Affinity

Health Services

State of Minnesota

Department of Veterans Affairs

Minnesota Veterans Homes

Phase II b Financial Recommendations and Considerations

Order of Contents

"Definitions"

For the purposes of this report, the following definitions apply:

a) **Affinity.** "Affinity" means Affinity Health Services, Inc., a corporation providing Senior Community Management and Consulting Services

b) **MVH.** "MVH" means Minnesota Veterans Homes

c) **Nursing Home.** "Nursing Home" means a dually licensed facility participating in both Medicare and Medicaid

d) **Skilled services/care. "**Skilled services" means Medicare Part A skilled care as defined by CMS

e) **CMS.** "CMS" means Center for Medicare and Medicaid Services, a federal program

f) **CoP. "**CoP" means Conditions of Participation and are the minimum health and safety standards that providers must meet in order to be Medicare or Medicaid certified

g) **Rehabilitation services.** "Rehabilitation services" means a therapy program with Physical, Occupational and Speech therapy services a minimum of five days per week

h) **Restorative nursing services.** "Restorative nursing services" means nursing interventions that promotes residents ability to adapt and adjust to living independently as safely as possible

i) **MDS.** "MDS" means Minimum Data set, a core set of screening, clinical and functional status elements with common definitions and coding categories. The MDS is also used to determine the Medicare and Medicaid classifications for payment rates.

j) **PAS.** "PAS" means Preadmission Screening, and is a screening tool completed prior to admission to any nursing home, nursing facility or board and care home

k) **MHCP.** "MHCP" means Minnesota Health Care Programs

l) **DHS.** "DHS" means Minnesota Department of Human Services

m) **RUG Rates.** "RUG Rates" means Resource Utilization Groups, a program where reimbursement levels differ based on the resource needs of the resident

n) **Gap.** "Gap" means a tool that helps a company to compare it's actual performance with its potential performance

o) **HCBS.** "HCBS" means Home and Community Based Services

p) **OBRA.** "OBRA means Omnibus Budget Reconciliation Act of 1987 is a Federal legislation and regulation addressing Quality of Care

q) **RAP.** "RAP" means resident assessment protocol and is a part of the comprehensive assessment

r) **CLIA.** "CLIA" means Clinical Laboratory Improvement Amendments is a Federal requirement that every facility that tests human specimens for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment meet certain requirements

s) **DOM.** "DOM" means Domiciliary facility for assisted living

t) **SNF.** "SNF" means skilled nursing facility that is Medicare / Medicaid certified

u) **SNF PPS.** "SNF PPS" means a skilled nursing facility prospective payment system use by Medicare to establish Medicare Part A rates for Medicare certified skilled nursing facilities

v) **SNF CB.** "SNF CB" means skilled nursing facility consolidated billing (CB - Consolidated Billing)

w) **RUG III.** "RUG III means the particular version of the RUG Rates that has been chosen by CMS to use for SNF PPS payment levels

x) **Case Mix.** "Case Mix" means a payment system which provides a mechanism for certified facilities to be reimbursed for the kind of residents and the types of services provided to those residents

y) **PIPP.** "PIPP" means Performance Incentive Payment Program

z) **GAAP.** "GAAP" means generally accepted accounting principals

aa) **HCPCS.** "HCPCS" means Common Procedure Coding System

I. Executive Summary

The Minnesota Veterans' Homes has contracted Affinity Health Services, Inc. ("Affinity") to conduct a cost benefit analysis to determine the feasibility for the five (5) homes to obtain Medicare and Medicaid certification. Affinity will be identifying the opportunities and challenges involved with this project including the financial impact on the various stakeholders. Affinity will also be providing a Gap analysis for compliance with CMS participation and an implementation plan for each facility to be utilized shall the MVH decide to proceed with certification.

This is the third of five (5) reports that will be provided to the Minnesota Veterans Homes as part of our contractual agreement. This particular report focuses on the implications in business office practices, financial accounting, and computer applications that are necessary if Medicare and/or Medicaid certification is pursued.

One of the primary objectives of the contract is to determine how certain key elements of the Minnesota Veterans Homes' operations compare to standard industry practices in Medicare and Medicaid certified facilities. In some cases reference will be made to best practice standards. "Standard" or "Best" industry practices may be derived from a variety of sources including:

- Nationally available publications and reference materials
- Information published on publicly available websites (i.e., Department of Health, Centers for Medicare and Medicaid Services, etc.)
- Information obtained on other similar facilities
- Proprietary data or information collected or retained by Affinity
- A compilation of Affinity experience in the healthcare and senior living industry
- Research and experience from previous veterans homes

When available, we will support standard or best industry practice recommendations with objective, documented sources. However, it is important to note that there are some observations, recommendations, and practices that simply are not well documented in publicized venues. We will, at times, rely on the collective experiences of our organization to identify operational considerations and recommendations for change.

As the MVH leadership evaluates considerations to become Medicare and Medicaid certified it is important for key decision makers to have ample understanding of programmatic nuances of both systems as well as the anticipated impact to the organizational structure, behavior, and practices should the decision be made to move forward with Medicare and/or Medicaid certification.

These aspects of the certification process are "softer" considerations but are nonetheless important for the MVH leadership to consider as change in any organization can be challenging.

It is important to note that we are providing these considerations and operational implications should the MVH decide to pursue Medicare and /or Medicaid certification. We recognize our role in this engagement is to provide information and data necessary for the MVH key decision makers to make informed decisions regarding pursuit of the certification process. Understanding the impact to the organization is a fundamental consideration in this decision making process. Ultimately, the decision to pursue certification is a management decision. Affinity has not been engaged to act in a management capacity.

The final report will include two (2) different financial projections and the subsequent impact to the organization should the homes become Medicare and Medicaid participating providers. The first projection and analysis will outline the impact of these two programs based on the assumption that the MVH will continue to operate under their current admissions and marketing structure. The second will provide a projected impact of these two government programs assuming the MVH changes their operational structure to mirror private sector operated nursing homes. Any decision-making regarding the pursuit of participation in either of these programs prior to the issuance of the final report would be premature.

II. Methodology

Affinity Health Services, Inc. has gathered information regarding the current operations, business practices, and clinical and financial outcomes of the MVH through a variety of sources.

The observations and comments enclosed are a result of our on-site visits, document review, inquiries, observation, analysis and other work performed.

The data and information included in, and used as a basis for, this report was compiled from a variety of methods and sources including, but not limited to the following:

a) Review of documents provided by MVH

b) Compilation and analysis of data provided by MVH

c) Observations made during on-site visits to each of the homes

d) Interviews with key management and departmental staff, including but not limited to:

- Nursing Home Administrator
- Director of Nursing
- Business Managers and Support Staff
- Admission Coordinators/Social Service Staff
- Pharmacist
- Therapist

e) Research on Minnesota Medicaid and Medicare payment methodologies

Our report is focused on those areas that are believed to present the most significant impact for the Minnesota Veterans Homes should they choose to pursue either Medicare and/or Medicaid certification. This report attempts to identify and address those key business practices that should be considered should the decision makers representing the Minnesota Veterans Homes' pursue certification.

The report also outlines observations and findings specifically related to the financial and business office operations and are organized according to the following:

- Minnesota Veterans Homes current practices
- Industry standard or best practice recommendations
- A brief synopsis of existing Gaps between the current practice and recommended practice

III. Analysis

A. Financial and Payment Methodology for Medicare and Minnesota Medicaid Program Participation

a. Medicare Part A

Medicare Part A is a hospital insurance that is free to those individuals who meet certain qualifying criteria. Medicare beneficiaries who need short-term skilled care (nursing or rehabilitative) on an inpatient basis following a hospital stay of at least 3 days are eligible to receive care in a Skilled Nursing Facility under the beneficiaries Medicare Part A benefit. Medicare Part A pays skilled nursing facilities on the basis of a prospective payment system known as the Skilled Nursing Facility Prospective Payment System (SNF PPS). Under SNF PPS, nursing facilities are paid a predetermined rate for each day of skilled care. SNF PPS payment rates are expected to cover all routine, ancillary, and capital costs that facilities would be expected to incur in furnishing covered SNF services. Per diem payments are case-mix adjusted using a resident classification system, called Resource Utilization Groups III (RUG-III). These per diem, RUG III rates are based solely on data submitted from the resident's Minimum Data Set assessment (MDS 2.0). The RUG III payment system has 53 distinct groups, each with a corresponding daily payment. Medicare Part A residents are assigned to one of the 53 RUG III groups based on the resources expended in the care of the resident, the type and severity of illness, and the resident's functional levels.

The RUG III per diem rate is the sum of three (3) components, including; a fixed amount for routine services (room and board, administrative services, etc.), a nursing component, and a therapy component. The nursing component reflects the intensity of nursing care that residents in each RUG III category are expected to receive, based on CMS staff time studies. For those groups that require intensive therapy, a therapy component is included that reflects the expected intensity of therapy provided to the resident.

The Balanced Budget Act of 1997 included a billing provision that requires a Medicare Certified home to submit consolidated Medicare bills for its residents for virtually all services that are covered under either Part A or Part B. The

statute excludes a list of services, primarily those of physicians and certain other types of practitioners that are not covered in the Medicare Part A per diem rate. The Consolidated Billing requirement requires a SNF to submit Medicare claims for all the services that the resident receives under the Medicare Part A payment system. Medicare Part A PPS, that includes the SNF CB, pays the nursing home a daily per diem rate that bundles all of the projected services and resources that the resident requires into this one daily per diem rate. There are certain exceptions under SNF CB, which are not included in the daily per diem rate but instead can be billed separately and in addition to the daily per diem rate. SNF CB eliminates the potential for duplicative billings for the same services to the Part A fiscal intermediary by the SNF and the Part B carrier by an outside supplier. It also enhances the SNF's capacity to meet its existing responsibility to oversee and coordinate the total package of care that each of its residents receives.

Attached is a schedule of services covered under the SNF PPS payment system. The attachment is titled Medicare Part A services (ATTACHMENT 1). Under the current program, the facility is responsible to pay and bill for all of the services provided, regardless of who provides the service. The facility is paid according to the resident's assigned RUG rate and not according to the total charges recorded on the bill submitted for a Medicare Part A resident stay. These charges are intended to be covered in the daily per diem rate that is based solely on the resident's RUG III Score. The RUG III Score is solely determined from the completed Minimum Data Set (MDS 2.0) completed at various times during a resident's Medicare Part A stay.

Each facility's federal Medicare rate is determined by a variety of factors. First, rates are established for both rural and urban classifications. The rates are also adjusted by a wage index to account for geographic variation in wages. In addition, rates are typically adjusted annually using a SNF market basket index. We will be addressing the completion of the MDS as it relates to both reimbursement and quality of care in subsequent reports.

Medicare Part A is a complicated payment system that requires nursing facilities to have very specific systems in place, both financially and clinically, in order to effectively administer the Medicare Part A program.

b. Medicare Part B

Anyone who is eligible for free Medicare hospital insurance (Part A) can enroll in Medicare medical insurance (Part B) by paying a monthly premium. Some beneficiaries with higher incomes will pay a higher monthly Part B premium. Under certain circumstances, individuals who are not eligible for Medicare Part A can purchase Medicare Part B insurance. In 2009, the Medicare Part B monthly premium for the majority of beneficiaries is $96.40 per month but can be adjusted up to $308.30 per month for those individuals with higher incomes.

Medicare Part B is a medical insurance that covers a portion of the Medicare approved costs for outpatient medical services, such as physician services, laboratory care, some outpatient procedures, outpatient therapy services, medical equipment and supplies, and ambulance services. Attached is a list of services that may be billed under the Medicare Part B program (ATTACHMENT 2) if the resident meets the coverage guidelines.

The Medicare Part B program pays for these services in the nursing facility only when the resident is not receiving services under the Medicare Part A program. The statutory provision requires SNF's to use HCPCS coding on all Part B bills, and specifies that they are to be paid an amount determined in accordance with the applicable Part B fee schedule for the particular item or service rendered to the residents

Medicare Part B services are also subject to SNF CB. As noted previously, there are a number of services that are excluded from the Medicare Part A per diem through the Consolidated Billing requirements. In essence, certain services fall outside the scope of the SNF PPS per diem payment and as such are able to be billed separately under Medicare Part B. Typically, those excluded services must be provided to a Medicare Part A resident by an outside supplier or health care provider. Services that are categorically excluded from SNF CB include, but are not limited to the following:

- Physicians' services furnished to SNF residents. These services are not subject to Consolidated Billing and are able to be billed separately to the Medicare Part B carrier
- Physician assistants
- Nurse practitioners
- Certified nurse-midwives

- Qualified psychologist;
- Certified registered nurse anesthetists
- Certain Dialysis services and supplies
- Hospice care related to a resident's terminal condition
- Certain ambulance services

The MVH currently provide certain supplies and services that are eligible to be billed by either the facility or a service provider under the Medicare Part B program. If the MVH would choose to pursue Medicare certification it would necessitate changes in contract terms and payment methodology for outside service providers. In addition, it would require the facilities to initiate documentation and tracking systems for related services and supplies for billing purposes.

c. Medicare Part D

Medicare Part D, which began in 2006, is a Medicare program that provides prescription drug coverage insurance for beneficiaries at participating pharmacy providers. Everyone with Medicare Part A and/or B is eligible for this coverage regardless of income and resources, health status, or current prescription drug costs. Beneficiaries pay a monthly premium for the Medicare Part D plan that is dependent on the type of plan in which they enroll. This premium can either be paid by the beneficiary or can be deducted from the monthly social security payments. Monthly premiums typically range within $20 to $100. Medicare Part D beneficiaries typically pay the monthly premium, medication co-payments, and a yearly deductible. Medicare Part D beneficiaries who also qualify for Medicaid have no monthly premium, no annual deductible, and no copayment when a prescription is covered by the plan at a participating pharmacy. Various plans exist for beneficiaries to choose the plan that best meets their prescriptive needs. These plans vary significantly and thus have impact to the nursing facility and pharmacy providers in that both have to be familiar with the various types of plans covering the residents. Each plan has its own prescription drug formulary, preauthorization process, and quantity limits that require additional work on the part of both the pharmacy and the facility to effectively manage for each resident.

Medicare Part D prescription plans cover antineoplastic medications, HIV/AIDS treatments, antidepressants, antipsychotic medications, anticonvulsive medications, and prescription drugs, biologicals, and insulin. Excluded drugs

include, but are not limited to: drugs for weight loss or gain, prescription vitamins, over the counter medications, barbiturates, and benzodiazepines.

The Medicare D program pays the pharmacy directly if the following criteria are met:

- Drug must be on the formulary
- Filled by a network pharmacy
- Not covered by Medicare Part A or by Part B

Currently one (1) of the two (2) MVH contracted pharmacy providers is a "network pharmacy" under the Medicare Part D program. The second provider is reportedly in the application process. The remaining three (3) homes operate their own internal pharmacies that are not approved as a Medicare Part D "network pharmacy." There is an application and approval process necessary to be considered a Medicare Part D network pharmacy. Further analysis of the financial implications of the Medicare Part D program will be provided in the final report.

d. Minnesota Medicaid Program

The Minnesota Medicaid reimbursement program pays the nursing home provider according to a Case Mix Classification. There are 36 distinct Case Mix Classifications under the Minnesota Medicaid system. Each Medicaid resident's Case Mix Classification is determined based on the completion of the MDS 2.0.

Each of the 36 Case Mix Classifications has a corresponding daily payment rate. Each Case Mix Classification is based on the resident's functional level, amount of care and staff support the resident needs, type of treatment(s) required, and presentation of certain diagnosis and care conditions. The 36 Case Mix Classifications are broken down into various groups, including Extensive Services, Rehabilitation, Special Care, Clinically Complex, Impaired Cognition, Behavior Problems and Reduced Physical Functioning. The Minnesota Medicaid Case Mix Classification System applies to residents in both licensed nursing homes and licensed boarding care homes.

In addition to the Case Mix Classification rate, the Minnesota Medicaid Program includes Pay for Performance opportunities for Medicaid participating nursing homes. This initiative provides add-ons to the Case Mix Classification rate for quality performance outcomes. This competitive program is designed to reward

those homes with innovative projects that improve quality or efficiency or contribute to rebalancing care from institutional to home/community based care settings. Selected and qualifying projects can receive temporary operating payment rate increases of up to 5% on top of their baseline Case Mix Rate.

Medicaid requires electronic billing of all claims.

A. Operational Consideration for Financial, Accounting, and Billing Practices

a. Financial Accounting and Expense Recording

Current Practice: Financial Accounting

Currently, the MVH utilizes a "Modified Cash" method of accounting for revenues and expenses. There are not currently accounting systems in place to produce an accrual based financial statement.

Accounting processes are completed at each of the facilities. There is no centralized accounting system. Preparing a complete consolidated financial statement encompassing all five Homes would be a labor-intensive process and not easily accomplished.

The Strategic Plan of the MVH includes the goal of establishing a GAAP system of accounting by the year 2011.

Current Practice: Expense Recording

In the MVH the senior accounting supervisor / business office manager is responsible for financial reporting. Revenues and expenses are grouped according to the following categories:

- Revenue
- Operational Expenditures
- Personnel Expenditures

Revenue includes two (2) primary sources:

1. Maintenance fees are paid by the veteran. Each veteran has a determined cost of care liability. Each veteran's income and resources are utilized in determining the veteran's contribution towards his/her cost of care.

2. The Federal VA Per Diem is received for each veteran in the MVH system. This is paid by the Federal VA to the state system at an established per diem rate.

Expenses are coded as either personnel expenditures or operational expenditures.

- Personnel Expenditures are labor expenses coded to each department. Expense detail includes: full-time/part-time status, overtime, premium, and holiday pay.

- Operational Expenditures are non-labor expenses coded according to the MVH chart of accounts, i.e. MAPS Object Codes.

Financial reports are produced at the facility-level by each respective business office. There is no capability within the current structure and systems to easily produce a consolidated financial statement. Monthly financial reports include:

- Actual expenditures versus budget
- Projected expenditures versus budget
- Actual revenue versus budget
- Projected revenue versus budget
- Collections report
- Census variance report

These financial reports are primarily used to:

- Identify outstanding revenue accounts by comparing actual revenue to budget and actual census to budget
- Determine the need for mid-year budget adjustments

- Establish historical benchmark and comparisons between each of the homes

Industry Practice: Financial Accounting and Expense Reporting

The basic process of recording revenues and expenditures includes a detailed chart of accounts that includes revenue, expense, asset, and liability accounts as the basis for the General Ledger Accounting System. The Medicare and Medicaid systems typically require several different payers and as such the accounting system differentiates revenues by the individual payer types. Expenses are allocated in detail by department. The detail includes items such as: actual costs associated with productive time, actual costs associated with non-productive paid time, costs of all benefit items in detail by type, and ancillary resident expenses, i.e. therapy by discipline, oxygen, pharmaceuticals (both prescription and stock), etc.

Private sector skilled nursing homes that participate in either Medicare and/or Medicaid utilize an accrual basis of accounting using GAAP principles. Under this method, revenues are recorded as they are earned and expenditures recorded when they are realized. The complexity of the accounting for revenues and expenditures in Medicare and Medicaid skilled nursing facilities requires detailed software systems that are customized to appropriately record the items.

Revenue recording is a fairly complex task in Medicare and/or Medicaid participating nursing homes. In addition to the increase in the number of payors and revenue accounts, there are contractual allowances that will need to be tracked for all third party payors. An additional revenue account for each payor is indicated to account for the contractual allowance.

Typical skilled nursing home financial statements consist of a balance sheet, income statement and a statement of cash flow. Similar to the MVH, various reports are generated to monitor budget and other financial and operational indicators. Skilled nursing facilities typically employ a Controller or Chief Financial Officer whose responsibilities include overseeing the financial reporting systems and preparation of monthly financial statements as defined above. Typically, multi-facility organizations have centralized processes for financial statement preparation that is prepared at the corporate or central location. Financial reporting systems include the ability to produce financial

statements for each facility as well as a consolidated report encompassing all the homes under the corporate structure.

The Medicare and Medicaid Programs require each participating SNF to file a cost report annually, which is an accounting of the costs to operate the facility. The cost report guidelines require the participating SNF to record their costs in an accrual based accounting system. If a SNF operates on a cash basis or a modified cash basis, they are required to convert their financial data to an accrual basis at least annually when the cost reports are completed. Converting the data annually is neither a standard practice nor a recommended practice.

Medicare and Medicaid cost reporting is completed on an annual basis by experienced reimbursement specialists. The guidelines for completing the cost reports are detailed and specific. Revenue and expense allocations must be readily available and in the appropriate format to file an accurate accounting for these third party payors.

The accrual based accounting system method is preferred as it provides the basis to generate management reports that allow senior leadership to monitor operational and financial performance on a routine and consistent basis. An accrual-based system provides internal controls to ensure appropriate coding of expenses. Accounts receivable reconciliation is also more readily completed which affords initiation of timely collection processes.

Brief Summary of Gaps between Current Practice and Industry Practice:
Financial Accounting and Expense Reporting

- Industry standard is to operate with an accrual based system of accounting

- Medicare and Medicaid Conditions of Participation require an annual cost report to be filed

- Industry standard is to have the financial reporting and preparation of financial statements directed and overseen at the corporate level

- Industry standard is to produce a financial statement for each home, each level of care, and a consolidated statement with which to analyze operational performance

- Industry standard is to have systems to track all Medicare census days for proper revenue recording and recording of Medicare related expenses, i.e. supplies and services in sufficient detail

- Industry standard is to have systems to track all Medicaid census days for proper recording of Medicaid revenue

- Industry standard is to record all Medicaid related expenses in sufficient detail through the accounting process for billing and cost reporting purposes

- Industry standard is that personnel costs are allocated in detail by department, including the recording of each employee benefit expense

- Industry standard is that the ancillary costs billable under Medicare and/or Medicaid would be allocated in sufficient detail to prepare monthly billing invoices

b. Governmental and Third Party Billing

Current Practice:

The MVH bills two payer sources: private pay maintenance fees and the Federal VA Per Diem. Billing personnel in all five (5) Homes lack prior experience with either the Medicare or Medicaid programs.

There is no invoicing process for the monthly maintenance fee. The resident/family/responsible party is informed at the time of admission of the monthly maintenance fee costs. Payment is expected by the 10th of each month. If payment is not received on time, the collections process starts.

Billing for the monthly Federal VA Per Diem is completed at the end of each month. Each facility's census is verified and reconciled at month end. The Federal VA program is invoiced for the number of in-house veteran days multiplied by the Federal VA Per Diem rate.

Industry Practice:

Billing systems in Medicare and Medicaid participating facilities are quite complex. Monthly billing for services is completed for multiple payors, including: private pay, Medicare Part A, Medicare Part B, Medical Assistance, Managed Care Providers and other third party insurance carriers.

In addition to billing for room and board, all ancillary charges provided to the resident during the billing cycle are recorded in the billing system. This includes, but is not limited to, therapy, medical supplies, radiology and lab services, and any specialty equipment that may have been provided to the resident.
Both Medicare and Medicaid billings are required to be submitted electronically. Both programs have specific time frames and requirements that must be adhered to for successful collection for the amounts due.

On Day 21, Medicare Part A pays the RUG rate less the publicized annual co-insurance amount. The remaining co-insurance amount must be billed to the resident's third party insurance. After Medicare payments are received the facility then bills for any appropriate co-insurances due from third party payers. Medicare and third party payor billing requires on-going billing processes throughout each month.

Because of the nuances and complexities of Medicaid, Medicare, and Third Party Providers, SNF's typically have business office staff that is trained in the billing requirements for each of these payers. Depending on the size of the facility and the utilization of the third party programs, it is not unusual for a facility to have business office staff dedicated to billing of specific payers.

Brief Summary of Gaps between Current Practice and Industry Practice:

- Industry standard is that the accounts receivable/ billing function includes multiple payers per resident

- Industry practice is to track and record ancillary services that are necessary for billing Medicare and other third party insurance programs

- Medicare and Medicaid certified facilities are required to electronically bill
- Industry standard is to employ staff experienced in billing or to provide training on third party insurances

c. BUSINESS OFFICE POLICIES AND PROCEDURES

Current Practice:

The MVH has various policies and procedures governing admissions, calculations of maintenance fees, and collection of fees, which are appropriate for their current operations. The collection process is adequate for the revenue accounts now in place at the homes.

There are guidelines governing expense tracking that addresses the coding and recording of expenditures. There are, however, some inconsistencies between the five (5) VA Homes in coding and recording of expenses. The business office managers also identified these inconsistencies. Specific accounting and business office policies governing the operation of the business office in areas such as Accounts Payable, Payroll, Petty Cash, etc. were not identified.

Industry Practice:

Medicare and Medicaid participating facilities typically have policies and procedures that govern the required accounting procedures. Standard policies and procedures include accounts receivable collection policies, billing requirements, accounts payable transactions, payroll system management, petty cash management, and cost reporting procedures.

Brief Summary of Gaps between Current Practice and Industry Practice:

- Industry standard is to have policies and procedures for billing and collections

- Industry standard is that the accounts payable and general ledger has a chart of accounts with detail to meet Medicare and Medicaid cost reporting requirements

A. Business Office Computer Applications

As a best practice, Medicare and Medicaid certified nursing facilities utilize fully integrated software systems with centralized system capabilities for multi-facility organizations

The MVH currently use QuickBooks software to manage the accounts receivable/billing component of the facilities operations. QuickBooks is a very efficient system for small business accounting. Medicare and Medicaid certified facilities use a variety of different software packages that are customized to manage the financial operations of our industry. The nursing home industry and its myriad of reimbursement streams are quite complex and far too complicated to navigate utilizing a standard bookkeeping program. QuickBooks will not be able to meet the needs of the organization should they pursue either Medicare or Medicaid certification.

The MVH currently utilizes Momentum software to manage the clinical aspects, including an electronic medical record. The Momentum software system has an accounts receivable/ billing module and a general ledger package available and can be purchased additionally and easily incorporated into the MVH current systems should the homes pursue Medicaid or Medicare certification. The Momentum software system offers a full line of integrated software modules to accommodate the additional tasks and responsibilities associated with Medicare and Medicaid certification. The MVH would need to further evaluate the software options.

Technically, the necessary and appropriate software applications can be obtained either by upgrading the current Momentum software into a fully integrated system utilizing all necessary applications or by simply purchasing an accounts receivable/billing application and a general ledger program. The latter would require interface between the currently utilized applications and the accounts receivable/billing and general ledger. The advantages of a fully integrated system are the single point of data entry with automatic transfer of data into all the necessary locations and applications within the program.

This benefit reduces the margin of error in data entry due to eliminating the need to enter data into multiple places. Another benefit of a fully integrated system (that includes a general ledger) is the automatic population of the general ledger from the accounts receivable module. Without this integration, business office staff would need to maintain a separate general ledger or pursue interface between the general ledger and the accounts receivable/billing software modules.

Further evaluation of the software systems would need to be completed by the MVH senior leadership team should the decision be made to pursue Medicare and/or Medicaid certification.

A. Report Conclusions/Recommendations

The Minnesota Veterans Homes are currently evaluating their accounting and financial reporting systems as evidenced by their Strategic Plan 2008-2011. Shifting from a modified cash basis of accounting to an accrual basis of accounting was a pre-established goal of the organization regardless of the outcome surrounding Medicare/ Medicaid certification. This is an admirable goal that will benefit the MVH in providing an improved system of accounting and overall financial reporting. Under the current system, reports lack consistency between the Homes' in coding expenditures. In addition, the current accounting system is an open architecture, with no defined end to each accounting period. These two factors create difficulties in analyzing and comparing the Homes' key financial indicators. Likewise, these factors are creating challenges for Affinity in precisely determining operating costs. Transitioning the MVH to a financial cycle with a defined monthly close period in which revenues and expenses are recognized in the period in which they are incurred will give the organization accurate, timely and consistent financial data. This type of accounting and financial reporting assists an organization in financial management, planning, and compliance with effective internal controls.

Financial analysis and benchmarking are critical in today's economic climate. We believe adopting a general ledger account structure as used in typical Medicare or Medicaid certified facilities might be beneficial regardless of the ultimate decision regarding certification in either program. By reporting revenues and expenditures in a similar format as a typical nursing home, the

MVH could participate in a greater detailed analysis of their existing operations. There are many financial and operational indicators that regardless of Medicare/Medicaid participation are comparable across the industry.

When considering Medicare and/or Medicaid certification, attention to consistency, uniformity and detail amongst the five (5) homes becomes critical. Recommendations for consideration of Medicare and Medicaid certification would need to include the following:

- Evaluate implementation of a General Ledger account system similar to a Medicare/Medicaid certified nursing home
- Evaluate the necessary internal system changes that would appropriately identify employee benefit costs from payroll costs
- Implement internal systems that identify both costs and revenues separately at each level of care provided in Minneapolis and any new service lines the organization may choose to add including but not limited to adult day care
- Implement policies and procedures that direct the facilities accounting processes including defining monthly accounting periods and clarification of expense coding practices
- Establish guidelines that require contracted ancillary service providers to bill the appropriate third party insurance if applicable to include both Medicare Part B and Medicare Part D