

# **Report of the Blue Ribbon Panel on the Convalescent Center**

**Final Draft**

## Convalescent Center Blue Ribbon Panel Members

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## **Executive Summary**

The DuPage Convalescent Center (DPCC) is a large skilled long-term and short-term care facility with many components, and the challenges it faces are complex. This report examines the current state of the facility, evaluates several options, and offers recommendations for future action.

### **Background on the Convalescent Center**

The Facility and Staffing: The DuPage Convalescent Center (DPCC) was originally built as the County Alms House in 1888 and has adapted over time to meet the changing needs of the DuPage county community. The current facility was built in four attached phases from 1949 to 1993, and it contains a total of 260,000 ft<sup>2</sup>. Of this, 27,000 ft<sup>2</sup> in the South Building is currently vacant. The facility is tied in to the County's centralized HVAC plant, and the main lines serving the east campus run through the DPCC.

The facility is in need of many repairs and upgrades. The facility generally is up to code because capital investments have focused on life safety issues, but basic maintenance has been delayed for a number of years. It is estimated that the facility has deferred maintenance needs of \$14.8 million. This does not include the much-needed renovation of the kitchen, which has not been updated since the 1960s and has an estimated cost of \$6.0 million.

The staff of the DPCC includes 374 full time positions, 98 part time, and 34 temporary for a total of 506. The tenure of this staff is above the industry average, which is one factor that adds to the quality of care. Additionally, there are over 400 active volunteers with the DPCC that are a major resource for enhancing patient care and the quality of life at the facility.

The Residents and the Care Provided: There are 360 beds in use at the DPCC, of which, 310 are for long-term care and 50 are for sub-acute rehabilitative care (short-term). Although there is continuous turn-over, it is essentially always full. Twenty-four hour skilled care is provided, and the quality of care at the DPCC is very high as evidenced by DPCC's accreditations, benchmarking on critical quality indicators, and recent Medicare ratings.

The patient mix at the DPCC is also unique. The current age range of long-term residents is 19 to 105, and 30% are under 65 (a much higher percent than average). This younger population means that the length of stay is substantially higher (over twice the national average even including the 50 short-term beds). It is also important to note that 74% of the care provided (expressed in "patient days") is for the lowest income Medicaid patients.

The Finances of the DPCC: The operating budget of the DPCC is about \$32.3 million per year. It is considered an “Enterprise Fund” in the County’s budget, which means that it supports itself with revenue. However, the County does provide financial support to that fund. Below are three key points.

1. The DPCC has multiple sources of revenue, but, in large part, is dependent on reimbursements for patient care. About 85.9% of the DPCC’s revenue (\$27.8 million per year) comes from the patients or third-party payors (referred to as “patient care revenue”). The largest payor is Medicaid, which provides over \$15 million per year in operating revenue. Another 2.2% of revenue (\$700,000 per year) comes as “non-patient” net revenue from dining services, housekeeping in other County buildings, and pharmacy services provided outside of the DPCC. The County’s financial support makes up 7.4% (\$2.4 million per year), but sometimes this contribution has been higher due to specific capital needs to address life safety issues.
2. The DPCC has taken a number of steps to contain costs and increase community support. The DPCC has closed down units and reduced the number of operating beds, reduced staffing, implemented several service delivery changes, better managed pharmaceuticals, and made several changes to procurement methods to reduce costs. Other than the life safety improvements done to meet code, budgeting for capital improvements has been close to zero. The DPCC also receives support from the DPCC Foundation, which has funded projects such as the construction of a Family Dining Room and new “wheelchair friendly” flooring in the DPCC lobby.
3. Medicaid payments are not sufficient to pay for the care provided to Medicaid patients. Only 54% of DPCC’s patient care reimbursement comes from Medicaid, but (as stated above) 74% of the services at the DPCC receive Medicaid reimbursement. That is because the rate paid by Medicaid is \$153.04 per day while the average cost of patient care is \$231 per day. The delays in Medicaid reimbursement also negatively impact costs. Some increases in the Medicaid reimbursement rate could be implemented soon, but the new rate will not cover the total cost of patient care.

### **External Factors – Market Growth and Change**

The Panel considered external factors that, over the next several years, will affect the market that the DPCC serves. The Panel noted, first, that the target population traditionally served by the DPCC is growing rapidly. These are primarily low income seniors with disabilities. The dramatic increase in the frail elderly population suggests a strong demand for the type of care provided by the DPCC. Second, the Panel evaluated the trend toward more in-home care and moving away from skilled nursing care. While it appears that the trend toward in-home care will help slow the increase in nursing home demand, but the increases in nursing home demand will continue. Third, the Panel examined

private sector supply to determine if this supply could absorb the demand traditionally met by the DPCC. This analysis showed that DPCC residents would generally not find alternative placement in DuPage County and that most residents would see a reduction in the quality of their care.

## **Recommendations**

The DPCC is a well-run operation that provides high quality care with a good staff and sound financial management. The management of the DPCC has made the best use of the resources available, is maximizing revenue streams to help support the facility, and is managing costs well. Therefore, the recommendations below focus on retaining the mission and quality of the DPCC.

1. The mission of the DPCC, specifically regarding the people served, should continue to focus on the underserved. The DPCC's mission emphasizes the provision of quality care to people who would not be able to afford this care in the private market. Focusing on the underserved is consistent with the mission of DuPage County government and DPCC's 120-year history of providing this care. Changing this mission to eliminate County support for the DPCC would be in competition with other private pay providers, and it would ultimately hurt the current and future patients (and their families) who depend on this facility.
2. The quality of the care at the DPCC should be preserved. The DPCC is well known for the quality of its care, and this level of care should be preserved. If the Medicaid patient mix remains the same as recommended above, it is not possible to cut costs to a level that will match the reimbursement provided by the Medicaid system. The consequences of such cuts would first be felt by the patients at the DPCC, but the County's liability associated with providing low quality care can be substantial.
3. A detailed capital improvement plan for the DPCC should be developed. This report notes that there is a considerable amount of deferred maintenance at the DPCC, and total cost of needed repairs and upgrades exceeds \$20 million. Further, this report notes that continued inaction regarding the capital needs of the DPCC will have negative consequences on patient care.
4. The County should seek to maximize patient revenue, which means focusing primarily on Medicaid. This report shows that the current Medicaid reimbursement rate falls considerably short of the cost of providing care. Although the County is continuing to work toward improvements in this rate, there is no assurance of adequate reimbursement from Medicaid.
5. The County should evaluate the financial benefits of additional support to the DPCC Foundation. An expansion could bring in additional revenue to the DPCC. It is recommended that a business plan for such an expansion of

scope be developed to determine the costs and benefits of such an expansion of scope.

6. The DPCC should not be sold, and it should not be closed. The report states that it is possible to sell the DPCC facility and that there would be some one-time revenue from such a sale. However, the amount of this revenue could be substantially diminished given the deferred maintenance and condition of the facility, its tie-in to County's HVAC system, and the general state of the market. Any entity purchasing the facility would certainly need to change the facility's revenue and expense structure to achieve a positive cash flow. This means that patients that are being cared for at a loss (essentially, the indigent Medicaid residents) would need to be relocated to other facilities. Many, if not most, would be moved outside of DuPage County because of the shortage of Medicaid beds here, and most would experience a decline in their quality of care. The negative impacts would be on these patients and their families. Additionally, the facility would remain on County land and using County HVAC infrastructure (thereby requiring a contractual arrangement with the owner), so the County could never be free of some association and possible liability relating to the DPCC.
7. The County should continue its financial support of the DPCC. Because the report recommends that the County retain the facility and retain its ownership, this means that the County's financial support will need to continue. This is true regardless of the specific management options that are pursued. The report outlines several options for oversight and management, and it discusses the need to continue to pursue improvements in Medicaid reimbursement (which can improve the financial situation). However, it is clear that none of these options will eliminate the need for the County's support. The report also recommends changes in the way that the DPCC's budget is presented (to make it more comparable to other departmental and elected offices' budgets) and places emphasis on the importance of financially supporting the implementation of a capital improvements plan.

## **Conclusion**

This report provides some basic observations and general recommendations for consideration by the County. The Panel has concluded that the DPCC is well run and efficient in its operation, that it is a valuable resource and its focus on the underserved low-income population should continue, that the County should seek to increase revenue with particular emphasis on Medicaid reimbursement, and that the County should focus attention on neglected capital needs.

# **Report of the Blue Ribbon Panel on the Convalescent Center**

## **Introduction**

The DuPage County Board Chairman established the Blue Ribbon Panel on the Convalescent Center in 2008. The charge given to this Panel is in five parts including: (a) evaluating the current and future needs of Convalescent Center residents; (b) examining options for ownership, management, and operation of the facility; (c) reviewing the need for property maintenance and capital improvements; (d) providing guidance on the use of vacant space in the facility; and (e) making recommendations regarding the County's financial support of the Convalescent Center. All five of these issues are discussed in the report that follows. The reader will see that these issues are linked in such a way that affecting one affects the others.

There are four parts to the report. Part One provides background on the DuPage Convalescent Center (DPCC) including the facility, its organization and staffing, the care provided, and the finances of the facility. Part Two Discusses external market factors and changes in external trends that will impact the DPCC. Part Three describes the analysis that was completed and presents conclusions and observations from the analysis and from the Panel members. Part Four provides recommendations. All of the report is organized in such a way that the reader is drawn to key statements, and additional information about these statements is summarized immediately below. If the reader requires additional detail, staff is available to provide that information.

## **Part One: Background on the Convalescent Center**

### **The Facility, Organization, and Staffing**

The DuPage Convalescent Center (DPCC) was originally built as the County Alms House in 1888 and has adapted over time to meet the changing needs of the DuPage County community. The current facility was built in four attached phases and contains a total of about 260,000 ft<sup>2</sup>. This section describes the physical facility and how the funding of the facility is organized within the County budget.

1. The Center Building of the DPCC is the oldest part and is mostly non-residential. This building contains about 30,000 ft<sup>2</sup> in three occupied levels, was completed in 1949, and now contains many common elements such as a cafeteria, a recreation room, a therapy gym, the kitchen, the maintenance shop, the laundry, and space for specialized recreational and education activities for residents. The top floor (level 3) also has 16 residential beds devoted to a special care dementia unit.

2. The South Building houses offices and common areas, and one wing (with 27,000 ft<sup>2</sup>) is mostly vacant. The South Building was completed in 1964, and it has a total of 85,000 ft<sup>2</sup> on four floors with a mechanical penthouse. The ground level currently houses the DPCC offices, and level 1 includes the residents' dining room, the chapel, and the family dining room. There are also 20 resident beds in the 2-South area. A key feature of this building is that the top three floors of the South Building are currently vacant. This vacant space in the South Building includes a total of 27,000 ft<sup>2</sup>.
3. The North Building contains the majority of the residential beds in the facility. The North Building, with 85,000 ft<sup>2</sup>, was completed in 1977 and contains four residential floors plus the ground level. There are 224 long-term care beds in this building, with 56 on each floor. The ground floor houses offices, storage, a resale shop, and mechanical rooms.
4. The East Building is the newest part of the facility and includes both long-term and short-term care. This building was completed in 1993 and has 60,000 ft<sup>2</sup>. Level 2 includes 50 long-term care beds, and level 1 contains a 50-bed sub-acute unit, providing short term rehabilitation and complex medical care. The ground floor of the East Building houses conference rooms, a space for DONKA, a College of DuPage classroom, and some mechanical space.
5. All four DPCC buildings are tied into the County's centralized heating and air conditioning plant. Not only is the DPCC facility tied into the centralized system, the main lines serving the eastern part of the campus (east of County Farm Road) run through the DPCC. This integration into the HVAC system is a key consideration when evaluating future options for the facility's ownership and management.
6. Basic maintenance of the DPCC facility has been delayed for a number of years. Although the DPCC is up to code because capital investments have focused on life safety issues, the facility has significant needs regarding its functionality and practicality. It is estimated that the facility has deferred maintenance needs of \$14.8 million. This does not include needed renovation of the kitchen, which has an estimated cost of \$6.0 million.

### **The Residents and the Care Provided**

There are 360 beds in use at the DPCC, of which, 310 are for long-term care and 50 are for sub-acute rehabilitative care (short-term). Below is a summary of key information.

1. Twenty-four hour skilled care is provided. Long-term care includes Alzheimer's and dementia care (later stage, non-ambulatory, as well as ambulatory wanderers), gastric (g-tube) feedings, wound care, palliative care, hospice/end-of-life care, and pain and contracture management.

2. There are over 500 employees connected with the DPCC. The staff of the DPCC includes 374 full time positions, 98 part time, and 34 temporary for a total of 506. The tenure of this staff is above the industry average, which is one factor that adds to the quality of care. Additionally, there are over 400 active volunteers with the DPCC that are a major resource for enhancing patient care and the quality of life at the facility.
3. The quality of care at the DPCC is very high. The DPCC is accredited by the Joint Commission, which sets a very high standard. In fact, only 8.2% of long-term care facilities are so accredited, and the DPCC has remained accredited for 40 years. DPCC is also significantly better than state and national averages on critical quality indicators. These include falls (8% at the DPCC vs. 13% statewide or nationwide), pressure ulcers (1.3% at DPCC vs. a range of 2.7% statewide), and urinary tract infections (5.6% at DPCC vs. 9% statewide). All this information is from the fourth quarter of 2008. Additionally, DPCC has been given the maximum five-star quality rating from the Centers for Medicare and Medicaid Services (CMS), which was given to only 5 of the 38 facilities in DuPage County. DPCC is the only facility in DuPage that received five stars for its staffing.
4. Physicians make rounds five days per week. This level of physician availability is much higher than the industry average. These are the private physicians of the residents and are not paid out of the DPCC budget.
5. The age range of residents is younger than the industry average. The current age range of long-term residents is 19 to 105, and 30% are under 65. This is a significantly higher percent of younger residents than other facilities.
6. More residents consider the DPCC as their home, for a much longer period, than the industry average. The average length of stay is 5.07 years (and this includes the 50 beds that are for short-term care) compared to the national average of 2.4 years. 41% have been residents for over five years, and 10% have been residents for over 15 years.
7. The DPCC is essentially always full. Of the 360 beds that are in use, occupancy ranges from 90% to 95%. Given normal turnover and required isolation restrictions, this rate is considered full occupancy. With the release of the CMS Five-Star rating in December 2008, inquiries about the facility, and demand, have noticeably increased.
8. There are many diagnoses of residents, but 42% have a primary diagnosis of Dementia or Alzheimer's disease. Other diagnoses include hypertension, arthritis, stroke, diabetes, osteoporosis, chronic heart failure, paralysis (not from stroke), coronary artery disease, atrial fibrillation, and others.

9. Short-term care includes rehabilitative and complex medical services following hospitalization. The average length of stay is 26 days, and 65% of patients return to their prior level of independence. Services include physical therapy, occupational and speech therapy, and psychiatrists (physical rehab doctors) who direct patient care. Average patient age is 80 years.

## **The Finances of the DPCC**

The FY2009 operating budget of the DPCC is \$32.5. The large majority of its operation is supported by its revenues. However, the County does provide financial support from its corporate fund. Below is a summary explanation of the key features of DPCC's finances.

1. The DPCC's budget is under the jurisdiction of the County Board, but it is treated as an "Enterprise Fund." Essentially, the DPCC is a County department and is under the jurisdiction of the County Board. However, the structure of an Enterprise Fund means that it has its own revenue sources, and all of its costs (including costs for employee benefits and centralized services) are specifically included in its budget. This is different than for most other County departments where such centralized costs do not appear in the department's budget, and revenue is accrued to the County general fund (i.e., not specifically reserved for the department). There are two exceptions to the Enterprise Fund structure. First, the cost of HVAC supplied to the DPCC by the County's campus-wide system amounts to approximately \$1.5 million per year and does not appear in the DPCC budget. The second exception is for occasional life-safety capital improvements (see point #4 below).
2. About 84.2% of the DPCC's revenue comes from the patients or third-party payors (referred to as "patient care revenue"). This includes Medicaid and Medicare, and from private insurance and fees paid. This is \$26.8 million per year.
3. Another 3.2% of revenue comes as net "non-patient" revenue. This net revenue is earned for services provided outside of the DPCC. These include: (a) dining services (the cafes at the 400, 421, and 505 buildings, plus catering and vending); (b) environmental services (housekeeping in other County buildings); (c) pharmacy services (to the Youth Home, to the Health Department, and providing County employee PPO prescriptions); and (d) miscellaneous/other revenue. The total net non-patient revenue (net of expenses relating to providing these services) is about \$1.0 million per year.
4. The County's operating support makes up 7.4%, but sometimes this contribution has been higher due to specific capital needs. This 7.4% amounts to \$2.4 million per year and is provided as a transfer into the DPCC Enterprise Fund budget. Information on 14 other county nursing homes in the

state shows that, in all cases, these counties do contribute substantial support to their county-run nursing home. This support is generally in the form of covering the retirement funds and other benefits for employees. Because of the Enterprise Fund nature of the DPCC budget, these costs are directly shown as expenses of the DPCC. Fluctuations in the County's contribution to the DPCC are based on two factors. One of these is the changing patient mix and the inconsistency of Medicaid reimbursements. Second, sometimes an additional contribution is made as dictated by the facility's annual Life Safety Survey conducted by the state for licensure. One example of this would be a fire system upgrade in 2001-2002, and another example would be HVAC modifications completed over a four-year period from 2002 to 2006 at a cost of over \$3.5 million. Both of these were required to address life safety capital needs.

5. The remaining 4.5% of the budget is technically considered an operating loss. This amount (\$1.46 million) includes a depreciation amount of \$1.28 million, which is not a cash expense. The remainder (\$182,000) is simply the difference between the budgeted amount and what is actually spent. Therefore, this operating loss is being absorbed, but it is not sustainable over the long run.
6. By far, the largest expense in the DPCC budget is for personnel. Personnel costs make up 71% of the DPCC budget. This includes salaries and wages as well as fringe benefits. Employees have the same benefits as other County employees (IMRF, health insurance, etc.). Paid time off is also a direct expense. As a critical 24/7 operation, holidays and vacation days must specifically be built into the budget (typically as overtime) to assure that the facility is adequately staffed at all times.
7. Historically, budgeting for capital improvements has been close to zero. Capital expenditures in 2007 were only 0.2 % of expenditures, and only 0.3% of the 2008 budget was devoted to capital improvements. Only life safety improvements (funded outside the DPCC's budget and described in point #4 above) are completed on an as-needed basis. The DPCC has also made use of grant funds to cover some capital costs, but grants for many of the needed improvements are not available. The 2009 budget does include \$744,757 (2.3% of the combined budget) for capital improvements. Only \$85,000 of this amount is budgeted for renovation of the facility. The remainder is budgeted for necessary relocation of some functions and for needed replacement of equipment.
8. The DPCC has taken a number of steps to contain costs. These include: (a) closing down units and reducing the number of operating beds (from 508 beds in 2001 to today's 360); (b) reductions in budgeted staffing (down 25% since 2001); (c) implementing several service delivery changes and avoiding the use of outside agencies to provide services; (d) better management of

pharmaceuticals to reduce costs; and (e) making several changes to procurement methods to reduce costs.

9. The DPCC Foundation provides important assistance to the DPCC. This Foundation is a separate non-profit organization that raises funds for the DPCC. Examples of projects that they have funded include the construction of a Family Dining Room and new “wheelchair friendly” flooring in the DPCC lobby. While fundraising levels vary from year to year, the average annual contribution from the Foundation over the last six years (from direct contributions and from a small endowment fund) has been about \$30,000. The Panel noted that, with some additional support and resources, the Foundation could expand the scope of their fundraising activities and provide some additional revenue for the DPCC.
10. Medicaid payments are not sufficient to pay for the care provided to Medicaid patients, but some improvements may be coming. On average, 74 % of the current patient population (expressed in total patient-days per year) is eligible for Medicaid reimbursement, but Medicaid does not fully pay for these services. As an indicator of the shortfall, even though 74% of patient care is eligible, only 54% of DPCC’s reimbursement comes from Medicaid. The rate paid by Medicaid is \$153.04 per day while the average cost of patient care exceeds \$231.00 per day. The delays in Medicaid reimbursement also negatively impact costs. The reader should note that any Medicaid increases will reduce the level of operating losses at the DPCC, but the operating support of the County (in the form of a transfer into the DPCC Enterprise Fund) will still be required.

## **Part Two: External Factors – Market Growth and Change**

There are external factors that, over the next several years, will affect the market that the DPCC serves, and these factors are undergoing significant change. These factors generally fall into two categories. The first category is the growth of our senior population and the resulting growth in demand for long term care. This category of factors can be predicted, although there is some significant uncertainty that will always remain. The second category of factors includes changes in the long term care industry and local “competition” from private facilities providing care. These factors affect both demand and supply, and this second category is much harder to predict because it is a combination of economic, public policy, personal preference, and medical technology factors. Below are comments on market growth and change.

1. The target population traditionally served by the DPCC is growing rapidly. The changing demographics of the population in DuPage suggest that there will be rapid growth in the numbers of individuals who could be potential residents of the DPCC. These are primarily low income seniors with disabilities. Based on projections by the Illinois Department of Economic

Opportunity, the total number of seniors (over 65) is projected to grow by 251% between 2000 and 2030, and the number of seniors over 85 will grow by 278%. This is even faster than the national rates of 201% and 225% respectively, which are a result of the aging of baby boomers. The number of persons in poverty in DuPage is increasing very rapidly (up over 38% from 2000 to 2006). Senior poverty in DuPage is not increasing as rapidly as in the overall population (up over 12% from 2000 to 2006), but it is still far above the national average growth, and the percent of seniors in poverty is growing. Projections of frailty and disabilities in old age are more uncertain, but a recent report by the Retirement Project suggests that these rates will stay constant or even increase slightly over time. When applied to a rapidly expanding senior population, this means a dramatic increase in the frail elderly population. These three trends (growing numbers, growing poverty rate, and growing disability rate) suggest strong demand for the type of care provided by the DPCC.

2. In-home care will not reduce demand on long term care facilities like the DPCC. Current trends are showing a movement toward more in-home care that is both paid (professional care) and unpaid (essentially from relative caregivers). Trend analysis by the Retirement Project projects that demand for all three forms of care, including in-home paid, in-home unpaid, and nursing home, will continue to rise. It appears that the trend toward in-home care will help slow the increase in nursing home demand, but the increases in nursing home demand will continue. The rise in in-home paid and nursing home demand will particularly come into play as baby boomers reach older ages because there will be fewer children to provide unpaid care than there are with today's frail elderly.
3. Based on current policies, private sector supply in DuPage will not be able to absorb the demand traditionally met by the DPCC. This is a more uncertain prediction to make because private sector supply in this market (essentially, the availability of Medicaid beds) is so dependent on State and Federal policy. Therefore, we can only rely on how current policies are impacting the industry in DuPage. Based on a snapshot of DuPage County nursing homes completed in May 2008 (and Medicaid policies have not materially changed since that time), there was a possibility of only 210 additional Medicaid beds that could be made available to relocating DPCC residents. The current Medicaid census at the DPCC is 270. However, note that there is only a *possibility* that these 210 beds would be available, and even this snapshot is probably a substantial underestimation of the gap. In discussions with providers, many qualified their availability by stating that they would not be able to serve high acuity residents. A large portion of DPCC residents are the type of high-acuity resident that these homes would be unable to care for.

### **Part Three: Analysis, Observations, and Conclusions**

In addition to the expertise of the Panel members themselves, the Panel and the staff called upon outside experts to provide information to the Panel. On market valuation issues, we consulted with a private brokerage company that has sold hundreds of nursing facilities throughout the U.S. We also sought advice from a developer of nursing and supportive living facilities and from a management consultant with particular expertise in government-run long-term care facilities. Finally, detailed analysis of financial and operating options was done by an accounting and management firm with a specific background in working with long-term care facilities. The statements below are based on the above-described analysis and address the current ownership and operational structure, alternative ownership and operating structures, the use of vacant space in the DPCC, and a review of impacts of changes to various components of DPCC's operations.

#### **The Current Ownership and Operating Structure**

1. The DPCC is a well-run operation that provides high quality care with a good staff and sound financial management. This needs to be said up front. Whatever decisions are made about the DPCC, it is important to note that they are not being made because of any problems in patient care or management. One area where nursing care facilities often get into trouble is when compensation and morale issues result in high turnover, which reflects in patient care. The DPCC has lower turnover than average, more years in service than the average, and consequently better patient care. A second area that can cause problems for nursing facilities is financial mismanagement. The management of the DPCC has made the best use of the resources available, is maximizing revenue streams to help support the facility, and is managing costs well.
2. Because of the fixed cost of providing care, further reductions in the number of available beds in the DPCC will reduce revenue without a proportionate reduction in costs. The DPCC reduced its bed count from 508 in 2002 to 360 in 2005. Corresponding reductions in staff took place over this period that reduced costs. Further reductions in bed count will not allow appreciable reductions in the fixed cost of operating the facility, but such reductions will result in lost revenue.
3. The DPCC provides for needs in the DuPage County community that would otherwise not be met. There are three factors that make the DPCC unique. One factor is the care provided to the younger population. This type of care (usually a very high level of care provided for many years, often decades) is generally not available elsewhere in DuPage. A second need being met is for Alzheimer's/dementia care. There is a waiting list for this care at the DPCC, which indicates a gap of unmet need in the community. A third unique factor

is that the DPCC has the largest number of Medicaid beds in the County, which means that it is providing for an essential need for affordable care for the financially indigent in DuPage.

4. Filling this gap for residents who would otherwise not find care in DuPage County (point #3 above) implies that the County will need to continue to support the DPCC financially. The logic behind this statement is as follows.
  - The core business of the DPCC is to provide for high quality care to persons without the resources to find this care in the private sector.
  - Focusing on this core business requires that the DPCC accept a disproportionate share of Medicaid patients. Although the County Board-adopted admissions policy does not specifically require admissions of Medicaid patients, the needs-based admissions policy has the effect of bringing in a high number of Medicaid patients.
  - The rate of Medicaid reimbursement will continue to be below the actual cost of providing care (see point #10 under “The Finances of the DPCC” above). Therefore, this financial gap must be addressed by County support.
5. Lack of attention to the capital needs of the DPCC is becoming critical. It is estimated that the cost of the capital improvement needs of the facility exceeds \$20 million. These needs range from lighting improvements to a complete renovation of the kitchen. Although basic life safety issues are being addressed, other upgrades are becoming critical to the comfort and safety of the residents.
6. If the DPCC were to close, a large portion of the residents would be relocated to facilities outside of DuPage. If the facility closed, the State of Illinois would manage the relocation of the residents, and the only location requirement they have is that they must be placed within the state. A recent study determined that there are not enough Medicaid beds in DuPage County to accommodate the residents of the Convalescent Center (see point #3 under “External Factors” above). The high cost of care for the younger population will make it particularly difficult to place these residents. Therefore, we can be virtually certain that many residents of the DPCC would be relocated to homes outside of DuPage County.
7. Relocating DPCC residents to other facilities will put the health of current residents at risk and will result in a reduction in the quality of care for most residents. The Panel noted that there would be significant negative impact on current residents if the DPCC is closed or changed to the point where residents would need to move to other facilities.

- A large body of research shows that there are negative health and mortality impacts when nursing home residents move. When such moves occur, mortality rates are two to four times higher than for residents who do not move, and these rates are higher when moving to a new facility as opposed to moving within the facility. Moving is also related to higher incidents of stress-related health problems and cognitive impairment.
- Many indicators suggest that residents who move will experience a reduction in the quality of care. As stated above, all indicators of the quality of care at the DPCC show it to be among the best in the state. Therefore, most residents would be moving to facilities with lower ratings.

### **Alternative Ownership and Operating Structures**

1. Sale of the DPCC to a private sector organization would eliminate the County's subsidy (but not all costs now associated with the DPCC), but it could have a significant downside to DPCC resident patients and to the County. The option of sale means selling the entire DPCC facility and its operation to a private sector organization. Although the option of selling off some select functions (and keeping others) was discussed, analysis and discussions with experts indicated that this partial-sale option is not feasible. The private group purchasing the facility could be a not-for-profit or a for-profit entity, but either of these options would have the same impacts for the County. Below are comments about this option.
  - The DPCC is marketable and could be sold in the private market. If put on the market, it must be marketed as a single entity. As stated above, buyers would not be interested in purchasing parts of the operation. Selling the facility also assumes that a suitable contractual arrangement can be made with the new owner regarding the heating and cooling that is provided from the County's main heating/cooling plant, and would also account for the fact that the main lines serving the east campus from the County's centralized heating/cooling plant run through the DPCC. All this can be dealt with, but it will affect the transaction.
  - The current market value of the DPCC is difficult to establish. Ordinarily, the value of such properties is based on net income, but the DPCC actually operates at a net loss. Therefore, a buyer needs to establish income potential, which means assuming a change in patient mix away from a Medicaid population. Note that a private entity would not receive the same level of Medicaid reimbursement that a county nursing home receives. Also, it is unknown how much the HVAC complications cited above would affect market price.
  - If sold, there would be one-time net revenue, but there would also be one-time costs. The net one-time revenue from selling the facility is estimated

at \$10 to \$11 million assuming a relatively optimistic selling price in today's market. For our analysis, we calculated this amount by assuming an estimated selling price of \$15 million and total transaction and ongoing costs to the County (ongoing costs including the cost to operate the heating plant, etc.) of over \$4 million. A large majority of the transaction costs are to pay off benefits owed to current employees in accordance with County policies relating to lay-offs. Again, it is worth restating that the selling price of the DPCC is very uncertain, and net revenue from such a sale could be substantially lower than the assumption built into this analysis.

- Following sale, the mission of the facility would change, there would be a change in the mix of patients served, and there is likely to be a reduction in the quality of care. We are assuming that the reason for selling the DPCC is to end the County's financial support of the facility. Therefore, (and as stated above) a new owner wanting to create a positive cash flow would have to change the patient mix toward more private pay and away from the low-income Medicaid population. This will increase revenue. A reduction in the staffing ratio would reduce costs, but sustaining the current standard of care would be unlikely.
  - Even after sale, the public is likely to continue to associate the facility with County government, but the County will have lost its oversight. The facility will continue to be on County property, and the County will have a contractual arrangement with the new owner to provide heating and cooling. The County's connection to the facility, without oversight, has a strong potential of creating public relations problems in the future.
2. Retaining ownership of the DPCC and changing its oversight structure could benefit the DPCC, but it will have little financial impact on the County. Currently, the oversight responsibility for the DPCC rests with the DuPage County Board. It has been suggested that the DPCC would benefit from a board with a narrower focus that could concentrate more of its attention on the DPCC. There are two such options that were considered. First, the DPCC could become an operation of the DuPage County Health Department thereby coming under the Board of Health as part of the public health functions of the County. Second, the County Board could establish a separate independent board to oversee the DPCC. Below are comments about these options.
- Board of Health oversight of the DPCC may have advantages relating to mission, but it would not eliminate the need for County financial support. The Health Department is an existing entity that already oversees other public health functions, so they would logically be more focused on the mission of the DPCC than the County Board. Although the Board of Health is relatively independent from the County Board, its members are

appointed by the County Board Chairman, and there is a budgetary connection between the County Board and the Board of Health. Moving under the Board of Health would not change the financial situation of the DPCC, which means that the County Board would need to continue to provide annual operating support. However, there is a one-time cost to the County. Moving DPCC employees under the Health Department would create a one-time cost of about \$628,000 to pay out accrued sick pay that is not eligible under Health Department Policy. This would also move the County's liability for retention costs from the County to the Health Department.

- Establishing an independent board for nursing homes in other counties has achieved success, but the situations in these other counties are not consistent with ours. In other counties, establishing a separate board was done for two reasons, and sometimes both of these reasons applied. One reason was to solve management problems and the second was specifically to instruct the new board to change the mission of the nursing home so that county government support could be eliminated. Also, two options for creating such a board have been used. One option turns over essentially all oversight power to the separate board. The second option establishes this oversight board as advisory to county government. In DuPage County, the DPCC is being managed well, so there is no need to appoint a board to address concerns. Additionally, there is no clear desire to change the mission in order to eliminate the County's financial support. Changing the mission in order to achieve financial independence is, in fact, not recommended by this report.
- The down side of these alternative oversight structures is that they create an additional layer between the needed financial support from the County and the operation of the DPCC. If the DPCC is to continue as a facility serving needy Medicaid clients (which is a recommendation of this report), the County Board will need to continue its partial support of the facility. Therefore, either of these alternative structures would give oversight responsibility to an organization that would be dependent on another board (i.e., the County Board) to provide a key part of its support. This is complicated by the fact that the DPCC is also dependent on the policy and budget decisions of State and Federal government as primary sources of financial support through Medicaid. However, resolving Medicaid underpayment issues is outside the scope of this report.

### **Conversion of Vacant Space in the South Wing**

There is 27,000 ft<sup>2</sup> of potential vacant space in the south wing of the south building. Most of this is currently vacant with additional space to become vacant soon when the DPCC offices move. As an overall statement, converting vacant space in the south wing to productive use will have little economic benefit to the

County. The Panel examined a number of options for use of the vacant space in the south wing. In general, it was concluded that developing this vacant space would be a policy decision to use this space for some productive use rather than having it remain vacant. However, the County should not necessarily view it as a revenue generating or cost savings opportunity. More analysis would need to be done on any of these options to determine specific viability. Below are comments on these options.

1. A Health Education Center would offer benefits to the community, but it would be financially neutral to the County's budget. Such a Center would convert about 27,000 ft<sup>2</sup> of vacant space in the DPCC and provide the capacity to train an additional 280 nurses and health care professionals. This capacity is needed to help address the current regional shortage of 2,500 in the healthcare industry. The "teaching hospital" concept would combine classroom training with practical application thereby offering benefits to DPCC residents as well training for these professionals. The statement of neutrality in the County's budget is based on the assumption that the development costs would be covered by grants and financing from a college or university partner. The College of DuPage and the County had previously entered into a memorandum of understanding to partner to create a Health Education Center. However, funding for the Center has not materialized and the College's priorities have moved in a different direction. Therefore, the concept of a Health Education Center, even with other partners, is now remote. Ongoing revenue to the County from such a facility is assumed to be \$330,000 per year, but this is only enough to offset the costs to the County associated with being the landlord for the Center.
2. A Supportive Living Facility (SLF) for seniors is not a viable use of the vacant space. This type of residential opportunity is the "Medicaid version" of assisted living, which offers more support than independent living, but is not as intense as long term nursing care. Based on discussions with developers of this type of housing, we have reached two conclusions. First, the amount of vacant space available in the south wing of the DPCC is not sufficient to develop an economically viable supportive living project. Typically, these projects are in the size range of 85 to 100 units in order to achieve the economies of scale needed for profitability. However, preliminary plans for this space only yields about 43 units. This means that a heavy level of subsidy would be necessary to make the project economically viable. Second, developers are more interested in building new facilities than dealing with the uncertainty of converting existing space. The vacant space in the south wing was originally designed with communal bathrooms, and there are no kitchen facilities. Converting to one-bedroom apartments would require substantial reconfiguration, and costs would likely be at least equal to building new.

3. Other uses would be equally costly to develop, and would not affect the County's ongoing finances. Other uses including housing for veterans or a medical facility associated with the Veterans Administration have been suggested. However, development costs would be equally high for these other types of uses. Additionally (and unlike SLFs, which are known to be in high demand), the market viability of other uses at this location would need to be studied. Regardless, such uses will require large capital investments and commitments of operating funding, so they should only be pursued if funding resources are available.
4. There are probably no cost savings to building office space for other County services. Again, development costs of conversion would be high because of the need to make this into modern habitable space. Although no specific analysis was done, it was estimated that there would be no cost savings over building new space.
5. Even using the space for storage would have few financial advantages. Use for storage would require fewer upgrades to the space, but it lacks a separate entrance. Therefore, there are costs associated with this option as well.
6. Demolition of the South wing is not feasible. This determination is based on three factors. First, the ground floor of this wing houses pipes and mechanicals for the campus-wide HVAC system that also serves the East Campus. Second, there are mechanicals for the DPCC's HVAC system on the roof of this wing that serve the other parts of the facility. Third, demolition is not practical because the main entrance to the DPCC is in this area. The building is "L" shaped with half of it still in use, including all four floors of the east wing.

## **Other Options**

The Panel was asked to examine other options that fall into two categories. The first category includes expansions of services that are being provided by the DPCC and new services that are consistent with the mission and operations of the DPCC. The second category includes services provided to other County offices that generate revenue for the DPCC.

1. Expanding existing services or creating new services in the DPCC could fill gaps in need, but any services that would earn net revenue would probably compete with the private sector. The Panel concluded that, as a government sponsored organization, the DPCC's role is to meet community needs that would not be met by the private sector. In other words, it would only be appropriate for the DPCC to develop these services if government support is needed to make them viable. The following are four types of services that were examined.

- Palliative Care Unit: This is end of life/hospice care. The Convalescent Center currently devotes a few rooms to inpatient hospice care, but it does not set aside a defined area or unit that is specifically designed for this purpose.
  - Dementia Care: The Convalescent Center currently has some defined areas for dementia and Alzheimer's care, but this type of care has the highest demand and there is a waiting list.
  - Outpatient Therapy: The Convalescent Center currently provides therapy to its short term and long term residents. Expanding to provide outpatient services could be done if there is a need in the community and funding were available.
  - Wellness Center: There is a significant opportunity, at no cost to the County, to establish such a center as a service to the community. The Convalescent Center has recently been awarded \$190,000 that was a special appropriation of HRSA funds obtained through Congressman Roskam's office. These funds were specifically awarded to purchase equipment and complete necessary renovations to establish a wellness center for seniors in DuPage County. This center will: (a) provide education and prevention activities to help seniors maintain healthy lifestyles; (b) address issues of both physical and mental wellness; and (c) help seniors improve strength and balance, thereby reducing falls. Services will be offered to DPCC residents as well as to members of the community at large. Additionally, the Northeastern Illinois Area Agency on Aging (NEIL) is offering assistance to establish and support "Community Connection Centers." Such centers also would address wellness issues and promote healthy, independent lifestyles. The DPCC staff is working with the Seniors Division of Community Services on a proposal to NEIL that will further enhance the services available in a new wellness center.
2. The DPCC has saturated the available market for its outside business services. The options discussed in this section are business services that are currently provided by the DPCC to outside organizations. The Panel concluded that the "market" for these services is really only within the DuPage County complex and its operations because a government supported enterprise should not be competing with the private sector. The descriptions below indicate that the DPCC has already saturated this market and that there is no significant additional revenue that can be generated from this source. However, these options could be more fully explored in the future if new opportunities arise.
- Laundry and Housekeeping Services: The DPCC has updated the equipment in its laundry and can use the capacity of this equipment to

earn revenue. In addition to meeting its own needs, linen and housekeeping services are provided in other County buildings.

- Dining Services: The DPCC operates the cafes in the 400, 421, and 505 buildings; and they provide catering and vending throughout the complex.
- The Pharmacy: The Convalescent Center's pharmacy not only serves its own needs, but also serves the Health Department, the Youth Home, and provides prescriptions for the County's PPO employee Health Insurance program.

#### **Part Four: Recommendations**

The recommendations below are based on the information and observations presented in the Part Three above. These recommendations begin by addressing basic questions about the mission of DuPage County government and how this mission relates to operating and financing the DPCC. These are major decisions that the County Board has actually made in the past, but they need to be restated here in clear and concise terms.

1. The mission of the DPCC, specifically regarding the people served, should continue to focus on the underserved. As outlined above, the DPCC's mission emphasizes the provision of quality care to people who would not be able to afford this care in the private market. By definition, this means a high percentage of Medicaid patients and a resulting revenue stream that will not cover all the costs of the care provided. The alternate decision would be to change the patient payor mix to emphasize private pay. We do not recommend this because: (a) it would not be consistent with the mission of DuPage County government and the 120-year history of providing this care; (b) it would be in competition with other private pay providers; and (c) it would ultimately hurt the current and future patients (and their families) who depend on this facility.
2. The quality of the care at the DPCC should be preserved. The DPCC is well known for the quality of its care, and this level of care should be preserved. This may seem like an obvious recommendation, but given that the Medicaid patient mix will remain the same (see recommendation #1 above), we do not feel it is possible to cut costs to a level that will match the reimbursement provided by the Medicaid system. The consequences of such cuts would first be felt by the patients at the DPCC, but the County's liability associated with providing low quality care can be substantial.
3. A detailed capital improvement plan for the DPCC should be developed. This report notes that there is a considerable amount of deferred maintenance at the DPCC, and total cost of needed repairs and upgrades exceeds \$20

million. Further, we note that continued inaction regarding the capital needs of the DPCC will have negative consequences on patient care. A capital improvement plan would establish priorities for making improvements to the facility and would create a plan for funding of these improvements. In addition, the County should identify where there is potential for federal or state grants to complete repairs and upgrades.

4. The County should seek to maximize patient revenue, which means focusing primarily on Medicaid. This report shows that the current Medicaid reimbursement rate falls considerably short of the cost of providing Medicaid-reimbursable care. This report also states that the DPCC is managing its costs well and cannot significantly reduce costs without affecting patient care. Therefore, to continue to provide quality care to the vulnerable population served by the DPCC, the County should take steps to increase the daily rate paid by the Medicaid system. Although some improvements in this rate might be put in place in the near future, the County should continue to work toward adequate reimbursement for its Medicaid care.
5. The County should evaluate the financial benefits of additional support to the DPCC Foundation. This report notes that the scope of this Foundation could be expanded in order to increase the contributions to the DPCC. However, expanding this scope will require a financial commitment to fundraising. It is recommended that a business plan for such an expansion of scope be developed to determine the costs and benefits of such an expansion of scope.
6. The DPCC should not be sold, and it should not be closed. This report evaluates the impacts of selling the DPCC facility to a private (profit or non-profit) entity and determines that there could be some one-time revenue from such a sale. The amount of this revenue is very uncertain, and it is likely to be substantially diminished given the deferred maintenance and condition of the facility, its tie-in to County's HVAC system, and the general state of the market. Any entity purchasing the facility would certainly need to change the facility's revenue and expense structure to achieve a positive cash flow. This means that patients that are being cared for at a loss (essentially, the indigent Medicaid residents) would need to be relocated to other facilities. Many, if not most, would be moved outside of DuPage County because of the shortage of Medicaid beds here, and most would experience a decline in their quality of care. The negative impacts would be on these patients and their families. Additionally, the facility would remain on County land and using County HVAC infrastructure (thereby requiring a contractual arrangement with the private owner), so the County could never be free of some association and possible liability relating to the DPCC.
7. The County should continue its financial support of the DPCC. Because the report recommends that the County retain the facility and retain its ownership,

this means that the County's financial support will need to continue. This is true regardless of the specific management options that are pursued. The report outlines several options for oversight and management, and it discusses the need to continue to pursue improvements in Medicaid reimbursement (which can improve the financial situation). The report even suggests that some additional financial support could come from the DPCC Foundation. However, it is clear that none of these options will eliminate the need for the County's support. In particular, the Panel specifically noted the following.

- The County should not refer to the DPCC's budget as an "enterprise fund." This term implies that the facility is self-funding, but, as noted in this report, the County needs to continue its financial support of the facility. The Panel also suggests that, when budgeting its support for the DPCC, the County should recognize the DPCC's special situation (i.e., different than most other County departments and elected officials' offices) whereby retirement and health benefit costs are included in DPCC's budget and not paid out of the County general fund. Recognition of the impact of these costs on the DPCC (and how they are budgeted) will help the County Board and the public compare its support of the DPCC to its support of other functions of County government.
- The County's support of the DPCC should specifically include funding for deferred and ongoing capital improvements at the facility. Recommendation #3 above outlines the need for a capital improvement plan. We are re-stating in this recommendation for financial support that this financial support should include a financing plan for these capital improvements.

## **Conclusion**

This report addresses a wide variety of issues surrounding the DuPage Convalescent Center as well as many suggestions that have been made about its future operation. It is worth restating in this conclusion that the DPCC is well managed both in terms of the high quality of its patient care and its financial management, so this report was not done to correct financial or management problems. This Panel's charge has been to review alternatives for ownership and management of the DPCC, examine the physical space (including its maintenance needs and use of vacant space), and evaluate the need for ongoing County financial support of the facility while keeping the needs of current and future DPCC residents foremost.

Our conclusion regarding the County's financial support is that, as long as the County intends to meet the needs of this underserved population in DuPage, it will need to financially support the DPCC. Changes in ownership or management that would convert the facility into a profit-making entity will mean

pulling away from serving this population in need. Nonetheless, the County's financial support can be minimized by continuing to work toward added revenue from the Medicaid system.

The physical facility of the DPCC needs attention, and an upgrade of several components (most notably, the kitchen) is needed. A specific plan for these improvements should be developed. There are potential uses for the vacant space which can offer new or expanded services to the community, but these options should be seen as a benefit to the community and not as a potential source of revenue for the DPCC.

As a final comment, the resident patients at the DPCC, and their families, seem to be very devoted to the DPCC as evidenced by the long tenure of the residents and the level of volunteer support. The physical and financial needs of these resident patients are met by the DPCC. We hope the County will continue to meet these needs into the future.