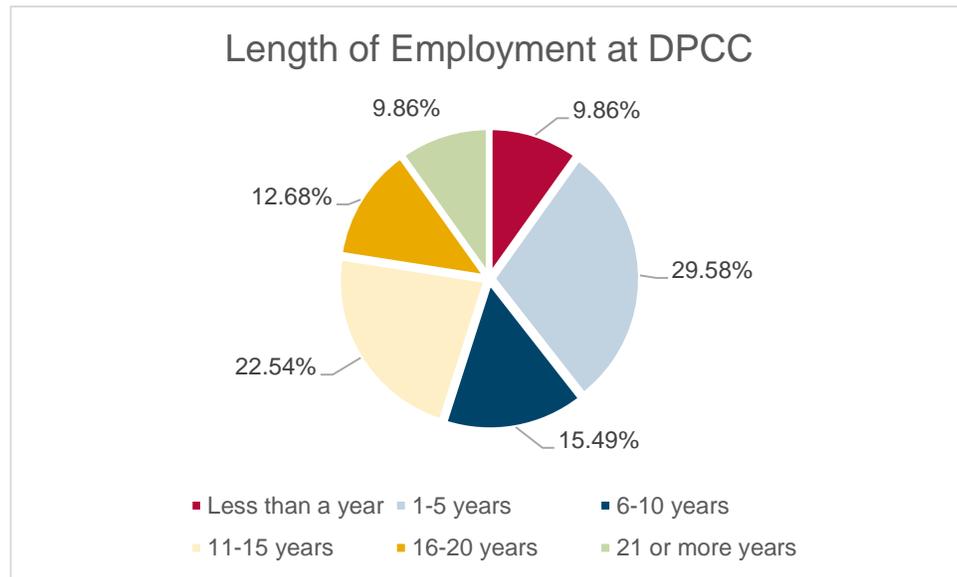
Many volunteers were effusive in their praise of Convalescent Center staff and their care for the patients of the facility. Most respondents highlighted the diversity and depth of recreation programs, the attentiveness of staff to resident needs, and the overall care that staff demonstrate for residents. When asked for suggestions to improve the facility, a majority of respondents pointed to the need for more staff, particularly more CNAs. A few mentioned the need for healthier food options for residents, and a couple mentioned upgrading the facility to look more modern.

When asked how the Convalescent Center could either save money or increase revenues, many respondents spoke to the need to engage in more fundraising or to press the County for more funding. Few offered suggestions for reducing expenses, and a number stated that they believe that DPCC already operates quite frugally. Of the handful that did make suggestions for lowering costs, one suggested relying less on contracted services, another speculated that there may be too many managers, and a third suggested improving the energy efficiency of the operation to save on utilities.

Staff Survey

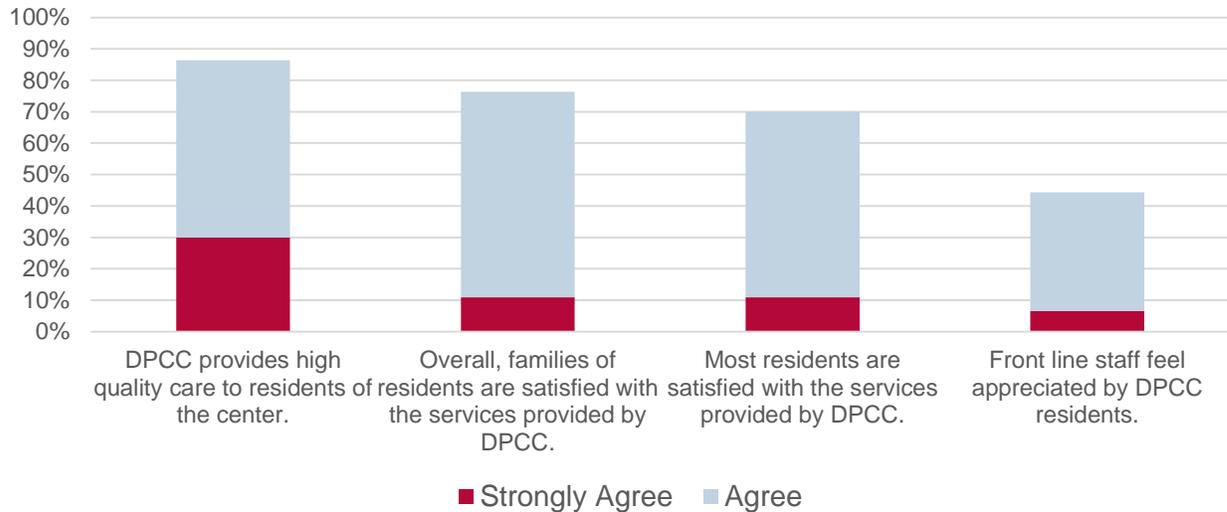
All staff at the DuPage County Convalescent Center were invited to complete an online survey, and 113 opted to do so. While many respondents chose not to answer the question about their department (38% of respondents left that question blank), of those that did, Nursing was the most well-represented group of respondents. Twenty-six of the 113 respondents were from nursing, followed by 25 respondents from Other Resident

Services, while 10 respondents worked in Administration. Survey respondents had a wide range of tenures with the organization. Slightly less than 10% had been there for less than a year, nearly 45% had worked there for between 1 and 10 years, and another 45% had worked there for 11 or more years. The chart below breaks down the tenure of the 71 individuals who responded to that question.



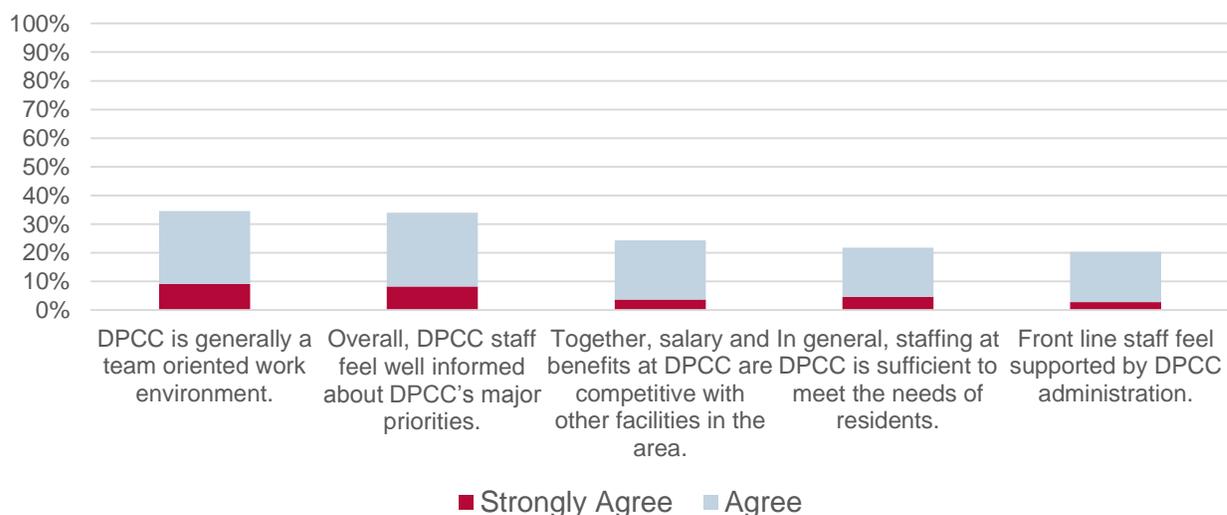
Staff were asked similar questions to those posed to volunteers, family members, and residents, but were also queried about some topics such as staff morale, communication, and work environment. Over 85% of staff survey respondents agreed or strongly agreed that DPCC provides high quality care to residents, and over 70% believe that families of residents and residents themselves are satisfied with the services they receive. However, no other question prompted more than a 50% favorable response rate, although over 40% of staff agreed that front-line staff feel appreciated by DPCC residents.

Staff Survey Questions with the Highest Rates of Favorable Responses



Most other questions elicited low levels of agreement or strong agreement from survey respondents. In particular, very few survey respondents believe that front line staff feel supported by DPCC administration, most do not believe salary and benefits are competitive with other facilities, and only a third believe Convalescent Center staff feel well informed about major priorities.

Staff Survey Questions with the Lowest Rates of Favorable Responses



Responses to open-ended questions were similar to those sentiments generated in the charts listed above, and matched some of the feedback our team received through interviews, focus groups, and town hall style meetings with Convalescent Center staff.

When asked what DPCC was doing well, many respondents took the opportunity to comment on the care DPCC provides residents and the commitment to meeting resident needs. Other respondents commented on the quality of recreational activities and the emphasis placed on maintaining patient well-being. Several individuals mentioned engagement with community, emphasizing the collaboration between staff and volunteers or facility enhancements provided for by the Foundation's fundraising efforts.

When asked for a few areas DPCC could improve upon, staff responses were varied and often quite expansive, but can be summarized into several key areas:

- ∞ A number of respondents mentioned staffing issues, including high turnover, low morale, use of agency nurses, and inadequate staffing during certain shifts.
- ∞ Many respondents mentioned issues of communication between departments and between front line staff and management. Several individuals encouraged facility management to spend more time on the floor interacting with staff and residents.
- ∞ Others mentioned a lack of teamwork between certain staff or departments, and a belief that hard working staff often aren't recognized for their hard work and care for residents.
- ∞ Several individuals suggested salary increases or again highlighted a perceived lack of salary competitiveness with other facilities in the area.

Staff survey respondents suggested a number of ideas for increasing revenue. A number of people suggested a more robust fundraising operation, with more events throughout the year. A few suggested renovating the empty wings for either more long term care, or for use by a complementary service like an adult day care, a child care center, or a trade school like cosmetology. A number of staff suggested improving the Convalescent Center's marketing or public image, and one even suggested changing the name to something more attractive for potential donors or residents.

When asked for ways that the Convalescent Center could save money, many staff shared a belief that the facility had already reduced expenses considerably, and suggested that it would be unwise to do so further. A few speculated on the increased usage of Agency staff for nursing coverage or highlighted overtime costs.

Comparisons with Other Nursing Homes

DuPage Convalescent Center is the largest nursing home in DuPage County, and also is larger than all other county-owned nursing facilities in Illinois. This makes direct comparisons with other facilities somewhat challenging. Nonetheless, it is worth comparing DPCC with all other public nursing homes in the state, and with all other nursing homes in DuPage County, regardless of size and ownership. The chart included in the Appendix offers selected comparisons that feature some of the more important distinctive features of the Center. These are highlighted below, based on 2014 data:

- DPCC generates more revenue per resident care day than do any of its fellow public nursing homes in the state, but it is slightly below the median when comparing with all other nursing homes in DuPage County.
- The gap in revenues per care day compared with other facilities in the county is largely a function of the fact that DPCC is 32nd out of 34 nursing homes in both the proportion of resident days paid for by Medicare, and the resulting total proportion of revenues attributable to Medicare. The 6 percent Medicare days lags far behind the 17 percent median in the county, as does the 16 percent revenue proportion, compared to the median of 37 percent. The DPCC Medicare proportions also are lower than the comparable median figures for public nursing homes across the state.
- The flip side of the Medicare revenues is the proportion of revenues attributable to Medicaid, at its significantly lower levels of reimbursement per day. Almost two-thirds of all resident care days at DPCC are paid for by Medicaid (proportions are even higher over the past several years combined, as noted earlier in the report), compared to the countywide median of 54 percent, and the DPCC proportion is even higher than most of its public colleagues. As a result, the proportion of revenues attributable to Medicaid is also higher at DPCC.
- As noted earlier, compared with both other nursing facilities and other public facilities statewide, DPCC has much higher proportions of residents under 65, residents with primary Alzheimer's diagnoses, and residents with either primary or any mental illness diagnosis, though we suspect that some homes in the state are not as consistent about reporting all diagnoses as DPCC is, based on what appear to be some missing values in the state dataset. Nonetheless, these realities have significant implications for the "safety net," hard-to-place mission that DPCC historically plays, as well as for the costs of providing services to these higher proportions of hard-to-serve residents.
- As also noted earlier, DPCC's ratio of RNs to LPNs is the second highest of all public county homes in the state, and the fourth highest of all nursing facilities in DuPage County. Its average number of residents per both CNAs and nurses is lower than most other nursing homes in the county and most other public facilities across the state. That is, each nurse and CNA is responsible on the average for fewer residents than is true in most of the other comparison facilities. However, in interpreting such

numbers, it is important to place the reported numbers in the context of the size of the units served, i.e., number and configuration of beds per wing that staff must serve, and how staff are allocated and spend their time (e.g., time providing direct face-to-face patient care services to residents versus spending time passing out medications to large numbers of residents on a shift). As suggested above, this may be an opportunity to reassess staff allocations to determine the most efficient future deployment of nurses and CNAs, given the existing configuration of DPCC units and existing staff.

Experience of Other Counties with Public Nursing Homes

CGR interviewed officials from three collar counties—Lake, McHenry and Will—to learn about their experiences in working to improve the sustainability of their public nursing homes. All three of the counties viewed the physical condition of their buildings as a primary impediment to sustainability, and each found a different way to address that concern. Lake County has moved toward privatization and construction of a new facility. McHenry funded construction of a new home through a tax levy approved by voters in 2002. Will has been doing extensive remodeling of its facility, one unit at a time, over the past 10 years.

Lake County

Lake's Winchester House shares several characteristics with the DuPage Convalescent Center—it has 360 beds and is located within a larger county government campus. It was constructed in the 1940s with an addition in the 1960s, and sits on a prominent corner of the county's main municipality of Libertyville.

By 2005, the home was experiencing a sharp decline in occupancy, attributed to growing competition from the private sector and independent living options for seniors. The county brought in a consultant and ended up doing widespread layoffs—staff had not been reduced when census declined. The county also did a market study examining whether it should stay in the business. The study concluded that there was still a need for the home, but that it was too institutional in style and outdated to effectively compete. The recommendation was to build a new, smaller home with 170 beds.

However, the home's operations have been funded for the past 30+ years through the proceeds of a tax levy passed by referendum in 1982. When the county board authorized the construction of a new home in 2007, it stipulated that the new home had to be constructed and operated within the constraints of the existing tax levy. Upon further study, leaders concluded they could not stay within the tax levy with the debt service that would be required to build a new facility.

A Winchester House advisory board was created to further study and recommend what to do. The board looked at how to find efficiencies and decided to solicit proposals for private management of the home. After receiving and evaluating two responses, the county in 2011 turned over management to a private firm headquartered in Minneapolis. The county laid off the nursing home staff and the firm hired them back. The main union representing workers at the home (AFSCME) remained in place. About \$1.6 million was saved, largely through reducing pension costs. This left an operating gap of \$3 million.

After management of the home was privatized, the advisory board looked again at options for constructing a new facility. A second market study concluded there was still a need for the home but that the market was changing as Baby Boomers age. They want to stay home longer, and want a private space with room for their possessions when they do go into a nursing home. Following that market study, the board spent 1½ years studying the likely impacts of the Affordable Care Act, including the transition to managed care for Medicaid recipients and the evolution of health care networks playing a larger role in determining when and where people go into nursing homes. This led the board to look for additional ways to partner with the private sector, and it issued an RFP looking for a firm to lease and manage the facility for a period of time before taking over its license and constructing a new home.

Two firms responded, including the incumbent manager. The county selected the other bidder, a for-profit operator – Transitional Care of Lake County. The firm was relatively new but its principals had owned and operated nursing homes for several decades.

The county's agreement with Transitional Care has three phases. In the first, which began in August, the company took over management of the home and applied to the state to assume the county's nursing home license, which was just granted in December. In the second phase, the company is to design and build a new facility, and in the third and final phase, the company will move operations to the new building.

Since taking over, Transitional Care has made some changes at the home, including selecting a less expensive, higher quality food vendor and repurposing space to allow an older part of the building to be shut down, reducing utility costs.

Over the three years of the agreement, the county is spending \$6.7 million to subsidize the home's operations, though \$1.9 million of that is in the form of a cash advance that the company will pay back. In year 1, the county is paying \$2.5 million, and years 2 and 3 a bit over \$1 million a year. The county's costs are capped at those amounts. If the company is able to find efficiencies or otherwise performs better than expectations, profits are shared 50-50 with the county.

The county has the right to withhold subsidy payments and/or levy fines if the company fails to live up to provisions of the agreement. In addition, the company is paying the county rent of \$500,000, and it turned over \$700,000 that the county is holding until the

company assumes the nursing home license. The money is paid back to the company as milestones in the project are met.

When the agreement ends, the county will be out of the nursing home business. If the company has not vacated the building by the end of the 3-year agreement, a major escalation to rent kicks in—providing an incentive to ensure the company completes a new facility and transfers operations to it.

The agreement requires the company in the future to accept Lake County residents in need of care, or to help them find another home if they do not accept them. An example of this would be providing placement services to prospective residents turned down because they are smokers.

McHenry County

In 2002, McHenry County voters approved a tax levy to fund the construction and operation of a new Valley Hi Nursing Home. The existing home had been constructed in phases from the 1950s through the '80s and was viewed as cost prohibitive to maintain and upgrade. At that time, annual operational deficits were running about \$2 million.

The county considered other options before passing the levy, including selling or leasing the home. But the decision was made to pursue a new levy—McHenry has had a public nursing home since the late 1800s, and it is seen as part of the fabric of the health care system and an important safety net for seniors. The levy passed overwhelmingly, though some in McHenry believe it would be far more difficult to pass such a levy today since voters' feelings about government, taxes and their own economic situations have changed so much since the 2008 recession.

Before the levy, Valley Hi was funded out of the county general fund. Now, it is funded through an enterprise fund and therefore does not compete with other county departments for funding. The levy authorized the collection of up to \$6 million a year, though in most years less has been collected. This year, the levy is collecting \$3 million.

The county borrowed \$12.5 million to construct the new home in 2005 and moved operations into it in 2007. The county was able to pay the debt off early in 2011 due to new home construction throughout the county and the resulting increased tax revenues. The new building has a less institutional design than the old facility, with rooms arranged as spokes coming off of the centralized nursing station for each unit. The new facility has helped attract more private pay and Medicare residents—about 65 percent of residents in the home currently receive Medicaid, compared to almost all residents before the new home was built.

The current home has 128 beds, including 80 Medicaid, 20 Medicare, 20 private pay and 8 that are flexible. The Medicare census has fallen to an average of about 12 in the last few years as changes related to the Affordable Care Act have taken hold. Hospitals placing patients for rehab increasingly want to see private rooms and staff such as nurse practitioners and physiatrists that the home does not currently have. In the works is a new

acute care facility attached to the main hospital, which would generate even more competition for the Medicare rehab work.

In the last five years, Valley Hi has moved toward resident-centered care, allowing residents to order meals off a menu and choose days and times for such things as showers. Though the home has many residents with dementia, it does not have a specialized dementia unit.

The home has about \$39 million in reserves—\$13 million would cover one year of operations if Valley Hi had no other revenues coming in. That would allow the home to operate for one year if it then wanted to close down or sell. Between \$5-8 million is for capital improvements/asset preservation. The home's leadership is trying to make the case to the county that it needs to keep/build those reserves as a hedge against the many negative things that might happen in the future with Medicaid and managed care.

The workforce at Valley Hi, along with other county departments, was organized several years ago by SEIU when workers were concerned about the stability of their jobs.

Will County

Sunny Hill Nursing Home was constructed in the 1970s. Believing it was outdated and had an overly institutional feel, the county has been doing extensive renovations to increase its appeal and make it feel more “home-like” for the past decade, a unit at a time. Each unit takes about a year, and the work is expected to be complete in November 2016.

In addition to the renovations, the home has cut staff, including the elimination of 13 staff in housekeeping (recommended by a consultant report). The 238-bed home is also attracting more private pay residents. Of patient care days in September, 55 percent were Medicaid funded and 32 percent private pay. The current subsidy is \$3.5 million, down from about \$7 million in 2008. All the beds are Medicaid and Medicare certified.

Sunny Hill is selective in admissions, only accepting people 65 or older and no smokers or people with criminal backgrounds or a primary diagnosis of mental illness. In addition, the home does not accept people with complicated chemotherapy regimens. The home is also slower to approve an admission than some others.

The home is also somewhat selective about staff, not hiring new graduates. RNs must work somewhere else for three years and LPNs one year. A committee of residents interviews all staff candidates and is empowered to veto hires.

The administrator's goal is to move to 150 private rooms. Residents would still need to share a bathroom, but this would help make the home even more attractive. It would increase the required subsidy, though no one has estimated the amount needed.

Earlier this year, the home opened an outpatient therapy unit—a suggestion of an architect that the administrator researched and adopted. It is not profitable and probably

will not be for a few years at least, but the administrator sees it as a way of getting the home's name out to a different population. It is staffed through the existing therapy contract.

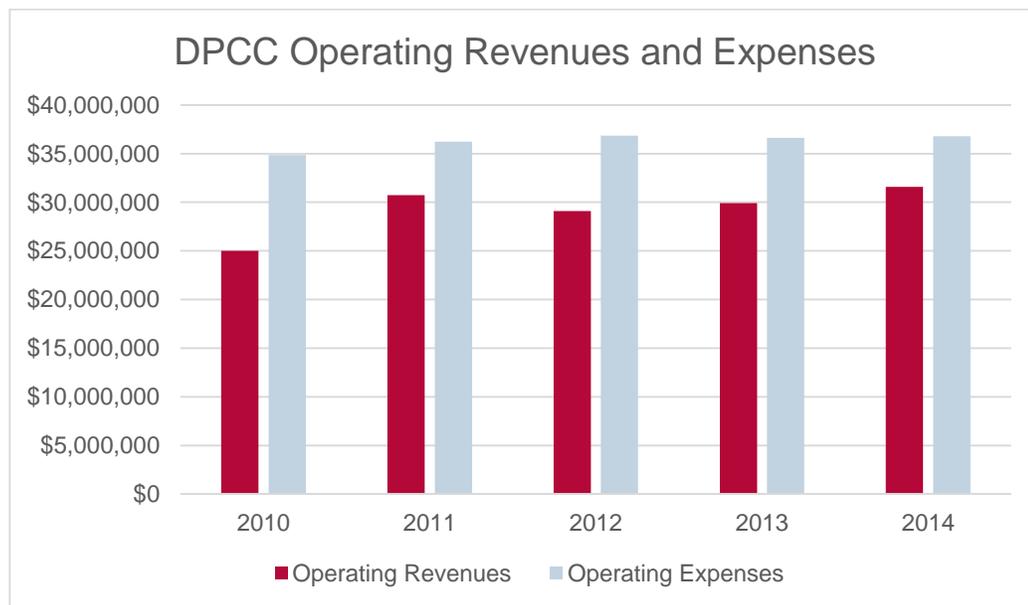
Sunny Hill is funded out of the county's general fund without a dedicated tax levy. Will has a county executive form of government, the only one in Illinois. Though the county board has over the years asked questions about whether to stay in the nursing home business, opposition has never solidified into a majority. The administrator makes monthly reports to the county board on the number of residents in the home broken down by city and legislative district so that leaders understand its importance.

In 2005, Sunny Hill changed its mission and adopted the resident-centered care model. The home uses consistent caregiving so that staff are matched and assigned to specific residents. This can mean traveling more for staff members, though they are assigned to "avenues," or units, of the home that they bid on through their union contract. Each unit has four CNAs and during the day and evening shifts an RN and LPN. Though that is more than other places, the administrator feels it is needed to meet the needs of needy and medically-compromised residents.

IV. Convalescent Center Financial Analysis

Overview of Revenue and Expenditures

The DuPage County Convalescent Center has operated with a structural deficit of \$5 million to \$7 million dollars from 2011 through 2014, down from a deficit of nearly \$10 million in 2010¹, but still a significant total. The Convalescent Center has typically generated approximately \$30 million in operating revenue each year, while spending over \$36 million on patient care and facility operations.



This deficit is only partially offset by an annual subsidy from DuPage County, which was recently increased from \$2.4 million in 2014 to \$3 million in 2015. The County also supports the Convalescent Center through various administrative services provided directly by the County. This includes support from the County's Human Resources, IT, Facilities, Security, and Finance departments. Most of these expenses are included as non-cash items in the Convalescent Center's financial reports, and together represent an in-kind contribution from the County to the Convalescent Center of about \$3 million or more per year, with the amounts based on an annual Cost Allocation Plan done for the

¹ Note: Revenues increased considerably from 2010 to 2011 and subsequent years due primarily to a change in the state's Medicaid reimbursement methodology for funding publicly-operated nursing homes, along with shifts in Medicare and private care resident days.

County under contract with MGT of America. The table below outlines the subsidy and indirect cost contributions by year.

Year	County Subsidy	Indirect Cost Contribution	Total Transfer
2010	\$2,550,000	\$3,158,183	\$5,708,183
2011	\$2,718,000	\$3,232,048	\$5,950,048
2012	\$2,400,000	\$3,694,119	\$6,094,119
2013	\$2,400,000	\$3,221,081	\$5,621,081
2014	\$2,400,000	\$2,998,598	\$5,398,598

It is our assessment that, with a few important caveats, the Convalescent Center's persistent operating deficit is primarily the result of insufficient revenue, rather than excessive expenditures (though rising expenses for nursing services is a bit of an exception to this statement).

Significant Trends in Operating Revenue

There are a number of important variables contributing to a nursing home's patient care day revenue, including daily census/bed utilization, the ratio of long-term care beds to short-term rehabilitation beds, and mix of payers, each of which pay different rates.

In recent years, the Convalescent Center has generally maintained a high utilization rate in long-term care beds, but a much lower rate in the rehabilitation unit. Only 5 percent of the 353 current beds in the facility are presently being used for short-term rehabilitation, an understandable approach given the traditional view of the Convalescent Center in the community, but still a difficult ratio through which to achieve higher revenues. Finally, in line with its mission, the Convalescent Center has traditionally maintained a high ratio of Medicaid-funded residents, as opposed to those residents with Medicare, private insurance, or those who pay for their own care from savings or family assets.

Patient Care Day Revenue

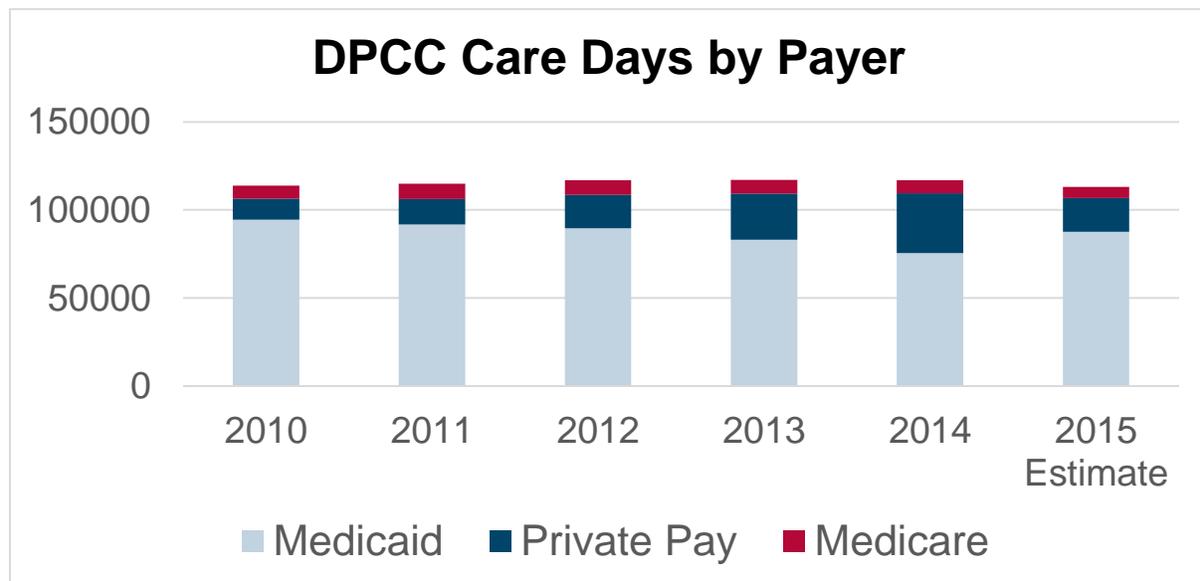
The Convalescent Center generates nearly all of its patient care revenue from three sources: Medicaid, Medicare and private pay. DPCC also serves a small number of residents each year whose private insurance covers their stay in the facility, but at less than 1 percent of total care days in 2014, private insurance is not material to this analysis.

Similar to other nursing homes that accept Medicaid-funded residents, DPCC relies upon Medicare and private pay clients to offset the loss generated by the low Medicaid reimbursement rate. Including the certified enhanced rate, DPCC receives approximately \$213 per day for each Medicaid-funded resident, while the facility's average cost of caring for each long term care resident is around \$290 per day. Therefore, DPCC loses

approximately \$77 per Medicaid resident each day. Conversely, the Convalescent Center is able to charge private-pay residents much closer to the average cost of their care at the facility, and is actually able to generate a profit when charging Medicare.

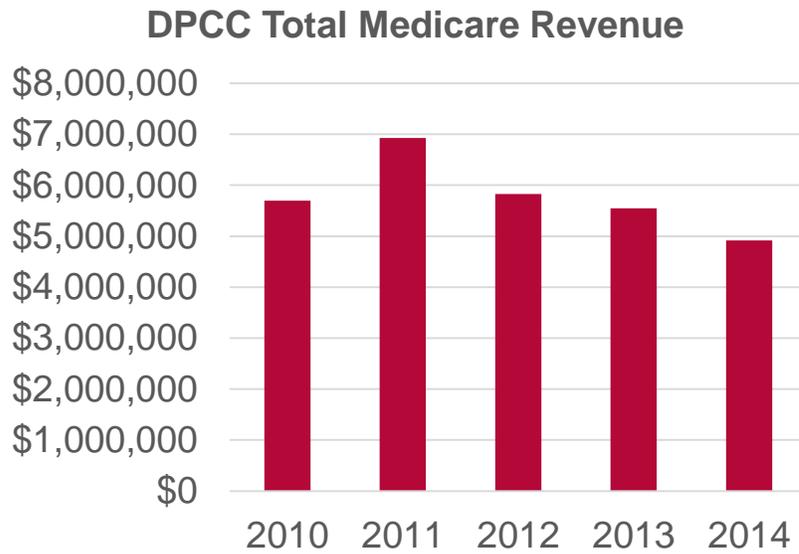
Therefore, attracting more Medicare and private pay residents is in the financial interest of the Convalescent Center. A higher share of Medicare and private pay residents vastly improves the Center's revenue outlook. However, the mission of the Convalescent Center is to provide high quality nursing care for the indigent residents of DuPage County, and Medicaid is the primary payer of health care services for individuals who lack significant financial resources.

From 2010 through 2014, Medicaid made up approximately 75 percent of all patient care days at the Convalescent Center, while it only comprised 55 percent of all care days in nursing homes throughout DuPage County over the same time period. The chart below illustrates the recent trend in care days at the Convalescent Center by each of the three major funding sources.



While Medicaid was responsible for 75 percent of all care days from 2010 through 2014, the program's low reimbursement rate caused it to only pay for 53 percent of all DPCC patient care revenue during the same time period. Conversely, while Medicare only paid for 7 percent of all care days during that period, it was responsible for over 20 percent of all revenue during the same period. Private-pay residents made up most of the remaining 27 percent of patient care day revenue during this time, with private insurance also contributing a small share.

While Medicare still comprises a substantial share of the Convalescent Center's patient care revenue, it has declined by almost 30 percent since 2011. The chart below details total Medicare revenue over the past several years.



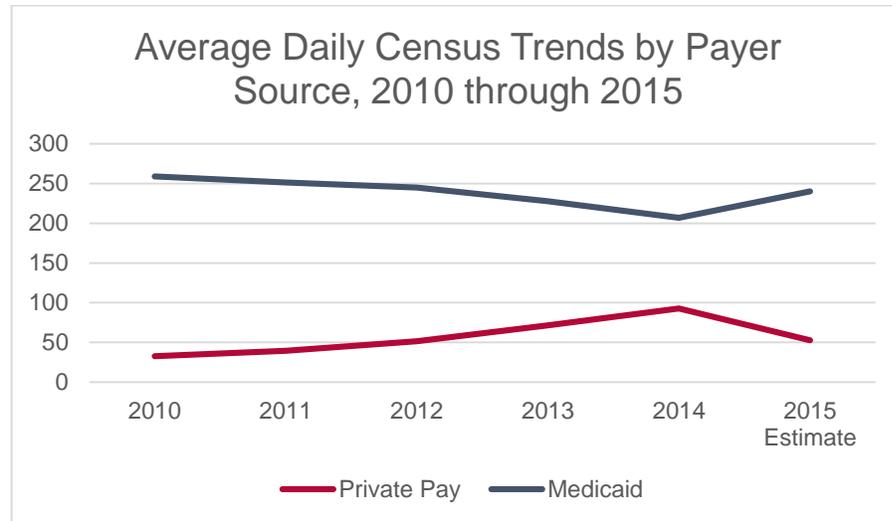
This reduction in revenue has primarily been the result of a shrinking census in the Convalescent Center's short-term rehabilitation unit. This unit, which historically has served 25 to 30 residents each day, has fallen to under 20 residents per day since the spring of 2014. While the Convalescent Center can generate some Medicare revenue in the long term care units of the facility, the short-term rehab unit is primarily responsible for the Convalescent Center's income from Medicare.

The reduced revenue from Medicare over the past several years was partially mitigated by an unexpected rise in private-pay residents during the same period. The number of residents who paid for their own care during at least a portion of their time while a resident at DPCC rose from just under an average of 33 residents per day in 2010 to 93 per day in 2014. Over the same period, the average number of Medicaid-funded residents at the Convalescent Center declined from 259 to 207 residents per day.

As the Convalescent Center is able to charge private-pay residents virtually the full cost of their care, and loses \$77 per day per Medicaid recipient, this shift in payer sources from Medicaid to private pay from 2010 to 2014 was extremely helpful for DPCC's bottom line. Had the Convalescent Center maintained the same number of private pay residents in 2014 that it had in 2010 (33 rather than 93), the facility would have generated nearly \$1.3 million less revenue in 2014.

While the growth of private pay residents from 2010 to 2014 was undoubtedly beneficial for the Convalescent Center's bottom line, the DPCC administration says that it was not the result of a deliberate effort to recruit residents with greater financial means, and was unclear as to why this trend occurred.

It also appears as though the trend toward private-pay clients reversed in 2015, and the average daily census of private-pay clients shrank by 40 residents per day through the first 10 months of Fiscal Year 2015. The graph below illustrates that reversing trend.



The Convalescent Center approached this topic conservatively in their Fiscal Year 2016 budget, anticipating that patient care revenue from private sources in the upcoming year will be about half of the 2014 total of \$12.4 million, and closer to the private-pay revenue totals from 2011 and 2012.

DPCC leadership and County staff constructed an overall budget for Fiscal Year 2016 that anticipates \$34 million in overall operating revenue (excluding the \$3 million subsidy), including \$32 million in income from patient care days billing. This is only \$600,000 higher than the anticipated final Fiscal Year 2015 patient care revenue, but, given the anticipated payer mix in 2016, will require a significantly higher census to achieve. The table below shows the shift in anticipated revenue from private-pay sources to Medicaid in 2016.

Payer	FY15 Annualized	FY16	Variance
Medicaid	\$13,073,014	\$19,772,531	\$6,699,517
Private Pay	\$13,752,403	\$6,483,198	-\$7,269,205
Medicare	\$2,932,940.00	\$3,351,363.00	\$418,423

In 2015, the Convalescent Center converted short-term rehab rooms on 1 East to long-term care beds to increase the overall census of the facility. It is unclear whether DPCC will be able to maintain a larger long-term care census in 2016, and if the overall census does not grow, then the Convalescent Center will be faced with a significantly larger deficit than budgeted.

Other Revenue Sources

In 2014, 89 percent of all Convalescent Center revenue was generated from patient care days, while the remaining 11 percent was primarily comprised of the income from the cafeteria and related catering operations, and pharmacy operations, including billings to Medicare parts B and D. As noted earlier in this report, the Convalescent Center has taken advantage of different opportunities to grow non-patient care revenue. Providing pharmacy and cafeteria services to the County collectively generate two to three hundred thousand dollars in profits for the Convalescent Center, helping reduce the Convalescent Center's annual deficit while also providing different services to the County and its employees.

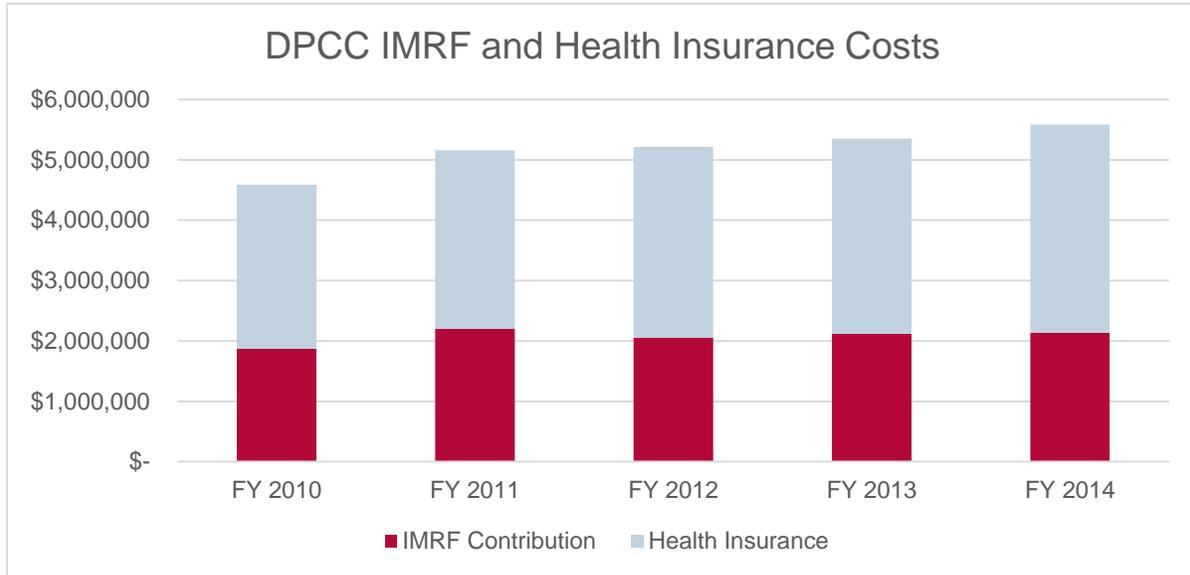
Expenditure Trends

DuPage County implemented a new accounting software in 2014. This transition was accompanied by a new set of expense codes and accounting units. Matching new codes with the older ones, we have examined trends in expenditures from 2010 through 2014.

The Convalescent Center's operating expenses have only increased slightly over the last several years. After a substantial increase of \$1.4 million between 2010 and 2011, the Convalescent Center's Operating Expenses grew by just over \$560,000, or 1.5 percent, from 2011 to 2014. This growth was primarily caused by increased health insurance and pension obligations, as well as increased costs for nursing services, mostly part-time, on-call and agency staff.

DuPage County participates in the Illinois Municipal Retirement Fund (IMRF) pension program, a defined benefit retirement plan that includes most governmental entities in Illinois outside Cook County. In line with national trends among defined benefit retirement plans, DuPage County's contributions to the IMRF have increased in recent years to meet the plan's funding obligations. A proportional share of this cost is passed on to the Convalescent Center, and appears as an indirect cost item in the Center's budget.

IMRF payments from the Convalescent Center increased by 14 percent from 2010 to 2014, or slightly over \$260,000. Health insurance costs have also risen considerably since 2010, increasing from \$2.71 million in 2010 to \$3.45 in 2014, a 27 percent increase. Together, health insurance costs and pension obligations added over \$1 million in additional expenses to the Convalescent Center's budget from 2010 to 2014.



The Convalescent Center's operating expenses grew by almost \$2 million from 2010 to 2014, with most of that increase coming between 2010 and 2011. Health insurance and IMRF costs grew by \$1 million over the same period, including the County's 85 percent contribution to employee health insurance costs. Collectively, those two expenses are responsible for over 50% of the Convalescent Center's overall increase in operating expenses since 2010.

Aside from pensions and health care costs, most other expense categories at the Convalescent Center have not experienced significant increases in recent years. Most departments at the Convalescent Center have actually seen their expenditures shrink, including Social Services, Recreation Therapy, and Housekeeping. One notable exception to that trend was Nursing Services.

Nursing Services is the single largest department in the Convalescent Center, and is responsible for roughly 30 percent of the facility's annual expenses. Along with health insurance costs and IMRF contribution requirements, expenses for nursing were the other significant contributor to increased Convalescent Center costs over the last several years. Nursing expenses grew by almost \$500,000 from 2012 through 2015 (annualized). Nursing Services as an accounting group is defined as all front line staff reporting up to the Director of Nursing, except for those staff assigned to the Short Term Rehabilitation Unit, which has its own accounting unit. Nursing Services also includes non-personnel expenses used by the Nursing Department, such as various medical supplies and equipment, as well as small expense items like printing and travel expenses allocated to nursing staff.

The table below includes direct personnel costs (salaries and benefits) in the nursing unit, plus any costs associated with the use of Agency RNs, LPNs, or CNAs to cover nursing staffing needs at the Convalescent Center.

Account Name	FY 2012	FY 2015 Annualized Expense	Variance
Regular Salaries	\$7,089,131	\$6,758,403	-\$330,728
Overtime Pay	\$1,175,118	\$1,236,005	\$60,887
Holiday Pay	\$111,179	\$140,000	\$28,821
Part Time Salaries	\$1,096,110	\$1,344,000	\$247,890
On Call Salaries	\$338,160	\$600,000	\$261,840
Agency Nursing Services	\$6,942	\$236,050	\$229,108
Benefits	\$297,490	\$289,727	-\$7,763
Total Staffing Costs	\$10,114,130	\$10,604,185	\$490,055

The various staffing issues referenced elsewhere in the report help explain some of these expense changes. This table shows that regular staff salary expenditures actually decreased by over \$330,000 from 2011 to 2014, despite no changes in budgeted nursing positions, a stable long-term care census, and modest cost of living increases throughout that period. The reduction in salaried hours also resulted in a small decrease in employee fringe benefits attributed to the Nursing Services unit. However, this decline was more than offset by increases in part-time salaries, on call staff expenses, overtime, and the use of Agency staff.

Fiscal Year 2016 Budget Outlook

Given the Illinois state budget environment and the Convalescent Center's heavy reliance on Medicaid funding, the Convalescent Center had an understandable challenge when asked to develop a budget for Fiscal Year 2016. The facility's leadership created a revenue forecast based on an expectation that Convalescent Center would maintain 353 beds in operation throughout the year, and achieve a 95 percent average daily occupancy for the year. They anticipated the payer mix in 2016 would be 77 percent Medicaid, 17 percent private pay, 5 percent Medicare, and 1 percent private insurance. The table below contains the anticipated daily census and rate for residents by category in 2016.

Payer	Average Care Days	Daily Rate
Medicaid	258	\$163.15
Private Pay	58	\$280.80
Insurance	0.87	\$600.00
Medicare	18	\$505.08

Combined with other care day-based add-ons like the inter-governmental transfer payments, Medicaid pharmacy and oxygen revenues, and Medicare Part B and Part D revenues, the Convalescent Center expects to generate \$32,065,449 in patient care revenue in 2016, a 1.9 percent increase from 2015, and a 6.8 percent increase from 2014. This growth is the result of greater reimbursement for higher acuity patients, a projected larger census, and increases in the daily rate for private pay clients, which together would more than offset a 9.5 percent expected Medicaid daily rate reduction from the State.

Non-patient care generated revenues in 2016 are projected to be \$4,952,779, which includes the \$3 million subsidy from DuPage County. This figure is roughly the same as the prior year, and up almost \$1 million from 2014, when the pharmacy and cafeteria generated substantially less revenue.

Including the \$3 million subsidy from DuPage County, the Convalescent Center anticipates generating just over \$37 million in revenue in 2016, a 1.5 percent increase over 2015 and 8.9 percent above the 2014 total.

The Convalescent Center's anticipated revenue for 2016 is necessary to meet budgeted expenditures for the year, which are also expected to reach \$37 million this year. Personnel costs are projected to grow by \$1.1 million in 2016. Approximately half of that growth is due to health care and pension obligations. IMRF and health insurance costs are expected to rise to a combined \$6.3 million in 2016, up from a budgeted \$5.8 million in 2015 and \$5.5 in 2014.

The Convalescent Center is responding to growing personnel costs by finding savings in various contractual services, but chooses to continue to invest in certain important capital outlays such as building improvements and equipment replacements.

Conclusion

Drivers of increased costs at the Convalescent Center are health and pension costs, over which the nursing home has little direct control, and nursing staff expenses, largely because of increased reliance on part-time, on-call and agency staff. Given these trends, along with the ratio of short-term rehab to long-term care beds and the high percentage of Medicaid-funded care days at the facility, it appears unlikely that the Convalescent Center will be able to generate sufficient revenue in future years to avoid an ongoing operating deficit that will necessitate the need for continued financial support from the County, unless there are significant shifts in the occupancy rate and payer mix that generate more revenues.

V. Potential Options for Future Consideration

Based on the information presented in the first four chapters, conversations with knowledgeable experts, review of various relevant reports and materials, and CGR's extensive experience working with long-term-care issues and dozens of public nursing homes, this concluding chapter outlines a range of potential options for the future operation of the DuPage Convalescent Center. For each option, we describe pertinent characteristics, perceived advantages and limitations, and the likely implications and value of implementing or not implementing various potential scenarios.

A number of options are discussed, all of which have at least some potential to be of value to DPCC and DuPage County. Some clearly have more merit and are likely to be more feasible and realistic than others, but we believe all are at least worthy of consideration as the County seeks to determine the most feasible and sustainable directions and strategies to continue the mission of the Convalescent Center in the future.

It is important to emphasize that all of what follows should be considered *potential* options. Thus each of the broad options in the list below is stated with a question mark to emphasize that none are being endorsed or recommended; rather, all should be considered as having the *potential*, under the right sets of circumstances, to contribute to the future sustainability of the Center. The numerous potential options for consideration that are discussed in this chapter all fall broadly within the following overall categories of options, which are broadly listed along a continuum roughly ordered from internal changes largely controlled by DPCC to options largely shaped by decisions made at the County level:

- Internal operational changes to maximize use of staff, reduce costs and increase revenues?
- Use of a management consultant?
- Use of vacant space at DPCC?
- Renovation of existing used space at DPCC, and/or building new facility?
- Partnerships?
- Dedicated tax levy?
- Diminished County role; changes in ownership of DPCC?

Options are discussed individually, and indeed should be considered as possible viable stand-alone initiatives. It is also entirely possible that various options, though outlined separately, may have value in how some may be mixed together. Thus the options should be considered both for their intrinsic potential value on their own, but also for their potential as hybrids, in various possible combinations with each other.

CGR has been requested by County officials to stop short of making specific recommendations, but rather to simply lay out options to help frame the discussion by DPCC and County officials concerning the future of the Convalescent Center.

Criteria for Assessing Viability of Options

In assessing and comparing the various potential options for consideration concerning the future of the Convalescent Center, various factors or criteria should be kept in mind. CGR has not attempted to assign any particular weighting or ordering of priority of the criteria, which the County Board and others involved in making decisions about the future of the Center may ultimately choose to do. Our intent is simply to outline factors that we think decision-makers should keep in mind as they review the options and ultimately determine the directions shaping the future of DPCC.

The suggested criteria include, in no particular order:

- Impact of the options and any resulting County actions on the quality of care and likely health outcomes for current and potential future residents of the Convalescent Center;
- Short and long-term financial implications for the County and its taxpayers;
- Impact on current and potential future employees;
- Feasibility/probability of successful implementation, realistic timelines, and the likely sustainability of changes;
- Legal/regulatory/political feasibility;
- Alignment with the historic DPCC mission and future goals of the County;
- Alignment with projected long-term-care needs of DuPage County residents, in context of availability of other local long-term-care options.

Potential Internal Operational Changes to Reduce Costs and Increase Revenues

Under this wide-ranging broad category, a variety of possible options or scenarios is outlined, involving various potential internal reforms or changes which could be tested and implemented individually or collectively in various combinations to help limit or even reduce the County financial contributions to the Convalescent Center in the future. They are outlined in the sections that follow in some detail, with a focus on their relative strengths and limitations, along with a bottom line summary of the likely overall implications of each.

Consideration of the various potential operational options summarized below would presume that DuPage County would be making a continuing commitment to and investment in the mission of DPCC. Should the County choose ultimately to make that commitment, CGR believes that combinations of the possible reform or restructuring

options described below—with the necessary combination of political will and management and staff collaboration—have the potential to create a politically and fiscally viable approach and strategies to help ensure a sustainable model well into the future for the Convalescent Center.

DPCC has a long history and reputation of respect within County government and within the broader community. It continues to have many strengths and continues to attract residents and supportive families who, as evidenced in the survey findings presented earlier, value and appreciate the care received at the Center. But, as with any institution, opportunities exist to strengthen the facility and to both improve the quality of care provided and strengthen the long-term financial viability of the operation.

With such opportunities in mind, the most feasible of the scenarios we have considered are presented below, in no particular order of priority.

Potential to Reduce Costs and Maximize Effective Use of Staff

It is important to emphasize up front that CGR sees little opportunity for the County to save significant amounts of money by making substantial reductions in staffing at DPCC. Frankly, in most studies of this type that we have done in other public nursing homes, there have been opportunities for such reductions to be made, without negatively affecting the quality of care offered within those facilities. That does not appear to be the case within the Convalescent Center. To the contrary, it would seem important to consider doing what is necessary to fill as many as possible of already-approved and budgeted, but vacant, positions. This could be done without adding to the annual budgeted costs, as the positions are already approved and included within the budgeted allocations.

To make significant staffing cuts at this point, particularly in front-line staff, would be to severely undermine the quality of care offered to residents, create more staff shortages on floors already operating on the margins, add to stress levels and morale issues already in play, raise questions in the community about DPCC's future stability and the level of care likely to be available to future residents—and ultimately, *as a result, in all likelihood negate any short-term savings in staffing costs by reducing future referrals, admissions and occupancy levels, thereby in the long run reducing the revenues that make it possible to sustain the operations of the facility.*

That said, we nonetheless believe that there are options and approaches that should be considered that have the potential to reduce costs and/or create more efficient and cost-effective use of available staff, including the potential to re-examine and possibility redefine responsibilities of some mid- to higher-level management and supervisory positions, while simultaneously helping to enhance the quality of care and services provided by functional units throughout the DPCC facility.

Potential to Change RN/LPN Mix Over Time

The Convalescent Center has consciously over time maintained a robust ratio of RNs to LPNs—a 3.7:1 ratio that significantly exceeds that of all but a small handful of other public nursing facilities in the state or other nursing homes within DuPage County. While this has proved beneficial to DPCC in obtaining the highest possible five-star RN Staff quality rating and a high Overall Staffing rating, and has helped enhance the overall quality of care provided within the facility, there are also significant cost differentials associated with salaries for RNs and LPNs. The cost of an average shift covered by an RN is about \$48 higher than the comparable shift covered by an LPN.

On the other hand, that cost differential is paying for added experience and the ability of RNs to provide some services and sign off on some things that an LPN cannot do. Thus a major shift in the mix of LPNs and RNs in the short run is neither feasible nor wise. However, over time, such shifts may begin to make more sense, as regulations are changing to enable LPNs to absorb more of the functions and responsibilities heretofore limited to RNs.

Likely Implications: It does not seem prudent to consider any significant shifts in the short run in the mix of RNs and LPNs. The Convalescent Center has been well-served by the more well trained RN staff over the years. But over time, as LPNs are able to take on more responsibilities previously reserved for RNs, it could become economically cost-effective as well as service-enhancing to begin to gradually change the ratio in the direction of a higher proportion of LPNs. Not only would DPCC save \$48 per shift where such changes occurred, but the changes could also help, through the resulting savings, make it possible over time to hire a greater number of total nurses and/or CNAs, to help enable a higher overall level of nursing coverage on the facility's floors in the future. All of this could be done without anyone losing her/his job, through normal retirement and attrition over time.

Potential Staff Efficiencies and Adjustments

Several opportunities may exist to either reassign tasks, consider combining positions or in some cases eliminating positions, perhaps through attrition. The discussion of potential options outlined below should in no way be interpreted as implying any lack of dedication or commitment on the part of staff associated with the services currently being offered, or that the existing services are not important or are of limited value. To the contrary, all involve important services, and the options are outlined in an attempt to see if the services can be provided more cost effectively in the future. Among the possible options to consider:

- DPCC has been slowly moving toward full implementation of an electronic health records system to record treatment plans and activities and services provided by staff. The rollout of the new electronic system has not been without significant problems, related to some technical glitches, resistance on the part of some staff, and a

significant amount of double entry during the transition, as some staff enter data both electronically and in a redundant manual paper system. CNAs have been trained and are routinely entering data electronically, albeit sometimes in both electronic and paper modes. Nurses are yet to be fully trained in the new system, and it is likely to be another year before full implementation occurs. Assuming full implementation and staff being comfortable with electronic entry without parallel manual entry, the system should ultimately require less time for data entry, better capturing of all relevant activities to enhance the ability of the facility to maximize revenues, better communications across staff and shifts, and ultimately freed up time for more provision of direct care to residents. DPCC is not yet close to this desired state, and it will take constant training, reminders of the importance and value of implementing the new system, and careful monitoring and holding staff accountable to ensure that these needed changes are fully implemented. Cost savings, service improvements and revenue enhancements are all possible and likely with a fully automated system in place, but full realization of these outcomes is at least a year or more away.

- Scheduling staff is currently an inefficient process that takes time of two persons with designated scheduling responsibilities during the day shift, a substantial portion of the evening and overnight Nursing Supervisors' time, and the regular attention of nurses on the floors who also get involved in scheduling and follow-up in response to both scheduled and call-in absences. Plans are being discussed for the purchase and implementation of an automated scheduling system, and the investment in such a system should result in the ability to potentially save a position or two through attrition, and if not to at least create additional time at the supervisory level to be devoted to direct supervision, training and provision of direct services to residents.
- There are currently four MDS Coordinators who help with staff training and direct data entry related to tracking treatment plans and activities that ultimately help determine reimbursement rates and patient revenue. These services are critical and deserve full attention. It seems likely over time, however, as automated systems are more fully in place, and staff are fully trained in desired procedures, that it may be possible to reduce the number of dedicated MDS Coordinators. Indeed other facilities with which we have worked have fewer Coordinators per beds/residents than does DPCC. Over the next year or two, it may be possible to reduce the number of these positions through attrition, or to reassign one or more to different responsibilities that could lead to expanded provision of direct services to residents on the floors or management of other critical administrative tasks.
- A number of questions were raised in interviews by staff at both top-level and "in the trenches" positions concerning the numbers of supervising nurses on the day shift versus evening and night shifts, and the overall levels of supervision and management within the facility. There may be opportunities to reassign some staff to different responsibilities and to reconsider the mix and ratio of supervisory and management staff versus direct service staff in the future. Some preliminary thinking has already

begun related to these issues within the facility. It may be worthwhile to have an outside consultant with direct management experience in operating nursing homes assess the current staffing mix to see where potential reallocations of staff could prove cost effective while also enhancing direct service provision.

- DPCC has implemented a mentor system to pair new CNAs with designated CNA mentors (who receive supplemental pay for their services) who help the new staff adjust to their new situations, help them learn how to juggle their responsibilities, work with residents, and generally learn the system. The initial implementation of the mentoring system has received mixed reviews, with some apparent successes but also a number of questions about its implementation and impact, with resulting suggestions for change. Although it is too early to draw definitive conclusions from the experiences to date, from a cost containment and staff performance perspective, consideration should perhaps be given to shifting the mentoring responsibilities, and the added costs of stipends paid to the mentors, to the CNA rehab aides who currently provide key therapy support and other leadership for CNAs and nurses on each floor, as outlined earlier in Chapter III. They seem well-positioned through experience, demeanor and their existing roles to be able to assume the mentoring roles in the future. This would not be likely to result in direct cost savings as much as a shifting of resources in ways that would be likely to strengthen the mentoring program and ultimately result in higher retention and better performance of new CNAs, which would in turn result in indirect cost savings via reduced turnover and reduced resulting need for costly overtime and contract agency coverage to fill staffing gaps. This might also lend itself to consideration of the concept of creating a Head CNA position as a broader role with more leadership and mentoring and oversight responsibilities.
- Recreation therapy staff are currently assigned to each floor, with all units having access to a dedicated recreation coordinator assigned to that unit. This assignment of staff to a specific unit is designed to foster ongoing relationships with residents that ultimately translates into increased engagement of residents in various activities designed to enhance the quality of their residential experience. As such, the existing staffing mix makes sense and is to be applauded. But it should be noted that such a robust recreation/activities staffing mix is not the norm in most nursing facilities with which CGR has had experience. Consideration could be given to modifying the staffing mix over time, through attrition, so that staff are assigned, for example, to two units rather than one—or such an approach could be tested on a pilot basis to determine what implications such a shift in coverage would have on the residents and their ability and willingness to access and engage in recreational activities. This option, like the others outlined in this section, should in no way be viewed as implying any lack of value to the services being provided, but rather is simply meant to raise the question, given experiences in other facilities, as to whether similar value in resident engagement in activities and resulting quality of life can be obtained with different configurations of staffing.

Likely Implications: Some of the options outlined in this section would, if implemented, be likely to result in greater staff efficiencies and improved service provision through expanded allocation of staff to direct services. Some direct savings could result if positions were to be reduced over time in areas such as housekeeping, MDS Coordinators and recreation therapy staff, but it is equally plausible that even reductions in such areas might result in reallocation or redistribution of staff to different purposes, rather than actual cuts and savings. All of these options are intended to create savings or better use of staff, so it would be important to ensure, as such options are explored, that no harmful impacts on residents inadvertently occur. Similarly, more efficient use of staff through better use of medical health records and better scheduling could save money, but is equally likely to result in freeing up time to make possible more efficient use of staff to devote to increased direct services. A very rough estimate of potential dollars that could be actually saved through the above options, or equivalent value in repurposed or reallocated staff time: approximately \$200,000 a year, with changes fully implemented., and perhaps more over time with longer-term changes considered.

Potential Reductions in Overtime: Expanded Use of Per Diems

Significant increases have occurred in recent years in payments of overtime and funds to cover contract agency staff needed to fill in staffing gaps resulting from increased staff vacancies and significant amounts of staff absences, often resulting from last-minute “call-ins.” Paying agency staff is especially costly as a solution: About \$20 per shift more than paying staff overtime for CNA coverage, \$46 more for LPNs, and \$72 more than paying RNs overtime. Moreover, agency staff reportedly create other problems, including inharmonious relationships with residents and staff, adding to stress levels and complaints from both, and questions about how well they record information needed to maximize reimbursement rates, among other issues.

A far better solution than contracting with agency staff would appear to be hiring more per diem/temporary staff and including them on DPCC’s registry list to be called when staffing shortages emerge. Ideally such individuals would become more regular service-providers on floors than the random contract agency staff; would develop better, more consistent working relationships with staff and residents—and while arguably enhancing services, doing so at considerably less cost to DPCC than either overtime or agency fees. Per diems on average cost \$26 less per shift than do agency staff among CNAs; about \$50 less than LPN agency staff; and \$125 less than for RNs.

Likely Implications: The DPCC budget includes approved funding for 20 per diem nurses, only 11 of which are currently filled. However, only half that total, 10, CNA per diem/temporary positions are approved, although the overwhelming majority of overtime and especially agency overtime hours are attributable to CNAs. Nine of those 10 per diem positions are filled. As plans are currently underway for DPCC to expand the number of contract agencies to help fill more staff shortages in 2016, consideration should be given longer-term to finding ways to expand the active list of per diem nurses

and especially CNAs in order to provide a more cost-effective alternative to expanded use of staff from contract agencies to cover staffing gaps.

Creating more per diem positions—coupled with more aggressive recruitment of nurses and CNAs to add to the active registry list (for example, attempting to sign up staff who retire or who leave DPCC for various personal reasons, but who would like to continue to work on an occasional basis)—would appear to be a good investment in the future. Given DPCC’s stated desire to expand the number of contract agencies on call, and given continuing growth patterns in overtime hours, we assumed that the number of contract agency hours would be likely to expand from 2015 to 2016. If one assumes 12,000 agency CNA hours (1,500 8-hour shifts) would be needed in 2016, at a \$26/shift difference in costs, per diems would cost \$39,000 less for those hours than would the average contract agency. Similarly, assuming 1,500 agency nursing hours (about 187 8-hour shifts), at an average per-diem saving of \$100 per shift, savings of about \$18,700 would result if those same hours were worked by per diem nurses. Thus, savings of almost \$58,000 could result in a year if agency costs could be eliminated and covered instead by per diem staff. A relatively small dollar savings in a \$37 million budget, but perhaps just as important, reported problems with having agency staff on the floors would be minimized, with greater consistency and continuity of care likely to result.

It should be emphasized that the expanded use of per diem/registry nurses and CNAs would be for the expressed purpose of using staff familiar with DPCC and avoiding more costly use of agency staff to cover staff shortages. In no way is this intended to create per diem staff in lieu of replacing approved regular full- and part-time employees.

Potential Reduction in “High Need” Admissions

Some nursing homes have placed significant restrictions on their admissions of persons with various characteristics likely to create problems for staff on the floor: For example, restrictions on admitting those with mental health diagnoses, persons under the age of 65, persons eligible for Medicaid, persons with dementia. DPCC could consider being more restrictive than it has been in the past, limiting the admissions of the more “hard to place” residents that it has often accepted in the past. The facility has internal proponents of applying more scrutiny to admissions, because of the added stresses placed on nurses, CNAs, and dining services, housekeeping and various other support service staff who serve such residents.

Likely Implications: By reducing the numbers of admissions in future years who are likely to be high-risk, high-need residents, DPCC would create the potential for either reducing the numbers of total staff needed, at reduced costs over time, or to free up existing staff to provide a greater frequency of quality services to higher numbers of residents, since they would not have to spend as much time with the higher-need residents. Of course, any consideration of such a policy of restricted admissions would need to be placed in the context of what it would mean for the historic mission of the Convalescent Center, and its primary avowed reason for existing. Advocates of such a

potential policy shift would presumably need to determine whether such a change in the mission of the facility could be justified if DPCC were to remain a publicly-supported nursing home.

Potential for More Aggressive Recruiting and Retention of Employees

Continuing and in some cases increasing vacancy rates create numerous problems across the facility of gaps and discontinuity of services for residents, and help create the problems cited earlier of added stresses on existing DPCC staff and added use of agency staff, with attendant coinciding problems. The difficulties in filling many of these vacant positions have been documented not only at the local level, but statewide as well, as nursing homes are often considered by potential employees to be more stressful and less pleasant places to work than in other health care settings.

As difficult as the recruitment and hiring process is, the efforts that go into an approved hire can often be quickly undermined by poor performance or a new employee walking away from the job within a few months, or even a few days, of starting the job (38 percent leave within six months, including 6 percent within the first two weeks). This is clearly a challenging proposition, but in order for DPCC to be sustainable and thrive going forward, ways must be found to find and retain qualified staff who can maintain good relationships with residents and provide high quality continuity of care.

DPCC and Human Resources staff work collaboratively in the hiring process. But it may be that more intensive efforts will be needed going forward. A task force of DPCC representatives from different functional areas (both recent and more experienced employees), DPCC leadership, and HR leadership may need to be created to explicitly develop new approaches to the hiring and retention dilemma. Part of their job may be to analyze the exit data referred to earlier in the report, and to test new ways of recruiting and working with new staff more aggressively to find ways to meet their needs and help ensure their retention.

Although it may not be feasible when hiring is already so difficult, consideration should be given, in the context of helping to improve the probability of retention, to the hiring approach noted with regard to the Sunny Hill nursing home in Will County, where the facility appears to be selective in who it hires—for example, not hiring recent graduates, and only hiring people with previous experience and some history of longevity. If DPCC were able to be more selective in only seeking and hiring staff with some demonstrated history of experience and commitment to a job, might that be a predictor that would help reduce rapid turnover among staff in the future?

Likely Implications: A focused collaborative effort involving high level and rank-and-file DPCC and HR staff seems needed to fully address the hiring, vacancy and retention issues. If progress can be made in reducing the vacancy and turnover problems facing the facility, more continuity of high-quality services is likely, and costs should be reduced substantially, as the \$1.5 million or more spent in the past year on overtime and agency costs should be able to be substantially reduced.

Potential to Improve Organizational Culture

Throughout our study, we heard consistently about issues related to ways of strengthening the culture of the DPCC organization and reducing related stresses summarized earlier in the report. These issues in turn contribute to staff inefficiencies, wasted time, call-in absences, added costs needed to cover staffing gaps on given shifts and floors, and potential threats to the maintenance of high quality of care.

Likely Implications: Gaining increased control over the internal culture, and filling staff vacancies, will go a long way toward maintaining the reputation and quality of care of the facility, while also enabling costs to be controlled. Many of these issues are currently being addressed by DPCC Administration.

Potential to Eliminate Non-Reimbursed Cleaning Services for County Buildings

As noted earlier, DPCC housekeeping staff provide “free” cleaning services for cafeterias in two County buildings on the government campus (505 and 421), as well as all cleaning services in other County buildings and offices on the west campus close to DPCC. The value of these services is estimated at about \$72,000 per year. The Convalescent Center currently receives no direct reimbursement for the services, and there does not appear to be any “credit” in the DPCC budget to offset the value to the County of these direct services. Going forward, the Convalescent Center could discontinue the provision of these services, forcing the County to come up with another solution to cleaning in these areas.

Likely Implications: Taking this action would be feasible and relatively easily implemented by DPCC, which could reduce its annual costs by about \$72,000 a year by reducing staff and related costs of equipment and chemicals. This would be reflected as a direct reduction in future DPCC budgets. On the other hand, although DPCC’s budget would be reduced, the cleaning would still need to be done by someone, presumably absorbed by the County’s Facilities Management department or via contract to another agency, which, with overhead, would be likely to cost the County more than the value of the DPCC-provided services. Another approach would be to find some way for the DPCC budget to reflect offsetting revenues for purchase of the services to cover the costs of the cleaning. Either way, the resolution of this issue may help reduce the deficit in the Convalescent Center budget, but from the broader County perspective, the services will still need to be provided by someone. If the cleaning services were able to be absorbed with no additional staffing or costs within the larger Facilities Management department, this could indeed represent a true savings to both DPCC and the County. If that would not be possible, and the costs and staffing needed to provide this service would need to be added to another department’s budget, any potential cost reduction for the Center would not result in any overall net savings to the broader County budget.

Summary of Likely Implications of Potential Options to Reduce Costs and Maximize Effective Use of Staff

There appear to be only limited opportunities for major cost-savings across the Convalescent Center. The facility currently operates as a relatively tight ship with little evidence of significant overstaffing, given the complex needs of residents of the facility. In fact, the facility is often operating with gaps in service coverage, with available staff often covering for each other, and costly overtime and purchase of contract agency staff needed to fill major coverage gaps. Rather than major reductions in staff, what is more likely to be needed are efforts to fill as many as possible of approved budgeted positions, as noted earlier.

There are certainly opportunities for some potential savings here and there, but not sufficient to significantly reduce the County's level of subsidy needed to balance the DPCC budget. We have identified the potential for perhaps \$300,000 to \$350,000 in actual annual cost reductions that could occur within the next year or two under certain scenarios. Significant additional opportunities exist for reduction of overtime and agency costs, if fewer vacancies and absences were to occur.

What is more likely is the potential for changing the culture and for significant reallocation of staff time. Some efforts already underway, and others with the potential to be kick-started in the near future, offer potential for improving morale, strengthening hiring and retention of staff, and effecting changes in the mix of staff, to create greater efficiencies in how services are provided, increased potential for expanding the numbers of staff providing direct services to residents, and increasing the amounts of time they spend with the residents.

Potential to Increase Revenues

Compared to the opportunities to reduce costs, there appear to be more viable potential opportunities to expand revenues in DPCC, though certain assumptions and favorable conditions would need to be in place for the most significant of these revenue opportunities to come to fruition. Opportunities that appear to be feasible and worth consideration are summarized below:

Potential to Limit Impact of Medicaid Reimbursement Rate Reduction

As noted earlier in the report, DPCC and the County still remain uncertain as to what the all-important Medicaid reimbursement rate will be for 2016, with no resolution of the state budget impasse. DPCC appears to have wisely opted to plan for a significant reduction in the Medicaid rate, budgeting for a 9.5 percent reduction from 2015. The resolution of this issue will obviously have significant implications for the ability of DPCC to meet or exceed its revenue targets and quality of care objectives for 2016.

Likely Implications: Knowledgeable stakeholders with whom we have discussed the budget at the state level seem to believe that the ultimate resolution will reflect a Medicaid

rate reduction, but not as severe as what DPCC has budgeted. If so, DPCC Medicaid revenues may exceed those projected for 2016, assuming occupancy rates as outlined in the budget proposal. Even if this happens, the larger issue is the need for expanded revenue sources for DPCC going forward, to help reduce the draw on the County's General Fund each year, through approaches such as changes in payer mix and occupancy rates and/or new revenue sources such as a dedicated tax levy or opportunities to lease vacant space to new partners (see discussions that follow). From a statewide perspective, there appears to be little or no organized advocacy efforts on behalf of the 20 county nursing homes in the state to attempt to influence the budget issues, or other issues affecting the future of county facilities. At one point there was an organization that represented the public homes, but that no longer is functional. DuPage County seems to have a strong presence in Springfield, and may need to take advantage of its connections at the state level to help ensure support for budget and other issues affecting the future well-being of the Convalescent Center, and it may also be important for it to be engaged in organizing a more robust multi-county nursing home voice at the state level in the future.

Potential to Improve Occupancy and Payer Mix of Residents

Average daily census at DPCC declined in 2015 to about 311 per day from 321 in 2014. And much of that reduction of 10 beds per day was attributable to a reduction of seven beds per day in short-term rehab beds. Restoring the average daily census to 2014 levels would have significant revenue implications for 2016, while hopefully providing a base to at least sustain but hopefully build on in future years. As outlined earlier in the report, if the restoration of occupied beds to the 2014 level involved solely Medicaid residents, the facility would take in an additional \$777,000 in revenues from those extra 10 beds compared to 2014—and, if seven of those 10 were short-term rehab beds, the additional revenues would instead total about \$1,510,000. Some other mix of Medicaid, Medicare and private pay beds would generate revenues somewhere in between those figures, depending on the numbers of each.

It seems realistic to believe that the occupancy rate can be increased by at least those 10 beds. What is more difficult to assess is the likelihood that the number of occupied beds paid for by either Medicare or private pay will increase over 2015's totals. The facility has generated more Medicare and private pay residents in previous years, so it is not unrealistic to think that it can do so again, particularly the private pay residents, since those had been steadily increasing for the past three years until 2015. But it is more of a stretch to forecast the ability to increase the number of short-term rehab residents over last year, given the reduction in numbers of designated short-term rehab beds in the Convalescent Center, and the increased saturation of the short-term rehab market, particularly with newer facilities and expanded availability in other facilities of single-bed rooms and other amenities such as free television and telephone service in the rooms (both of which are more limited in DPCC since mid-2015). And, with the pending finalization of the purchase of the Marianjoy facility by Central DuPage Hospital and its parent Northwestern Medical network, CDH may continue its pattern of declining numbers

of referrals to DPCC, thereby potentially further reducing the pool of short-term rehab residents available to DPCC in the future.

Nonetheless, there are opportunities for partnerships with other health care facilities in the community, as discussed in more detail below, which have the potential to generate more traffic to DPCC. And the Center has never been aggressive about marketing its services to the larger public, or to physicians or other caregivers in the community, so there should be opportunities related to more aggressive marketing approaches.

Visibility in the community is critical to a facility's ability to attract referrals. While DPCC has a strong reputation in the community, and receives a number of strong word-of-mouth referrals, it may need to become more aggressive in working with hospital discharge planners in multiple hospitals (especially ones with few referrals to DPCC in the past, and ones such as Edward and Good Samaritan, where few of their referrals have resulted over the years in admission to DPCC), physicians, other nursing homes that may have limitations on the extent to which they serve people on Medicaid, and other agencies working with older citizens in order to make sure that DPCC receives full consideration, especially with those with private pay insurance or Medicare coverage initially. With the facility's admissions unit finally getting back to full staffing levels, and a more aggressive approach to marketing and finding ways to reduce barriers to admissions, it should be possible to begin to overcome recent downward trends in referral patterns.

Likely Implications: A more aggressive and visible outreach effort by DPCC admissions staff may be helpful in generating greater awareness of the facility and a greater willingness to consider referrals for both potential long-term care and short-term rehab residents. It may even be worth considering expanding the admissions staff, at least for a year or so, in order to test the proposition that more aggressive community outreach can lead to increased referrals to the Center. The County itself may wish to consider a separate advertising/marketing campaign to further spread the word about the nature of the services available at the Center, and how many of its services are distinct from what is offered by many of its competitors. Assuming these efforts happen, and are successful in driving more traffic to DPCC, then the test will be how well and quickly the facility responds to the referrals (see next section).

It is likely that the ability of the Center to be competitive in the marketplace will also be shaped, in part, by decisions it makes about the number of short-term rehab beds it offers in the future, and the extent to which DPCC enters into partnerships with other service providers in the community. Both of these issues are addressed in more detail below.

It seems reasonable to assume that DPCC will, with more aggressive marketing and admissions processes, expand its occupancy rates and daily census in future years back to levels pre-2015. This should help generate increased resident-driven revenues in future years, compared to 2015 levels. We estimate additional revenues of between \$780,000 and about \$1.5 million in 2016. These may be conservative, based on 2016 budget assumptions, in which the Center projects occupancy at the 95 percent level, which would mean daily occupancy of about 335, well above even 2014 levels.

Potential to Get to “Yes” Quicker and More Frequently in Admissions Decisions

Referrals to DPCC for short-term rehab which resulted in the person being referred making a conscious choice to opt for another nursing facility have doubled in recent years, but the Center itself has also declined to accept growing proportions of referrals for a variety of reasons related to financial, health and behavioral criteria. Moreover, of those admitted to the facility as long-term care residents (as opposed to short-term rehab), the beds ultimately occupied had been open/unoccupied for an average of the previous 50 days per bed. The average time from initial application to final admission date for new admissions averaged more than 100 days. In order for the Center to take full advantage of any expansion in referrals for long-term care, those numbers must be reduced. And those referred for short-term rehab services must be given reasons quickly for why DPCC should be the facility of choice, instead of putting up barriers to prevent the admission. The DPCC administration, admissions office and nursing staff are currently collaborating on finding ways to make it easier and quicker to say “Yes” to applications and to have its Yes reciprocated by the prospective resident.

Likely Implications: This issue is inextricably intertwined with efforts to increase referrals to DPCC. In 2012, DPCC declined to admit about one-third of all short-term rehab referrals. Those proportions have subsequently grown to between 40 and 45 percent, while those choosing other facilities doubled. In order to have any realistic prospects of admitting more short-term rehab residents, not only will the single-bed room and amenities issues need to be addressed, and more aggressive marketing occur, but DPCC will need to be willing to be more flexible in its consideration of criteria which too often in the past have led to rejections of people that other facilities were willing to admit in order to obtain the highly lucrative short-term rehab residents. If the proportion of rejections can be reduced by half, for example, admissions should begin to increase. Similarly, among long-term-care referrals, quicker admission decisions that minimize the time a bed remains unoccupied can have a significant impact on increasing revenues. As noted earlier, by reducing by 50 percent the days a long-term bed remains open, given recent referral and admissions practices, we estimate that DPCC would realize an additional \$250,000 or more per year in Medicaid and Private Pay revenues.

Potential to Expand Entrepreneurial Opportunities and Revenues from Support Services

Support Services, made up of Dining Services and Environmental Services (Housekeeping/cleaning and Laundry), is currently generating revenues for DPCC, and has the potential to generate more, with the approval of the County to expand its entrepreneurial initiatives. Housekeeping in 2016 is projected to generate net profits, after expenses, of about \$13,500 for reimbursed cleaning services provided in two offices close to DPCC. There is the potential for the unit to add cleaning services on a contractual basis in the future with the Health Department, though no arrangements have

been formally discussed. Housekeeping is interested in exploring other possible options, should it be given the green light to proceed.

Similarly, Laundry is expected for the first time in 2016 to generate net profits of about \$25,000 on behalf of DPCC, and has discussed opportunities to use its laundry equipment on the currently-unused second shift to offer laundry services to other long-term care and perhaps other types of facilities.

Dining Services currently is projecting net profits from its three cafeteria operations of about \$125,000, after expenses. With its expanded space and new kitchen, it has considered bidding for other contracts such as dining services for the County jail, Home Delivered Meals, and the senior congregate meals program. The County jail currently has a contract worth about \$760,000 a year with a private sector vendor. Should the County be open to having the Dining Services unit bid on providing food services to the jail, it is prepared to consider the possibility.

Likely Implications: There appear to be several potential opportunities for the units of the Support Services department of DPCC to generate significant amounts of revenue on behalf of the facility. For example, it believes that it could reduce the total costs the County currently spends for providing food services to the jail, while bringing the revenues into DPCC and therefore the County, as opposed to having those dollars going to an outside vendor. Nothing has been even tentatively costed out, so there are no estimates of what potential net revenues might be generated through such an effort. The Laundry unit also believes that it could generate net revenues after expenses in excess of \$100,000 providing laundry services with a long-term care facility. Other opportunities are likely to present themselves if the County is willing to have Support Services competing directly with the private or non-profit sectors for business. It is already doing so in some limited settings, and appears to be poised to expand its entrepreneurial efforts with the County's support. No overtures have yet been made, and none will be made, without the County's blessing, but should that occur, it does not seem unrealistic to think that the Support Services unit could generate net revenues on behalf of DPCC in the vicinity of a quarter of a million dollars annually within two to three years of approval to proceed.

Potential to Increase Revenues through MDS and Electronic Health Records

The four Medical Data Set (MDS) Coordinators work closely with nurses and CNAs to help ensure that all legitimate activities and services provided to residents are captured for reimbursement purposes. Their ability to maximize revenues is somewhat compromised by the delays in the full implementation of electronic health records, especially among nurses, and the resistance of some employees to fully embracing the electronic process. The Coordinators appear to be thorough in their efforts to train and educate staff as to the importance of accurately recording their services and activities.

Likely Implications: It seems likely that full implementation of the EHRs will help the MDS Coordinators maximize available revenues through more accurate and consistent recording of all relevant data, but the Center is probably at least a year away from having the electronic procedures fully in place. While some revenue enhancements seem likely, the attention already being given to faithful recording of the data suggest that there may not be major increases in revenues as a result of the full-scale implementation of the EHRs; rather, the major benefit is likely to be from more efficient use of staff time and more availability to provide direct services, once staff are more comfortable with the electronic processes and no longer are doing dual electronic and manual entries.

Other Potential Opportunities

Several other opportunities for enhancing revenues and improving services for residents at the Convalescent Center are discussed below in the context of other issues. For example, ways to help ensure that revenues under managed care are maximized, development of partnerships to help enhance services and revenues for the facility, and issues related to the space and condition of the facility all have implications for revenue generation, but all are discussed in different contexts below.

Summary of Likely Implications of Potential Options to Increase Revenues

Opportunities exist for revenue enhancements within the context of existing services and operations within the Convalescent Center. They are not likely to be sufficient in and of themselves to eliminate the need for ongoing County subsidies to balance the DPCC budget. But there is the potential to reduce the level of the deficits and resulting subsidies, given certain assumptions and circumstances.

Internal processes being put in place within DPCC have the potential to quicken the process for admitting residents into the facility, for both short-term rehab and long-term care. The ability to expedite the process has the potential, we believe, to generate about a quarter of a million dollars currently unavailable to the facility because of beds being left open for inordinate amounts of time. Under the right circumstances of more aggressive marketing, more effective admissions processes, and more flexibility on the part of nurses in their willingness to accept residents on the margins of acceptability for health and behavioral reasons, we believe that occupancy rates can be substantially increased over 2015 levels back to at least levels in 2014. That alone would generate expanded revenues year over year ranging from about \$780,000 to about \$1.5 million, depending on the mix of payer sources. DPCC officials are even more optimistic that they can raise the occupancy levels even higher, to 95 percent occupancy of all beds in the facility, a level not reached in recent years.

If the County provides the permission to pursue work outside DPCC, the dining services, housekeeping/cleaning and laundry units all have potential plans and preliminary proposals to use their staff and resources to provide services to outside programs and agencies, with “profits” being returned to DPCC. Potential business opportunities

discussed to date would, based on estimates we have reviewed, have the potential to generate roughly a quarter of a million dollars annually, should these Support Services units be allowed to pursue their entrepreneurial instincts.

Potential of Hiring a Management Consultant

In some cases, counties have found it helpful to hire a management consultant to help operate its nursing home, either on a short-term or longer-term basis. Some have found it helpful to bring in an outside firm with experience managing and operating nursing homes to provide guidance and a fresh outside perspective to help sort through some of the types of issues outlined in the internal options discussed above. Some counties have found such an outside perspective to be useful, while others have felt no need to engage in such a process.

In addition to the experience of Lake County described in Chapter III, we are aware of three other counties with public nursing homes—Champaign, DeKalb and Monroe—that were facing deficits in their operations and a mix of issues similar to what DPCC is facing and that sought outside management support. Each hired an independent management consultant on an ongoing long-term basis to provide oversight and a big picture independent perspective to help manage costs and expand revenues. In each case, the management consultant worked with the existing nursing home administration and staff; the facility and employees remained under overall county direction and ownership. Although the circumstances and results varied, in general the introduction and continuation of an ongoing contractual arrangement with an outside management consultant helped to reduce, though not eliminate, budget deficits; strengthened management oversight; and in at least one case helped change the underlying philosophy of the home, in that case away in part from its previous mission-focused, safety-net perspective to a more bottom-line, revenue-driven focus.

Should DuPage County choose to consider such an option to provide an outside management perspective to work with the Convalescent Center, a number of such consultants with experience in operating nursing homes—public and otherwise—exist in Illinois and elsewhere. (For the record, CGR is not one of those firms, as we do not do such ongoing management consultation work, and therefore have no vested interest or potential conflict of interest in this discussion.) Should the County choose to pursue such a contractual arrangement, it would presumably explore its options through an RFP process.

The County could decide to enter into a long-term management contract, or simply seek one-shot consultation to explore in more depth the types of issues raised in this report, including the potential to conduct individual performance reviews and undertake internal restructurings as needed. That is, rather than the big-picture assessment of the future sustainability of DPCC, and exploration of options to help make that possible—the requested focus of this CGR analysis—a management consultant would presumably be given the reins to “get into the weeds” and move from the identification and exploration of issues to more extensive development of solutions and strategies to address them and

come up with specific recommendations beyond what was requested in this CGR engagement.

Under such a scenario—either a one-shot consultation or an ongoing management contract—the County would presumably continue to operate the Convalescent Center with County employees and administration who would work closely with, and with the overall guidance of, the consultant to help address key issues. The County would need to determine how much power and authority to place in the hands of the consultant, and how much would remain in the hands of County officials and the DPCC administration

Likely Implications: Such an option may not be needed or worth the cost to DPCC and the County, but many of the issues raised earlier in this report are complex and may be amenable to guidance and support from an outsider with experience dealing with such issues in a variety of other settings. For example, with the issue of managed care looming over nursing homes and long-term care in general, DPCC and the County might benefit from consulting with an outside management firm with experience in working with companies to get contracts signed, negotiate satisfactory reimbursement rates, resolving conflicts—in short, helping DPCC maximize its opportunities and minimize its risks. Such a management consulting firm might also work with DPCC to help it strengthen its performance on and management of quality-of-care metrics that are likely to be pivotal in the future in determining reimbursement rates negotiated with managed care companies.

More broadly, an outsider could work with DPCC to provide a fresh in-depth knowledgeable third-party management perspective and provide support for the existing management team in addressing a range of issues under the overall guidance of the County Board, with whatever degree of latitude it would choose to provide. An outside perspective could be particularly valuable in addressing the critical workplace climate and culture issues we identified and developing strategies to improve communication facility-wide and increase employees' job satisfaction.

One caution: such management consultation could be expensive, but that issue could be sorted out as part of the RFP process and subsequent negotiations with the County. In that context, the County could choose to limit its costs for such consultation by deciding to enter initially into a single one-shot consultation, and determine from there whether it believes a longer-term investment would be of value.

Potential of New or Expanded Services in Vacant Space at DPCC

Since the Convalescent Center decertified more than 100 nursing home beds years ago, three floors in the South building of the DPCC complex have remained vacant. They remain an untapped resource, albeit one that would need considerable capital investment to activate. Various proposals to renovate some or all of the space have been explored but not come to fruition in the past. We have received various estimates of the square

footage involved, but believe the figure to be in the vicinity of about 27,000 square feet across the three floors.

It is assumed that any efforts to open any or all of the floors for new purposes would involve substantial initial work to restore them to usable form. They would need to be completely gutted and rebuilt, presumably including rewiring, re-plumbing and fire safety upgrades. Any uses separate from standard nursing home extensions would also need clear walls of demarcation separating the nursing home from the other uses. It is assumed from previous preliminary explorations of alternative uses of the vacant space that several million dollars would need to be invested in any effort to restore the space to current use.

Throughout this process, several ideas have been suggested for use of some or all of the vacant space. Some involve conversion of space to various offices, either for the use of County government or for lease to outside organizations. Such options may be worth exploring. For purposes of this discussion, however, we have primarily focused attention on those options that would offer some logical linkage to the existing nursing home.

Potential for Creation of Multi-Specialty Clinic

One intriguing idea would be the potential to develop and house a multi-specialty clinic on one of the floors of the South building. The idea would be that a local hospital would operate the clinic and lease the space, thereby providing an additional source of ongoing revenues to DPCC. The clinic would offer seamless access to care and be accessible to all residents of the facility, and at the same time it would provide a consistent level of dedicated physician coverage and chronic disease management for all residents. Physicians at the clinic would become responsible for providing and managing health care for all DPCC residents. One of the goals of the clinic would be to improve clinical outcomes/metrics for both the hospital and the residents of the nursing home, such as reducing the level of re-hospitalizations. Presumably the clinic and the relationship with the physicians serving there could also serve as a source of referrals to DPCC.

Likely Implications: Based on initial conversations, this appears to be an idea worth further consideration and follow-up discussions. It offers the potential for possible shared costs of the renovation and construction that would be needed to develop the clinic, as well as a source of revenues for DPCC through an ongoing lease arrangement and a source of consistent medical care and disease management for residents of DPCC. Both parties would potentially benefit in various ways from the arrangement, including improved health care metrics and reduced costs and higher quality of care through management and reduction of events both parties would like to limit, such as re-hospitalizations.

Potential for Creation of a Short-Term Rehab Wing

Despite the fact that DPCC offers a strong, respected short-term rehab program, its ability to attract people to the facility has been limited by the older institutional feel of the building, and by the fact that there are currently limited numbers of single-bed rooms with amenities such as free TVs and telephones, spa-like activities, etc. Major competitors currently offer such rooms. It may be increasingly difficult for DPCC to compete for short-term rehab residents without such beds. The vacant space would lend itself to the possibility of creating one floor dedicated to single-bed short-term rehab beds.

Likely Implications: While this may be necessary for DPCC to compete more effectively and aggressively for the short-term rehab market, there are certainly no guarantees that there is sufficient demand for added rehab beds, no matter how attractive. The market appears to be becoming saturated with rehab beds, and it is not clear that the market would support and justify the upfront costs of reconfiguring the space. It is also not clear that there would be a partner to help support the reconstruction costs, given the fact that a major player and potential referral source such as Central DuPage Hospital is currently engaged in finalizing the purchase of a facility that already offers high-level short-term rehab beds that meet the needs and expectations of many potential residents. The question must be raised as to whether sufficient numbers of people would be attracted to the facility to justify the expenditures of the new construction. The County would need to do a more extensive assessment of the potential market now and in the future, in the context of the growing elderly population, to determine whether such an investment is worth making.

Potential for Creation of a Child Care Center

Considerable interest has been expressed in the possibility of the creation of a child care center in vacant space in the South building. The idea of a child care center that could be available to the children of employees at DPCC and within the County complex has considerable appeal. Depending on the available space, the idea could also be appealing to one or more nearby medical providers, which have several thousand local employees, many of them women with child care needs at all hours 24/7. The potential would appear to exist for a collaborative approach to making such an option happen, given the commonality of needs.

An on-site child care center could be a significant selling point in recruiting and retaining quality new employees. Not only would the idea of such a partnership be potentially appealing, but an additional unique aspect of such a facility located in a nursing home would be the potential for an intergenerational child care center, where the children would be able to interact on a regular basis with residents of DPCC, with both generations benefiting from the experiences.

Likely Implications: It is possible and maybe even likely that for such an idea to work, a child care center may need to be located on the first floor of the South building, which could mean the relocation of offices and services currently existing on that floor. It seems

likely that such relocation could be possible and feasible in the context of other renovations that may be going on within the facility. Easy access for the children and families would seem to be an essential factor in the possible development of such an option.

This option offers the possibility of a partnership with a local medical provider to share developmental costs of any physical reconfiguration needed, as well as shared ongoing operational costs, with a creative use of space that could meet the needs of numerous employees of DPCC and the overall County government, as well as the needs of one or more large medical providers in the region.

Potential to Develop Adult Day Services Program

A number of people we interviewed mentioned the need for an adult day services program in the county, and suggested the possibility of opening such a program in unused space in the South building of DPCC.

Information available from the Illinois Adult Day Services Association indicate the existence of six adult day care centers serving DuPage County—in Downers Grove, Glen Ellyn, two in Wheaton and two in Naperville. We were not able to obtain information on the size of these centers, or the extent to which they are sufficient to meet community needs. But both local and state officials knowledgeable about long-term care needs and community-based services emphasized that adult day care services are currently insufficient to meet the needs in DuPage County. As one expert indicated, “The need is huge, perhaps especially in the north end of the county, but the need exists everywhere.”

Likely Implications: There is currently no formal research or market study that we are aware of that documents the extent of the need. But our experience with some other counties suggests that this is frequently an unmet need, especially in the context of seniors desiring to maintain independent living status within the community for as long as possible, and co-location of such programs within a nursing facility can provide financial benefits in term of lease revenues accruing to the nursing home, while also creating visibility and awareness of the facility for program participants who at some point in the future may need to access a skilled nursing facility. Further study would be needed of the extent to which there is an unmet demand for such services in this area of the county, and whether locating a program in the nursing home would be a draw or drawback for potential participants.

Potential Creation of Sheltered Living Facility

Some interest has been expressed for use of some of the vacant space for the creation of sheltered living facility beds. We were not able to find any independent assessment of need for new sheltered beds, though three sheltered living facilities are currently in existence within the county.

Likely Implications: It is not clear without further analysis whether such a facility or creation of a floor of such beds would be economically viable. Perhaps more to the point, there is currently a state moratorium on the creation of any new sheltered living beds. It is not known how long the moratorium will be in existence.

Summary of Likely Implications of Potential Options for Using Vacant Space at DPCC

Several options appear to have sufficient merit and feasibility to be worthy of further consideration. The ideas of a specialty clinic and child care center on floors of the South building appear to have special appeal, as they both offer the potential for partnerships that could possibly share construction costs as well as create lease revenue for DPCC, while at the same time offering potential value to both residents and employees of the Center and County, and meeting other needs of the potential partners. The Adult Day Services idea also has merit, though at this point it has no active proponent. The short-term rehab unit may have considerable upside potential in terms of attracting residents to the Center, but it also has considerable risk in terms of whether the investment in constructing the wing and rooms would have sufficient payoff to justify the effort. Other ideas also surfaced as possible options to explore, such as a cosmetology program, CNA training program, and collaboration with the College of DuPage

Potential for New Construction or Major Renovation of Existing Space

As discussed in the earlier review of the experiences of three other counties with public nursing homes, the physical condition of their older facilities was considered pivotal in decisions about the future of each county home. In each case, either new homes were eventually constructed, or major renovations occurred in the existing facility. Both of these options are discussed below.

Potential to Build New DPCC Facility

Some have advocated for the construction of a new facility.. Part of the potential interest in building new, in the eyes of some, is the possibility of creating a new Continuing Care Retirement Community (CCRC), which would presumably be aimed primarily at a private pay constituency, with the potential for the overall operation to help subsidize any operational losses associated with the Convalescent Center nursing home component of the CCRC.

We attempted to find locally or through the state any indication of an assessment of need for future CCRCs, or any indication of gaps in numbers of projected need for beds/apartments in such facilities. No one we talked to was aware of any such analysis. Data available from the state health department does indicate that there are at least seven CCRCs already in existence in DuPage County, including one geographically close

to the Convalescent Center. It may make sense to convene a group of local developers to discuss whether there may be any interest or perceived need to consider the possibility of creating a new CCRC, with a link to DPCC as the nursing home component of the continuum. But short of some tangible indicator of such need or interest, our study was not able to identify any need to pursue a CCRC investment at this time.

Concerning the potential to build a new free-standing county nursing home to replace the current structure, the key question appears to be whether the County would be able to recoup the investment with primarily Medicaid residents, given the reimbursement rates that fall considerably short of covering total costs of operating the facility. A new facility may indeed be desirable in attracting higher proportions of private pay and Medicare residents, particularly if many of the new rooms were single occupancy for short-term rehab purposes. But if that is the primary reason for building new, i.e., to attract a different and financially more well-off resident base, how does that square with the County's and DPCC's stated mission to serve those with fewer resources, especially as that population is likely to increase in future years?

Those expressing concerns about the focus on new construction emphasize the concern that going in that direction would be tantamount to at least implicitly changing the facility's mission and restricting the ability and likelihood of continuing to provide the primary safety net function that has set DPCC apart and distinct from most of its competitors, and even from some of its public home brethren. By building new, the fear is that a different constituency would potentially be attracted, and that DPCC would feel pressure to admit higher proportions of higher-income residents with the ability to pay, either on their own or through insurance coverage, and that the Medicaid population and other high-risk individuals would tend to be frozen out, without other viable options for long-term care among other providers in the county. And, as one person put it, "While a newer facility would be nice for future residents, the reality is that most of them won't have a lot of choices if they are looking for a Medicaid bed, so I'm not sure it would make a difference from a competitive standpoint. It would be great from an operational perspective, but I'm not sure it's a significant factor in the future sustainability of the home." New construction could certainly potentially be helpful from the perspective of creating an attractive short-term rehab wing, but it may be more economical to consider creating that wing in the current space, rather than building an entire new facility. Should there be interest in pursuing the construction option, architects and developers, along with marketing experts, should be engaged in a process of comparing the relative costs of each option, and the relative desirability of both from a marketing perspective.

One additional factor that should be considered in the discussion about whether or not to build new: if a new facility were to be built, consideration should be given to the question of what would happen to the current DPCC facility in the midst of the government campus.

Potential to Renovate Existing DPCC Facility

As noted earlier, the County and the DPCC administration have done a good job of maintaining and upgrading the current facility, and making it as attractive as possible for a facility with an older institutional feel. Nonetheless, 260 of the facility's 353 beds currently in operation are in buildings which are at least 40 years old, including 224 in the North building built in 1975. Over that time, changes in codes and standards have created some rooms that are currently below standard except for having been exempted/grandfathered for continued use. Thus consideration may need to be given to making significant renovations in the resident rooms and common areas of at least the four floors in the North building, much as was done in Will County over the past decade, unit by unit. If no new construction is undertaken, it may be that at least renovations to make the facility more livable, with more of a homelike feel, will be needed in order to remain competitive and meet expectations of future residents and their family members.

An architectural assessment completed in 2010 estimated the costs of renovating all rooms in the North building at a bit over \$13 million. This total did not include any new furnishings or costs of renovating any of the common areas. On the other hand, some of the work envisioned in 2010 has since been done with state grant funds (e.g., lighting improvements, painting, adding vanities), so new estimates would need to be obtained for the remaining work to be done, including any improvements to the common areas.

Likely Implications for Building New or Renovation of Existing Structure

Assuming DuPage County chooses to continue to own and operate the Convalescent Center, it is likely that the County will need to make an investment commitment on behalf of DPCC—either to substantially renovate and upgrade the existing facility or to build a new structure. To simply make cosmetic changes and needed preventive maintenance updates may not be sufficient to meet the evolving expectations of future potential residents and their family members. It would seem reasonable to think that basic decisions should be made within the next two years to set in motion a plan of action to take place over the next decade at most, and perhaps over the next four to five years,

As the decisions affecting the future of the physical facility are made, consideration will need to be given to determining the comparative costs and likely return on investment of both the build and renovate options (and potential suboptions under each), as well as how any such investments will be paid for—e.g., through grants, borrowing and major capital funding, tax levy, or other means or combinations of the above. The County should be clear if it opts to retain its ownership and historic commitment to the Center that that commitment should be linked to a parallel commitment to some type of facility upgrade. Otherwise, it is likely that DPCC will become less competitive in its perceived attractiveness to many of those it will need to continue to attract to remain viable in the future.

Potential for Partnerships and Collaboration

It is likely to be increasingly difficult for public nursing homes to survive and flourish in the future as single stand-alone entities, without partnering with others. Increasingly, long-term care entities are consolidating or finding other ways to collaborate. It is likely that DPCC will need to find such collaborative opportunities in its near future. These may take several different forms.

Potential for Local Partnerships

In earlier sections of potential options, we discussed a number of potential partnerships, which are briefly summarized again here:

- Potential partnerships in the form of agreements and in some cases contractual arrangements in which DPCC's Support Services department provides current services to other units of government—some via formal contract agreements in which revenues are earned, and others in which services are provided without compensation. Other partnerships in the form of contractual arrangements are possible going forward.
- Potential partnership in the creation of a multi-specialty clinic in currently-unused space.
- A similar potential partnership in the creation of a child care center on the grounds of DPCC.
- Other potential partnerships that could arise around such issues as the creation of an Adult Day Services Center or other potential uses of vacant space at DPCC that were not specifically referenced.
- Potential partnership with a management consultant to help sort out various management and operational issues within DPCC, and to consult on issues related to effective transition to managed care over time. A contractual arrangement with such a consultant would not typically be considered as a collaborative partnership, but in the context in which we have raised this potential option, a partnership with the DPCC administration and County seems an appropriate way of thinking about the relationship.
- Potential for expanding partnerships working with various providers to expand referrals to DPCC.
- Preliminary conversations involving CGR concerning potential partnerships and collaborations, as referenced above, should be followed up on by DuPage County officials, with the intent of developing one or more potentially mutually-beneficial collaborative efforts.
- With the significant number of residents of DPCC who are under 65 with, in many cases, a variety of disabilities and behavioral issues, it may be appropriate for DPCC

to explore partnerships with community agencies that address issues related to people with disabilities and with behavioral health concerns to see if any might be willing to provide support services to DPCC residents that might not only improve quality of life for such individuals, but at the same time help free up time and relieve stresses on existing Convalescent Center staff.

- In addition, community experts suggest that some of these relatively young residents with various disabilities may be better served in permanent supportive housing facilities, rather than residing in a nursing home almost by default. The County may wish to explore the potential eligibility of such residents for supportive housing in the future, and the potential financial viability of such housing compared with existing Convalescent Center costs for such residents. The DuPage Federation on Human Services Reform may be a willing and interested partner in pursuing such options, should be County be interested.
- The DuPage Federation on Human Services Reform and the DuPage Health Coalition are currently collaborating on the development of a safety net plan for health and human services for county residents. Part of the groups' efforts involve the development of community strategies for long-term-care services to help the senior population of the county age well, with maximum use of community-based services, where appropriate and needed. DuPage County is a participant in that process, which represents a local partnership with the potential to develop a needed strategic plan for community-based long-term care for residents of the county who may not need institutional care, or who may be able to delay admission to such a facility if appropriate community services are in place.

Potential for Partnerships with Other Counties

Neighboring Kane and Cook counties together have at recent count 28 former residents now living in the Convalescent Center. Neither county has a county nursing home. In a couple of our conversations during the study, the question arose as to whether there might be a potential for DuPage to partner with either or both of these counties that may be interested in “reserving” beds for low-income county residents who might have few nursing home options available in their home counties, given the absence of a public nursing facility in either county.

The potential for a neighboring county to be willing to spend tax dollars to “purchase guarantees” of bed slots reserved over some specified period of time for residents seems unlikely to come to fruition, and has not been discussed with anyone in those or other counties, but it seemed to have enough intuitive sense of possibility, as populations age, to justify at least raising it as a possible, albeit unlikely, option. Kane and DuPage have engaged in a cross-county partnership around detention center slots, so there is some context and history of working together. That collaboration was based on mandated services, which of course county nursing homes are not, so that experience may have no particular ability to inform the nursing home issue, but we thought it at least had sufficient

merit as a possibility to mention it in case anyone from DuPage County wishes to pursue it.

Likely Implications of Partnerships

A number of possible collaborative partnerships have been referenced in the report that we believe have the potential to be of mutual benefit, should DPCC and the County choose to pursue some or all of them. They have the potential to enhance DPCC revenues, as well as to strengthen services and enhance the physical environment in which DPCC residents live.

Potential for Tax Levy Dedicated to DPCC

Data we were able to gather concerning other counties with their own nursing homes indicate that eight of 20 have a dedicated tax levy targeted to support operations of the nursing facility. Indeed, DuPage County at one point had such a levy, which was in place for at least a dozen years through the mid-1990s. Over a 12-year period leading up to its termination, data from the County Finance office indicates that the levy yielded annual amounts ranging from about \$1.2 million to as much as \$3.8 million, with typical years ranging between about \$1.8 million and \$2.2 million.

A number of those we interviewed over the past few months suggested that the County consider reinstating a tax levy dedicated to DPCC and/or to DPCC and a broader array of long-term care services.

The threshold question involves whether DPCC is considered sufficiently important by the County Board and populace that they would be willing to approve a dedicated tax levy to help ensure the financial well-being of the facility well into the future. Even with potential limited cost savings and possible revenue enhancements, it seems likely that the County will continue to be called upon to provide annual subsidies to balance the DPCC budget. Our analyses suggest that these can be maintained for the foreseeable future within the recent range of about \$3 million a year, and perhaps less, depending on the annual resident payer mix. Other County agencies also provide over \$3 million in additional services to DPCC, such as Facilities Management, HR, Security, Finance, etc. (itemized in the annual Cost Allocation Plan prepared for the County by an outside consultant).

An annual dedicated tax levy, if focused exclusively on DPCC, could be limited to the amount needed to cover the recent core County subsidy contribution, which would prevent the need to take the funds from the County General Fund, or it could be increased to include the value of both the actual subsidy and the indirect allocated costs, which would bring the levy to a value of about \$6 million a year, based on recent years. Beyond those possible benchmark amounts, others have suggested having the levy be large enough to set aside sufficient funds to cover long-term capital needs and to create a fund balance for the facility. One preliminary proposal shared with us would suggest a tax levy in the \$12 million range, with roughly equal quarters split between coverage for

the County annual subsidy, the indirect cost allocation, capital funds, and fund balance. A total of \$12 million would be equivalent to roughly \$36 per average homeowner, or about \$3 per month. A more limited \$6 million levy would cost the average homeowner about \$18 per year.

Suggestions have also been made that any dedicated levy should have a somewhat broader focus beyond just DPCC. Suggestions have included funds set aside for the development and implementation of a long-term services plan which would strengthen the array of community-based services for seniors. Currently, there is no such strategic plan in place in the county, and the array of community-based services appears to be insufficient to meet the needs of the growing senior population.

One other suggestion involves the possibility of incorporating within the levy an allocation for transportation services for seniors and perhaps people with disabilities. Such an inclusion could potentially add several million additional dollars to a possible levy.

Likely Implications: There is clear precedent for the creation of such a dedicated tax levy, both years ago in DuPage, and currently in a number of other counties with public nursing homes. If the decision were to be made to pursue this option, careful consideration will need to be given to how inclusive or limited the levy would be. Taking any new tax proposal to a public referendum in this day and age has built-in strikes against it, but many believe that the Convalescent Center has such a wide array of built-up good will throughout the county that a proposal with this specific focus would have a good chance to overcome initial skepticism and opposition, given what some consider a modest per-household annual cost of the magnitude of possible tax levies that have been discussed. Any such levy would generate an estimated \$1 million for every \$3 per household per year.

Potential for Changes in Ownership and Operation of DPCC

If the County should choose to no longer be responsible for the ownership and operation of the Convalescent Center, it could explore several possibilities. The most likely of these are outlined below. We have not included the most “nuclear option” of actually closing the facility, as it seems clear that there is no expressed interest at any level within the County of considering such a possibility. The most likely options resulting in change of ownership of DPCC would both involve the County forfeiting central control over the future mission and operations of the facility, i.e., the County would no longer be in a position to shape the future of DPCC for all practical purposes.

Potential Option to Privatize and Lease the Facility

Under this option the County would sell the bed license for the entire facility to another operator who would take over and administer the Convalescent Center operation on site.

The County would continue to own the land and facility and would rent or lease them to the new operator. The new operator would be able to staff the facility at its discretion. This option would reduce or eliminate County contributions, other than any potential remaining “legacy obligations,” such as obligated payments to current or retired employees. In addition, the County would receive an immediate flow of cash from the sale of the bed license. An RFP process may be needed to determine interested operators of the facility.

If the County were to choose this option, it would not only receive an infusion of cash from the sale of the bed license, but it would also be able to receive ongoing rent. However, unless otherwise negotiated, the County would likely retain the obligations as owner for all facility-related repairs and maintenance costs. Under this option, the new operator would be free to determine the level of staffing, along with salary and benefit levels, without any guaranteed commitment to existing DPCC staff, depending on negotiations and terms of purchase worked out in advance with the County. State approval would be required for this option to occur.

Likely Implications: This option would enable the County to give up the responsibilities of operating the Convalescent Center, while also eliminating the responsibility of subsidizing any future annual operating deficits incurred by the Center. It would also provide a one-time infusion of cash as well as ongoing rent/lease payments, while enabling the County to continue to own the land and facility (albeit with ownership responsibilities for obligations to address ongoing maintenance and upkeep of the facility and land). In exchange, *unless specifically negotiated, the County would give up any future ability to hold the new owners accountable for ensuring continuity of care for existing DPCC residents, for maintaining the historic mission of the Center, or for any ability to ensure the future employment, salary or benefit status of current employees.*

Potential Option to Sell the Facility

Under this option the Convalescent Center would no longer remain under County control. The County would simply sell the license and all related assets for the Center and would have no further financial or other commitments, other than any remaining “legacy obligations.” The County would receive an immediate flow of cash from the sale of the facility to a new owner. Some of the proceeds could potentially be invested in other community-based long-term-care services, should the County decide to help expand such services.

Under this option, the County would no longer have any control over what happens at the facility, including any ability to control future mission and quality of life provided by the new owner. Unless specifically negotiated, there would be few if any protections for current employees, and there would be no guarantees that the historic mission of the Center would continue, or that the “safety net” function of providing care to the “hard to place” would be continued in the future. Indeed, there is at least some risk that a future owner could turn around and sell or close the facility in the future, with the County having

no legal recourse to fight the decision, unless some protections could be built into the terms of the purchase agreement.

Under this scenario, the County would make the decision to divest itself of the ownership and operational responsibility for DPCC, and would either proactively select an entity to negotiate a takeover, or would issue a Request for Proposals or similar process to gauge the level of interest among potential purchasers of the facility. The RFP would ascertain the extent to which there would be sufficient interest and willingness and resources to satisfactorily operate the Center under terms acceptable to the County. Interested entities could include voluntary/ nonprofit organizations, or proprietary/for profit corporations licensed to operate nursing homes in the state. The sale of the facility would require approval from the State.

The County would need to be clear about the terms under which it would be willing to consider transfer of the ownership of the Center. For example, in the RFP and/or individual negotiations concerning the final terms of sale, *the County would need to clearly specify its expectations and any non-negotiable terms and requirements. The County would ultimately need to determine what levels of assurances regarding residents and staff it needs and deems sufficient for it to feel comfortable relinquishing control over the facility and going forward with a sale or transfer.* Any RFP or negotiation process can be undertaken with no obligation on the part of the County to go through with a final transfer if no offers meet the County's criteria and expectations.

It should also be noted that the County could be flexible about the timing of any effort to put the Convalescent Center on the market. A decision to "test the market" through discrete inquiries or a more overt RFP process could be made very early in a decision-making process, before or simultaneously with other options being undertaken. Or a decision to consider selling could be delayed for some time, until other options have had sufficient time to be implemented and tested. Ideally whatever decision is made about selling would be part of a carefully-crafted strategy designed to best meet the needs of both residents, employees and taxpayers of the County.

Likely Implications: As with the previous option, this scenario would enable the County to give up the responsibilities of operating the Convalescent Center, while also eliminating the responsibility of subsidizing any future annual operating deficits incurred by the Center. It would also provide a one-time infusion of cash. If this option were to be implemented, the County would *remove itself permanently from the responsibilities of operating the Center in the future—thereby protecting itself from the changing and unknown financial realities related to the long-term care and overall health care systems in the coming years.* But it would also, *unless specifically negotiated, give up any future ability to hold the new owners accountable for ensuring continuity of care for existing DPCC residents, for maintaining the historic mission of the Center, or for any ability to ensure the future employment, salary or benefit status of current employees.*

Summary Implications of Divestment

Once any sale of licenses or of the overall facility is complete, the County would be removing itself from any future ability to control the mission of DPCC or the fate of its current or potential future residents or employees. It would save money each year, but would in effect be altering the historic commitment to service and to the low-income and “hard to place” population that has been the hallmark of the Convalescent Center’s mission over the years. Terms of the RFP process and potential sale would be important to craft carefully to protect residents, mission of the facility and employees as much as possible in the future.

The County would have the option to “test the waters” should it wish to check out the types of responses it receives from prospective buyers, the amounts of money involved, and what protections potential buyers might provide in response to any concerns raised by the County as part of the sale process. Thus if the County were ambivalent about any decision to consider selling, it could explore its options and still pull back before finalizing any sale, as long as it has reserved the right to do so in the RFP or related documents.

Conclusions

This report was intended to provide the public and DuPage County decision-makers with a roadmap or blueprint to guide the County and help it make the most informed and cost effective decisions possible about the future of the Convalescent Center—balancing the legitimate concerns of the residents of the facility, the employees, and the residents and taxpayers of DuPage County.

CGR was not asked by the County to make specific recommendations, but rather to outline an array of options for the County’s consideration regarding the future of the Center. We believe that, as outlined above, a number of feasible, practical options exist for County and DPCC action, either individually or in various combinations, that offer viable opportunities for a sustainable model of operations for the facility well into the future, should the County decide to continue its historic mission to DPCC and those it has traditionally served.