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ManorCare

December 3, 2007

Hon. Kathy Angerer
Chair
Michigan Health Policy Committee
Michigan House of Representatives
S0989 House Office Building
P.O. Box 30014
Lansing, MI 48909-7514

Dear Chairwoman Angerer:

I sincerely appreciate the opportunity to offer written testimony on behalf of Manor Care. Our organization has a long and proud tradition of providing quality rehabilitation and health care services across the state of Michigan in 29 skilled nursing facilities, 5 assisted living facilities, 14 home care and hospice offices, and 6 outpatient rehabilitation centers. Our centers in Michigan are on the vanguard of our short-term, high-acuity care delivery model, and our company continues to view the state of Michigan as an ideal market in which to invest. Manor Care has opened two new state-of-the-art nursing centers over the past 24 months, and these facilities have generated over 200 new, high-paying jobs to the Michigan economy.

This testimony is intended to address the general concerns recently raised regarding private equity investment in the long-term care sector. As you are well aware, on September 23, 2007 the New York Times published an article that was highly critical of "private equity" investment in the nursing home sector. The focus of the investigation centered on nursing home purchases in the state of Florida. The investigation erroneously labeled these transactions as "private equity" transactions when in fact these transactions were largely conducted by Real Estate Investment Trusts or REITs. The Times article made several more assertions that are *not applicable* to the impending acquisition of Manor Care by The Carlyle Group, and the SEIU and other interest groups have used these assertions as the basis for acerbic and unfounded attacks against our employees and our collective reputation of excellence.

Below I have highlighted the major issues raised in the New York Times investigation and explained why the nuances of the Carlyle/Manor Care transaction are not consistent with the issues elevated in the article.

Separation of the Real Estate and Operating Entities

The New York Times article highlighted how Florida REITs have purchased nursing homes and retained the ownership and management of the real estate but leased the facility to a separate operating company. The SEIU has erroneously stated that Manor Care and Carlyle plan to implement the same practice in an effort to minimize transparency and limit liability. In fact, nothing could be further from the truth.

While there will be changes in the corporate structure post-transaction, Manor Care will continue to *own and manage both the operations and real estate of the company.* Responsibility and accountability will continue to lie with Manor Care.

More specifically, each operating company will be:

- An indirect, wholly owned subsidiary of Manor Care, Inc.
- Insured by Manor Care, Inc.'s general and professional liability coverage described below. Manor Care will be insured at the same level post-transaction as it is today.
- Managed by the same Manor Care leadership team currently in place.

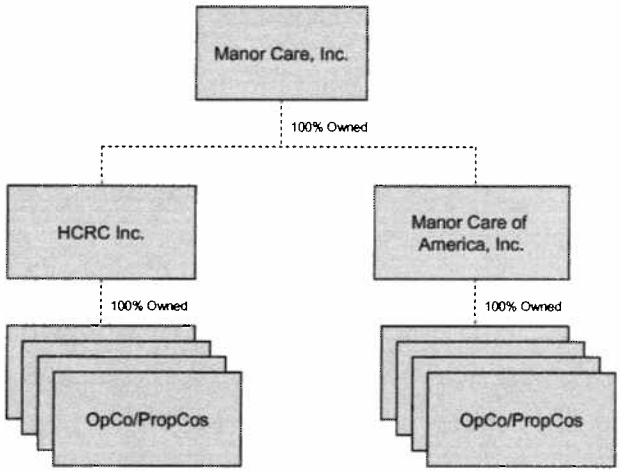
In order to finance the transaction, Manor Care has arranged financing secured by Manor Care's real property. Because the real estate financing is secured only by real estate, our lenders required that the real property be organized in newly formed limited liability entities tied to the specific mortgage for each of the lenders.

This structure in no way affects the day-to-day operations of the skilled nursing facilities. It is also not a shield against ultimate liability of Manor Care - all of the assets will still be owned 100% by the parent company, Manor Care, Inc.

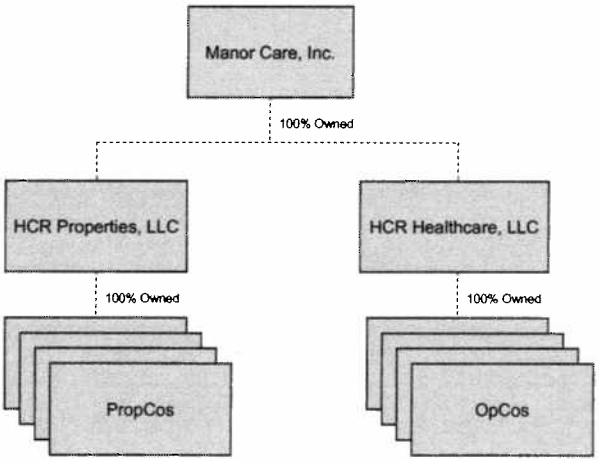
Manor Care shares your goals with respect to transparency, and has ensured that state regulators responsible for oversight of the industry have all essential information on our structure and ownership.

We also intend to continue to provide insurance coverage for private rights of action. Manor Care's current general and professional liability program consists of $125 million primary and excess insurance including a $5 million self-insured retention, as well as $100 million in property risk insurance provided by some of the largest and highest rated insurers and re-insurers in the marketplace. The current coverage will not be affected by the change of ownership and will continue in place after the closing of the transaction. I have provided you with a diagram of our current and future structures below.

Manor Care, Inc. Corporate Structure (Pre-Transaction)



Manor Care, Inc. Corporate Structure (Post-Transaction)



Again, Manor Care will own and be responsible for all of its operations and real estate.

Financial Strength of the Company

The New York Times article also stated that after the Florida REITs purchased these nursing homes the new debt associated with the purchase forced the operator to cut direct care staffing in an effort to cover high lease payments. The SEIU has asserted that the outcome of the Carlyle/Manor Care transaction will result in similar staff cuts and declines in quality of care.

Once again, the circumstances described in the article have no relevance to our transaction. After this transaction is completed, Manor Care will be the most financially solvent long-term care company in the United States. The Carlyle Group will be investing approximately $1.3 billion in equity in the company -- twice the level of equity that is on our balance sheet at the present time.

Our ability to service our increased debt results from the fact that we will no longer be making interest payments associated with prior debt, repayments of existing debt, share buybacks or quarterly dividends to our public shareholders. During the past five years, the amounts that the company has paid for these items (which will not occur in the future) approximate or exceed the new debt service obligations on an annual basis. Manor Care will be able to adequately fund our obligations and ensure continued quality care to our patients and families.

Manor Care's financial viability has been reviewed by an independent third party, Duff and Phelps, which has provided our Board of Directors an opinion attesting to the solvency and viability of the company subsequent to the transaction. Our Board of Directors has dutifully represented the interests of our shareholders and our company in ensuring that this arrangement with The Carlyle Group is in the best interests of all stakeholders, including our patients, families and employees, as well as our shareholders.

Quality of Care

Testimony at recent hearings in other states emphasized the New York Times assertion that quality of care at nursing homes acquired by private equity firms dramatically deteriorates. These findings have been put into serious question as a result of reports completed by both the Agency for Health Care Administration of the state of Florida and by the firm LTCQ, which is led by researchers from Harvard and Brown Universities and which specializes in data analysis of long-term care companies.

We urge the Subcommittee to thoroughly assess and validate the assertions of the New York Times. Private investment in the long-term care sector has been a critical factor in providing essential capital since 1940 and remains a vital element today, whether in the form of equity or debt. It is noteworthy that both of the studies referenced above indicate that there is no evidence to support that the quality of care suffers when a facility is owned by a private equity firm or an investment company.

In terms of our company, Manor Care is a leader in quality short-term post-acute services and long-term care. With more than 54 facilities in Michigan serving 3,700 patients daily, with nearly 10,000 caring employees, Manor Care was first in this state and industry to broadly measure patient care outcomes, with a continuing emphasis on meeting patient care goals. Our company has invested in clinical skills and technology to produce desired outcomes for patients who require more complex medical care and intensive rehabilitation, and does so in an environment that is more home-like than traditional providers (e.g., acute care hospitals). We provide high-acuity care to many of our patients, as well as chronic care services, and we do so in a cost-effective manner, ensuring that individuals receive care in the most appropriate setting.

Our principal mission is to have our patients use long-term care services as an interim step between the acute care setting and their primary residence. Our company discharges 150,000 patients a year from our skilled nursing facilities. We are very proud that nearly two-thirds of these individuals stay in our centers for less than 40 days and half less than 30 days. Our strong medical, nursing and rehabilitation programs facilitate a shorter-term use

of our centers, which enables us to provide more care to individuals throughout the United States. As part of our commitment to the best in care, we are expanding technology in our organization, increasing the use of physician and nurse extenders, broadening our information dissemination, improving the lives and involvement of our employees, and working to bring improved programs of care and services to our patients and their families.

Finally, regardless of the validity of the New York Times article, Manor Care's performance should be judged on its own merits – and, we are confident that this transaction positions us to continue and improve quality care for our patients and residents.

Management and Expertise

In previous testimony the SEIU has raised the concern that The Carlyle Group has no experience managing nursing homes and as a result the Health Department should deny approval of license transfer. The Carlyle Group believes that the best investment approach is to allow Manor Care to continue doing what it is already doing so successfully – delivering quality care -- and they intend to maintain the model that has shown proven results. Carlyle will not be involved in the management of Manor Care operations. The current management team at Manor Care will continue to operate the company, and there will be no staffing reductions within our caregiver ranks due to the investment. We felt it was important to assure our patients, families and employees that at no time have we considered, nor will we implement, a staffing reduction in our centers as a result of this transaction. To that end, we provided assurances in writing to them, copies of which are included with the accompanying materials.

The Manor Care Board will continue its Quality Committee and additionally appoint an independent and well-regarded committee of experts to advise the Quality Committee and Board on quality of care. And Manor Care will continue publishing its Annual Report on Quality, a copy of which is available to the public on our website.

Again, we want to reiterate that within our transaction we will have the same management, staffing, policies and procedures, and protocols and controls, as well as additional oversight within our Board of Directors. We take our participation in the overall health care system very seriously and are committed to quality measurement and initiatives that will continue to work to increase transparency for our patients, families and referral groups on the issue of quality.

Summary

Manor Care has provided exceptional and comprehensive health care services to millions of individuals over its history. We acknowledge and take seriously our responsibility to ensure that the care provided to our patients and families is consistent with all appropriate rules and regulations as well as all appropriate medical and clinical standards. We also believe that our structure, financial viability, governance and commitment to quality provide our patients and their families with the assurances that the Aging Committee and Michigan Department of Health ~~is~~ are seeking from financial sponsors and management professionals.

In closing, we are appreciative of this opportunity to provide additional information on the transaction between Manor Care and The Carlyle Group, and appreciate this opportunity to reaffirm our commitment to continue managing the company with the same dedication to quality care, staffing levels, employee benefits, capital investment and the caring culture that has made Manor Care the most uniquely successful and respected provider in our industry.

Please let us know if you have any questions or if we can elaborate further on any of these key points.

Sincerely,

Clifton J. Porter, II
Assistant Vice President
Government Relations

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAR 19 2002

The Honorable Charles Grassley
Ranking Minority Member
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Senator Grassley:

As required by the Omnibus Budget Reconciliation Act of 1990, a study was performed on the appropriateness of establishing minimum staffing ratios in nursing homes. The enclosed study reflects the conclusions of Abt Associates, Inc., which prepared the work under a contractual relationship begun by the previous administration in 1998.

This Phase II study was designed to respond to the current public concern about inadequate nursing home staffing and a long-standing requirement for a study and report to Congress on the "appropriateness" of establishing minimum nurse staffing ratios in nursing homes. As you know, the Phase I report was delivered to Congress in July 2000.

The question of the relationship between the number of staff and quality of care is complex and the Phase I and Phase II studies made good faith efforts at addressing the question. However, the Department has concluded that these studies are insufficient for determining the appropriateness of staffing ratios in a number of respects. Specifically, we have serious reservations about the reliability of staffing data at the nursing home level and with the feasibility of establishing staff ratios to improve quality given the variety of quality measures used and the perpetual shifting of such measures.

In addition, the studies do not fully address important related issues such as:

- the relative importance of other factors, such as management, tenure, and training of staff, in determining nursing home quality;
- the reality of current nursing shortages; and
- other operational details such as the difference between new nurses and experienced nurses, staff mix, retention and turnover rates, staff organization, etc.

For these reasons and others, it would be improper to conclude that the staffing thresholds described in this Phase II study should be used as staffing standards. Most important, the Phase I and Phase II studies do not provide enough information to address the question posed by Congress regarding the appropriateness of establishing minimum ratios. We will continue to work to address critical knowledge gaps. For example, one project that we are currently funding will develop a method to more accurately collect nurse-staffing information.

Apart from this report, the Department has taken and continues to take several important actions toward fulfilling this Administration's commitment to achieving high-quality nursing home care and providing reliable, understandable information to the public. Last November, we announced an initiative that will help Medicare and Medicaid beneficiaries find those nursing homes that consistently provide high-quality care using risk-adjusted, valid quality measures. Under the initiative, CMS is developing reliable, straightforward information on the quality of nursing homes, to help beneficiaries find the best facility for their needs. In order to accomplish this, CMS is conducting a pilot program in six states using Quality Improvement Organizations (QIOs), formerly known as Peer Review Organizations, to help disseminate and publish this information. The six states in the pilot program are Colorado, Florida, Maryland, Ohio, Rhode Island, and Washington. Following successful implementation of the pilot project, CMS will refine and expand the initiative to provide risk-adjusted quality information for nursing homes in every state. Importantly, the QIOs will work with the nursing home industry on quality improvement efforts based on the publicly reported measures and will actively help people to better use quality information.

While we implement this nursing home quality initiative, CMS will continue to move forward with our Nursing Home Oversight Improvement Program. This program is a multi-pronged approach designed to improve our oversight of nursing homes and to build consistency and accountability into the survey and certification process. The Nursing Home Data Compendium for 2000 that we recently forwarded to Congress is a direct result of this initiative. This report, the first comprehensive aggregation of individual-level data will serve as a valuable resource for policy makers concerned with nursing home care.

I look forward to working closely with you as we strive to improve nursing home quality in America. I am also sending a copy of this report to other Congressional leaders.

Sincerely,

Tommy G. Thompson

Enclosures

THE CARLYLE GROUP ManorCare®

CARLYLE'S INVESTMENT WILL BUILD ON MANOR CARE'S DELIVERY OF QUALITY CARE

The Carlyle Group, a global private equity firm based in Washington, D.C., and Manor Care Inc., a leading provider of post-acute services and long-term care, have agreed to an investment in Manor Care that will enhance Manor Care's capabilities to provide the quality care that has made it so successful. The proposed investment – valued at approximately $6.3 billion – was announced on July 2, 2007 and was approved by shareholders in a nearly unanimous vote on October 17, 2007. Completion of the investment is expected in November 2007.

MANOR CARE IS A LEADER IN QUALITY CARE

- With more than 500 facilities in 32 states, and facilities spanning a care continuum – skilled nursing and rehabilitation centers, assisted living facilities, outpatient rehabilitation clinics, and hospice and home care agencies – Manor Care was first in the industry to broadly measure care outcomes, with a continuing emphasis on meeting patients' care goals.

- Manor Care has invested in clinical skills and technology to care for patients who require more complex medical care and intensive rehabilitation. By doing so, Manor Care delivers equivalent or superior outcomes compared to rehabilitation in more expensive settings. Manor Care also provides an environment that is more home-like than traditional providers (e.g., acute care hospitals), and at a lower cost to federal, state, and private payors.

- Patient improvement rates consistently exceed national averages for more costly care settings. Manor Care performs better than comparable skilled nursing facilities and rehabilitation hospitals in improving patients' mobility and patients' ability to care for themselves.

- Manor Care assembles multi-disciplinary teams tailored to patient needs. These teams draw on a range of professionals, from a medical director, RNs, and LPNs to certified nursing assistants and physical, occupational, and speech therapists.

- Manor Care's satisfaction scores from patients and family members consistently reflect the quality of care:

- ✓ More than 85% rated nursing care as "excellent or good" in 2006, and more than 80% rated rehabilitation care as "excellent or good".
- ✓ Patient satisfaction levels rank within the top third of providers in the Alliance for Nursing Home Quality Care.

- ► Manor Care has a strong record of regulatory compliance. Since 2003, Manor Care's compliance with nearly 200 federal health regulations has been more than 96%, with identified deficiencies addressed routinely.

MANOR CARE IS COMMITTED TO ITS EMPLOYEES

- ► Manor Care respects and values its 60,000 employees.
- ► Manor Care's staffing levels exceed requirements in each of the 32 states where Manor Care operates.
- ► For 20 years, Manor Care has provided comprehensive training for each of its employees through its unique and proprietary Circle of Care program.
- ► Manor Care attracts well-qualified home office and field personnel, including 450 medical directors, 240 RNs, and 76 nurse practitioners, to provide assistance, training and clinical oversight for Manor Care's facility-based staff. This breadth and depth of support is unmatched by any other long-term care organization.
- ► Manor Care Education Assistance programs have helped more than 10% of current LPNs advance from their positions as CNAs, and more than 10% of current RNs advance from their positions as LPNs. Employees from more than 100 of Manor Care's facilities participate in the company's Nurse/Therapist Scholarship Program to advance their professional credentials.
- ► All full-time employees and their eligible dependents are offered a full array of employee benefits, including health care with fully paid preventative care; prescription drug program; dental care; vision care; life insurance; disability coverage; employee assistance plan; retirement and savings plan; adoption assistance plan; and education assistance plan.

CARLYLE INTENDS TO BUILD ON MANOR CARE'S STRONG RECORD

- ► On October 22, 2007, The Carlyle Group and Manor Care announced a "Patients First" pledge, which articulates its commitment to five key operating principles:
  - ✓ Quality health care services for our patients and residents.
  - ✓ Education and training to help ensure our professional staff and frontline caregivers have the tools to meet the needs of our patients and residents.

- ✓ A primary focus on providing care for patients who require complex medical care and intensive rehabilitation; those whom other providers must often turn away.
- ✓ Staffing based on our patients' clinical needs, many of whom are higher-acuity, while striving to exceed all federal and state requirements.
- ✓ Capital investment that helps ensure Manor Care's facilities continue to be well-maintained, attractive structures, as well as state-of-the-art in their rehabilitation capabilities, clinical technology and record-keeping.

- ► The Carlyle Group believes that the best investment approach is to allow Manor Care to continue doing what it is already doing so successfully – delivering quality care. Carlyle intends to maintain the model that has shown proven results.
- ► Manor Care operates less than 3% of the industry's facilities in a highly competitive environment. Its success will depend on its ability to deliver quality care to patients and residents.
- ► The current management team at Manor Care will continue to operate the company, and there will be no staffing reductions due to the investment.
- ► Manor Care's emphasis on quality will be maintained and reaffirmed. Under Carlyle ownership, the Manor Care Board will continue its Quality Committee and appoint an independent and well-regarded committee of experts to advise the Quality Committee and Board on quality of care. Manor Care will continue publishing its Annual Report on Quality.
- ► Manor Care will receive strong financial backing from this investment. This strong financial position will enable Manor Care to execute its strategy, which Carlyle supports. The strategy includes sustaining and enhancing staffing levels; providing training for nurses and care givers; and investing at least $100 million every year in renovations, expansions, and improvements at care centers, including expanded therapy space, clinical programs, new equipment, and information technology.
- ► Manor Care will continue to own and operate the assets. The company is not spinning off its real estate assets or selling them to a Real Estate Investment Trust (REIT). Manor Care will retain full accountability and liability, with adequate insurance coverage, for all operations.

THIS INVESTMENT MUST BE EVALUATED ON ITS OWN TERMS

- ► Carlyle is a unique investor with an emphasis on creating value. Carlyle's investment philosophy is distinct from other entities that have invested in this sector.
- ► Manor Care is a unique company with a long track record of industry leadership and enters this proposed transaction poised to continue its strong performance.

HCR Manor Care
A Record of Quality in Michigan

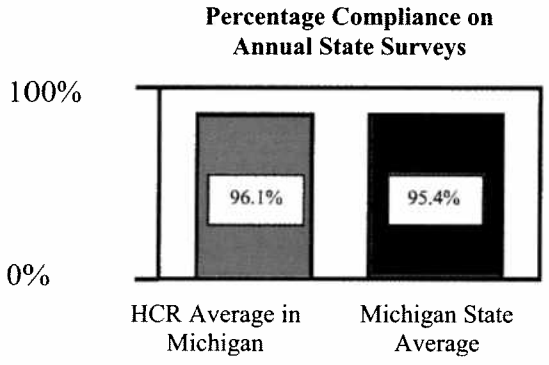
ManorCare

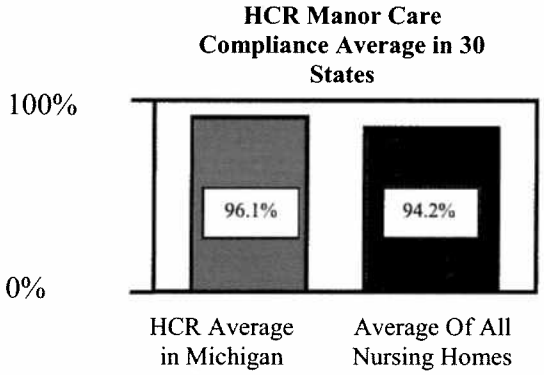
Who We Are

- HCR Manor Care is a leading provider of health care in the long-term care and post-acute services areas.
- We are also a provider whose care model is emulated in the industry, which has translated into a quality record that speaks for itself, in Michigan and across the country.

Our Record in Michigan

- A record of compliance with federal regulations that is above both the average in Michigan and across the country (see charts below*).
- In Michigan, our number of deficiencies for the latest 12-month period have declined 32% from the previous 12-month period, and are 15% below the state average for the most-recent 12-month period.
- In 2007, 78% of patients and families surveyed across the state rated our service as good or excellent. Based on their experience, 76% said they would recommend our services.
- Staffing for each of our nursing centers in Michigan exceeds the state-mandated requirement and exceeds federal requirements by the Centers for Medicare & Medicaid Services, the federal regulatory agency for skilled nursing homes.





A Leader in Quality

- HCR Manor Care was the first major provider in the long-term care industry to comprehensively measure its health care outcomes, providing a valuable tool to patients on the care they can expect upon admission.
  - Over 90% of our patients and families upon discharge report they are prepared to manage their care needs, compared with only 3% upon admission.
- The HCR Manor Care model has consistently achieved two critical benefits -- quality care for patients with complex medical and intensive rehabilitation needs and care that comes at a lower cost than acute care or rehabilitation hospitals.

Striving to provide quality care in all we do.
That's our commitment. That's our promise.

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* *Data used to determine compliance rates was compiled from the Centers for Medicare & Medicaid Services' databases by Team TSI, a quality analytics consultancy, for the period Oct. '06 through Sept. '07. Government Surveys are used to identify deficiencies.*

LTCQ

Acquisition of Nursing Home Chains by Private Investment Groups
Abbreviated Analysis of the New York Times Article
November 6, 2007

LTCQ, Inc. was founded in 1992 as a data-driven consulting company by four leading academic experts in the field of long-term care: Barry Fogel, MD, Lewis Lipsitz, MD, Vincent Mor, PhD, and John Morris, Ph.D. Dr. Mor, Chair of the Department of Community Health at Brown University, and Dr. Morris, a senior researcher at Boston's Hebrew Rehabilitation Center for Aged Drs. Fogel and Lipsitz are both geriatricians and professors at Harvard Medical School. LTCQ is the industry leader in providing data driven business intelligence to the long term care industry, serving more than 1,600 facilities nationwide. We are privately held and have 40 employees including clinical teams of advanced practice nurses and nursing home administrators, master's and Ph.D.-level researchers and technologists, and a highly-skilled executive team.

The New York Times (NYT) article of 9/23/2007 on the acquisition of nursing home chains by private equity (PE) investors has evoked great concern among families, advocates and politicians nationwide. However, the article is based on the application of problematic analytic techniques to problematic data. LTCQ offers the following observations, based on our long experience in analyzing public data on nursing homes, and chain-by-chain analyses of public data on over 800 of the 1,200 PE-owned facilities referenced in the NYT article – those for which we had accurate knowledge of the dates the PE firms acquired the properties. We could not analyze data on the full set of 1,200 facilities, as the NYT did not disclose their identity, but doubt the results would be materially different.

1) **Undisclosed expertise of those analyzing complex datasets.** The author reports on the analysis of complex datasets with many data quality issues and pitfalls for novice analysts. Just the data management necessary to create analyzable datasets can be daunting. He does not disclose whether he performed the analysis himself, or whether he relied on others to prepare the data and analyze them. Thus,it is not possible to evaluate whether the analysts were qualified to do a proper analysis of the data – or whether he relied on individuals with a declared bias against for-profit chain ownership of nursing homes.

    a. **Example of likely invalid data sampling.** Facilities are surveyed approximately annually, but they may not have a regular survey in any given year. For example, in calculating a summary statistic for a group of facilities in 2002 one must rely on data from surveys conducted in 2001 for over 25% of facilities. If an analyst uses such data to describe changes in a facility acquired at the beginning of 2002 a significant amount of *pre*-acquisition data will actually be used. The author did not say how he dealt with this issue.

2) **Questionable alignment of time periods**. The article reports on changes between 2000 and 2006 in staffing and survey performance. The author probably compared 2000 data with 2006 data, though acquisitions of facilities by PE took place on a range of dates within that period, right up to its end in 2006. If this is what he did, many of the changes observed

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may have taken place *prior* to the acquisition of the facility. LTCQ knows this to be the case with staffing at one major chain that was acquired in 2002. This chain had a drop in RN staffing from 2000 to 2001, but then actually *increased* staffing after PE acquired the facility. The drop from 2000 to 2006 was totally explained by events occurring before the acquisition. Many facilities reduced staffing between 1999 and 2001 because of major changes in Medicare reimbursement that adversely affected their revenue.

3) **Licensed staff counts excluded LPN.** The author focuses exclusively on RN staffing, while the industry in general – including non-profits and owner-operated facilities – has relatively more LPNs than RNs in its pool of licensed nursing staff. Looking at *total licensed* staff tells a different story than just looking at RNs. In fact, the facilities studied by LTCQ generally increased their LPN and total licensed staff ratios over the years after they were acquired by PE firms.

4) **Reliance on OSCAR staffing data is limiting.** The article drew its staffing data from OSCAR data, not payroll records or staff schedules. OSCAR staffing data are based by sampling staff hours over a two-week period; the data are collected using a complex and difficult-to-understand form that usually is completed by facility staff who often have no connection to the payroll or scheduling processes. Even when the hours they report are accurate they are not necessarily representative of year-round staffing. Examination of the raw staffing data from OSCAR shows improbable values for staff ratios, such as >10 hours per resident per day, or less than 1 hour per resident per day of total staff time. Because the form collects data over a two-week period, a common mistake is for facilities to report hours over a one-week period, leading to a reported staff ratio one-half of those that actually exist.

   The OSCAR staffing data do not take into account any qualitative aspects of staffing, such as staff experience, turnover rates, and the use of contract (agency) staff. Most long-term care experts would agree that an experienced staff with a low turnover rate may provide better care than one with somewhat more staff hours due to heavy use of agency staff and relatively inexperienced nurses. Finally, the total staffing of nursing homes includes physical and occupational therapists, physician extenders, medication aides, and other ancillary personnel. In facilities with a high rehabilitation and/or sub-acute care population these staff play a major role, and may decrease the number of nursing hours needed for optimal care.

5) **Comparisons drawn to national staff ratios ignore state and local influencers.** The author compares staff ratios with *national averages*. Using *national* data neglects differences in state regulations and local labor markets. Using *averages* amplifies the effect of outliers such as hospital-based sub-acute facilities with very high numbers of registered nurses. It also amplifies the effect of data errors. In any case, the distribution of hours is not (statistically) normal. For these reasons, the majority of *all* nursing homes in the US are *below the national average*. The use of *geographically-adjusted benchmarks*, a more appropriate analysis, mitigates much of the difference between PE-owned facilities and others.

6) **Comparisons drawn to national survey performance ignores well documented regional variations.** The author notes that serious deficiency citations rose at PE-owned

facilities, "even as citations declined at many other homes and chains". It is also true that citations increased at many other homes and chains *not* owned by PE firms. The author compared deficiency counts of "typical" PE-owned facilities (not specifying where he was reporting on a mean, median, or mode) with the *national average* number of deficiencies. It is well-known, and acknowledged by CMS itself, that there are large differences from state to state, and within some large states, in the rigor with which surveyors apply regulations. Since the geographic distribution of PE-owned facilities is not uniform, it is inappropriate to use a national average as a benchmark. Many PE-owned facilities are located in states and survey districts where the average number of deficiency citations received by all facilities is greater than the average number received nationally. PE-owned facilities are disproportionately located in such areas. When geographically adjusted benchmarks are applied, it is no longer true that the number of serious deficiencies is 19 percent higher at PE-owned facilities.

7) **Complaints typically rise after change in ownership, regardless of new owner.** LTCQ found that complaint allegations and complaint survey deficiencies tend to rise significantly in the year or two following a change in ownership. After that time, the level begins to fall to pre-acquisition levels. Certain effects attributed by the author to PE ownership may actually be due to the disruptive effects of a change in ownership and management, a phenomenon described in peer-reviewed journals on nursing home quality as applicable to ownership changes not involving PE firms. If a snapshot of a facility's performance is taken during the transition period it will look worse than it did before the acquisition or three years after it. If the author had used a baseline during the peak in complaints and a follow-up three years later he would have found improvement under PE ownership.

8) **Clinical management cannot be measured by unadjusted CMS Quality Measures.** The author points out that nursing homes owned by PE firms had worse scores on 12 of 14 publicly-reported quality measures (QMs). These measures have acknowledged limitations, particularly in the area of pressure ulcers, where they do not distinguish between pressure ulcers present on admission and those acquired in the facility, and do not credit facilities for decreasing the number, size, and stage of a resident's pressure ulcers. The QM for pressure ulcers is all-or-nothing. Facilities that specialize in wound care and admit many residents with advanced or multiple pressure ulcers will always look bad on such measures. By contrast, OSCAR has information on the percentage of residents in a facility with pressure ulcers that were *acquired after admission.* Many facilities owned by PE firms have reduced the rate of such ulcers.

    a. **Further example of Quality Measure limitations.** Facilities that treat greater numbers of more medically acute or complex and/or functionally impaired residents will look worse on QMs, because they are not fully adjusted for residents' baseline condition or baseline risk of adverse outcomes. In general, the chains purchased by PE firms served a relatively high number of residents on Medicare and Medicaid as opposed to private pay. Private pay residents tend to be healthier than Medicare and Medicaid residents, so facilities with high private pay proportions would look better on many of the QMs even if the quality of care was the same.

An unequivocal conclusion of LTCQ's study of over 800 PE-owned facilities is that ownership by a PE firm and operation by a different organization is compatible with the highest quality of care. Problems with care quality that do exist at some facilities owned by PE groups relate to the operations of the specific facility and not to ownership arrangements as such.

Long Term Care Review:

Florida Nursing Homes Regulation, Quality, Ownership, and Reimbursement

Prepared by the Florida Agency for Health Care Administration

October 2007

Long Term Care Review:
Florida Nursing Homes
Regulation, Quality, Ownership, and Reimbursement

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Overview

Recent headlines have questioned the appropriateness of nursing home ownership by investment firms, focusing on concerns of possible cost shaving that affect nursing home residents' care and limitation of liability for potential resident harm. Six years after implementing significant regulatory reform in Florida, this report reviews nursing home issues including regulatory requirements, reimbursement, quality, and ownership. The scope of this review is limited to the areas of authority for state licensure and Medicaid participation, but provides insight to the current regulatory oversight of Florida nursing homes and examines potential recommendations for change.

Nursing homes provide long term and sub-acute care to persons in need of 24-hour nursing services or significant supportive services. The quality of care and quality of life for residents of nursing homes have been a concern for decades. Nursing home residents are generally frail, physically and psychosocially compromised, heavily dependent upon others for basic care and sustenance, and in some cases near the end of their lives. When residents live in an environment where they are totally dependent on others, they are especially vulnerable to abuse, neglect and exploitation. Nursing home licensees must protect these vulnerable persons and are expected to provide the necessary care and services to allow each resident to achieve and maintain his or her highest possible level of function and well being.

Nursing homes must be licensed in accordance with state regulations to operate in Florida. To qualify for acceptance of Medicare or Medicaid reimbursement they must also be certified in accordance with federal regulations. Medicaid is the primary payer of nursing home care in Florida, paying for 61% of total nursing home patient days. Medicare pays for 19% of nursing home patient days and the remaining 20% is paid for through private sources such as insurance or residents' personal funds. At 80% government funding, nursing homes are heavily subsidized and dependent upon state and federal funds for operation.

At 80% government funding, nursing homes are heavily subsidized and dependent upon state and federal funds for operation.

Of the 673 nursing homes licensed in Florida, 645 are certified to accept Medicaid and Medicare, 21 are certified for Medicare but not Medicaid, six accept only private pay or private insurance (not certified for Medicare or Medicaid), and one is inactive. If a nursing home is certified to accept Medicare or Medicaid, it is considered to be "federally certified".

Regulatory Oversight

Nursing home regulation has evolved over the past 20 years at both the state and federal levels. The Agency regulates nursing homes for state licensure and acts as an agent under contract with the Centers for Medicare and Medicaid Services (CMS) for nursing home certification. A significant amount of the Agency's regulatory resources are devoted to the inspection and monitoring of the state's 673 nursing homes.

Nursing home regulation has evolved over the past 20 years to become the most stringent of any health care provider regulation at both state and federal levels.

Federal Standards

The regulatory approach to quality of care and quality of life in nursing homes is primarily based upon federal authority for nursing home certification which includes:

- Resident rights
- Protection of residents from abuse, neglect and exploitation
- Quality of life that enhances resident dignity, honors resident preferences, and provides activities in accordance with individualized plans of care
- Maintenance of a clean and safe, homelike environment that is comfortable

- Resident assessments and plans of care that contain measurable objectives to meet the residents' needs
- Quality of care and services to help each resident attain or maintain the highest practicable, physical, mental and psychosocial well-being
- Nursing services including sufficient nursing staff to provide nursing and related services
- Dietary services that provide a nourishing, palatable, well-balanced diet that meets each resident's needs
- Physician services that allow for review of each resident's total program of care including medications and treatments
- Specialized services and dental services
- Infection control designed to provide a safe, sanitary and comfortable environment
- Administration that enables effective and efficient use of resources to comply with state, local, federal laws and professional standards

Florida Standards

In addition to federal standards, significant Florida-specific nursing home regulatory reforms have been implemented over the past ten years, including:

- Increased staffing requirements for direct care nursing staff, which are among the highest requirements in the nation
- Creation of the Nursing Home Guide and Watch List to provide information about how to choose a nursing home and display regulatory histories of facilities
- Creation of the Nursing Home Gold Seal award to recognize excellence in long term care
- Mandatory background screening of nursing home staff
- Quality of Care nurse monitors who visit each nursing home quarterly
- Required risk management programs with adverse incident reporting
- Enhanced sanctions for failure to meet minimum standards including mandatory fines, conditional licenses and more frequent inspections for significant deficiencies
- Funding of quality of care and quality of life improvement agreements allowing many facilities to implement programs that directly improve the lives of their residents

A complete list of Florida statutory reforms is available in ***Appendix A***.

Nursing Home Inspections

Agency surveyors conduct routine, unannounced licensure and certification inspections, and investigate complaints of regulatory violations. In Florida, nursing homes are also monitored quarterly by registered nurse monitors employed by the Agency (refer to page 8). Agency staff that inspect nursing homes must meet specific qualifications including a federal Surveyor Minimum Qualification Test (SMQT) and participate in annual continuing education. Each federally certified nursing home must complete a standardized assessment of each resident (Minimum Data Set – MDS) at the time of the resident's admission, whenever a significant change in condition occurs, and each calendar quarter. The MDS is used to identify resident conditions and produce Quality Indicators for each nursing home. Quality Indicators are used during inspections and monitoring visits to target areas of potential concern. For example, if a resident is considered "low-risk" for the development of pressure sores, but develops a pressure sore while in the nursing home, the care would be reviewed as a potential concern. In preparation for an inspection, surveyors review past inspections, deficiencies, complaints, and adverse incidents. On average, each nursing home receives a full licensure and certification inspection annually, although there is flexibility to inspect facilities between six and 15 months depending upon their compliance history. The Agency also conducts inspections in response to complaints received from consumers, the public, or other state or government entities. During fiscal year July 1, 2006 through June 30, 2007, the Agency received 7,547 total complaints with 2,268 of those specific to nursing homes. On average, less than 25% of nursing home complaints resulted in deficiencies after investigation.

Surveyors document deficiencies or violations in a Statement of Deficiencies sent to the licensee who must respond with a Plan of Correction. Federal deficiencies are documented with a "severity and scope" to represent the seriousness of the violation in terms of risk to residents. The most serious federal deficiencies are classified as "Immediate Jeopardy" to resident health, safety or welfare and can result in expedited and immediate sanctions including an expedited termination from Medicare and Medicaid. State deficiencies are documented with a classification and scope to represent the severity of risk to residents on a scale of I to IV, Class I being most serious and Class IV being minor with no concern of resident risk. Most state deficiencies correspond to federal violations, although state-only violations can also be cited. State and federal sanctions may be imposed for the same underlying violations. See ***Appendix B*** for matrix and definitions of state and federal classifications.

Quality Indicator Survey Process

Florida is one of six states piloting the new federal Quality Indicator Survey (QIS) process. The QIS is a revised long-term care survey process developed for the Centers for Medicare and Medicaid Services (CMS) through a multiyear contract. The QIS process utilizes customized software to guide inspectors through a structured investigation.

The QIS was designed to achieve several objectives:

- Improve consistency and accuracy of the survey process
- Systematize the survey process so that it is more comprehensive
- Enhance documentation by organizing survey findings through automation
- Focus survey resources on facilities with the largest number of quality concerns

The demonstration and evaluation of the QIS is being conducted in six states; California, Connecticut, Kansas, Louisiana, Ohio and Florida. Florida was specifically selected as the first state to pilot the implementation of this process on a statewide basis, to test the training and implementation strategies on a larger scale. Initial survey outcomes using the QIS process demonstrate an increased focus on resident assessment and care planning activities.

The federal regulations for nursing homes have not changed, but this more structured process improves the uniformity of inspections and enhances the use of facility-specific quality indicators to target areas of concern.

Current versus Past Non-Compliance

During an inspection, surveyors evaluate a nursing home for current non-compliance. If a violation existed prior to the inspection and the nursing home licensee has fully corrected the issue before the Agency's visit, violations will generally not be cited. There are exceptions for federal violations considered egregious (result in serious and immediate threat or harm), and for failure of a nursing home to self-impose a moratorium when it fails to meet required state minimum staffing ratios for two consecutive days.

Informal Dispute Resolution

Certain federal deficiencies may be challenged through the Informal Dispute Resolution (IDR) process administered by the Agency, which is generally complete within 30 days of an inspection. If deficiencies are mitigated by the IDR, revisions are considered for both state and federal deficiencies. For this reason, non-emergency sanctions are generally not imposed until after the IDR process is complete.

Trends in Deficiencies

Overall significant reduction of the most serious deficiencies has occurred since the 1990s as shown in the chart below. The chart displays federal deficiencies classified as "Actual Harm" or "Immediate Jeopardy" (G level or higher, refer to ***Appendix B***) for each fiscal year (July 1 – June 30).

***Exhibit 1*: Total Serious Deficiencies Cited By Fiscal Year**

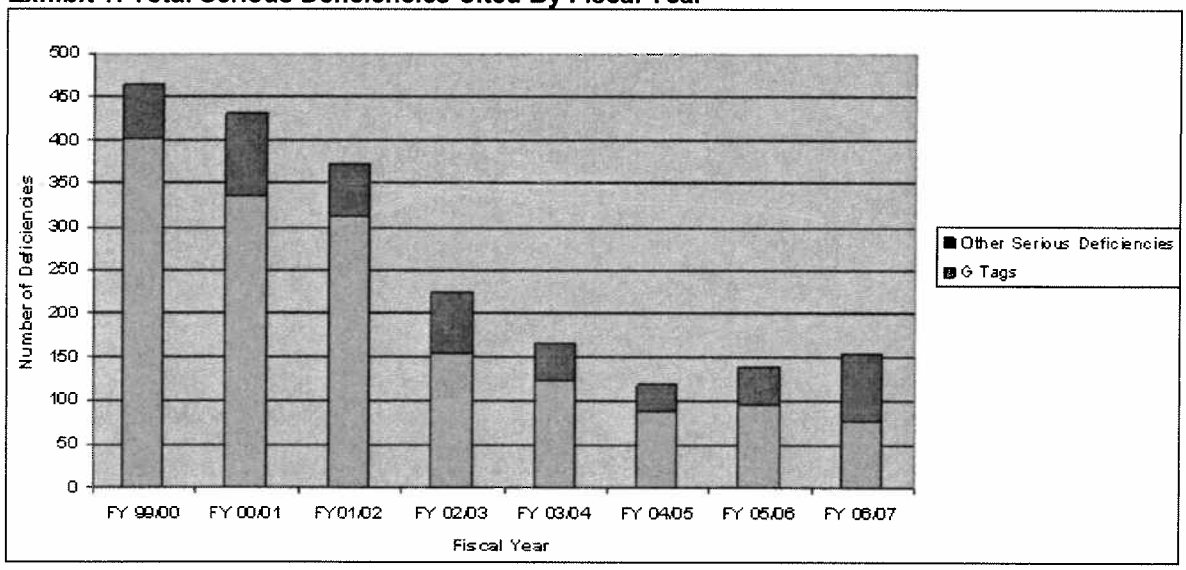
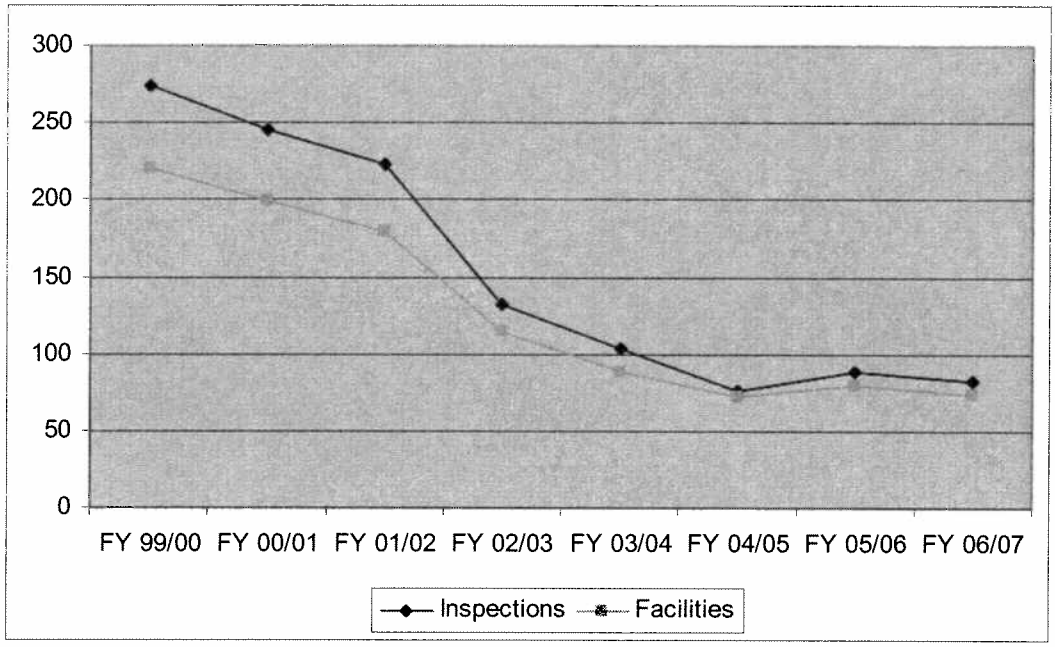


Exhibit 2 shows the number of inspections and nursing homes where serious deficiencies were cited for each fiscal year, indicating a significant decline since 99/00. Although there has been some increase in the serious deficiencies over the past two years, the number of nursing homes cited remains relatively low. The Agency has emphasized citation of all related regulations when deficiencies are found which may be attributing to the increased number of serious deficiencies.

***Exhibit 2*: Total Nursing Homes and Inspections with Citations for Serious Deficiencies**



Other Government Nursing Home Oversight

In addition to the regulatory oversight of licensure and Medicare/Medicaid certification, several other government organizations are involved in nursing home reviews. In Florida each nursing home must display a poster that provides information to residents and their families about how to contact related organizations if they have concerns about the nursing home. Related agencies include:

- State Long Term Care Ombudsman – The Ombudsman Program administered through the Department of Elder Affairs engages volunteer resident advocates to assist residents and families in dialogue with representatives of long term care facilities.
- Adult Protective Services – The Department of Children and Families investigates complaints of abuse, neglect or exploitation of vulnerable persons including those who live in long term care facilities.
- Medicaid Fraud Control Unit – The Attorney General's Office (AG) investigates allegations of Medicaid fraud. Under the PANE Project, (Patient Abuse, Neglect and Exploitation), AG staff may also investigate abusive situations in long term care facilities.
- Advocacy Center for Persons with Disabilities – The Advocacy Center is available to assist with concerns of discrimination or failure to accommodate residents' needs in long term care facilities.
- Statewide Human Rights Advocacy Committee – The Committee may investigate resident rights violations for persons with disabilities or mental illness in long term care facilities.

Nursing Home Enforcement

There are prescribed methods of imposing sanctions against a nursing home licensee who violates state or federal regulatory requirements. Serious or uncorrected violations are subject to progressive sanctions based upon the severity and scope of violations and can escalate to termination from Medicare/Medicaid and/or license revocation if warranted. Both federal and state sanctions may be imposed against nursing homes.

Federal Enforcement

The federal enforcement process generally provides more flexibility and greater impact than state nursing home enforcement. Federal sanctions are not imposed until the Informal Dispute Resolution process is complete. Federal sanctions include:

- Civil Monetary Penalties (CMP) – fines that are generally imposed for each day of non-compliance or per incident. Fines range from $50 to $10,000 per day or incident and can escalate for extended periods of non-compliance. Nursing home licensees that do not contest the CMP may receive a 35% discount if payment is made within 60 days. In 2006, $786,461 in federal CMPs were paid by 35 Florida nursing homes. Excluding one significant outlier, the average CMP per nursing home was $10,487.

- Denial of Payment for New Admissions (DPNA) – places a prohibition on the payment for nursing home stays for newly admitted Medicare or Medicaid residents. This sanction is generally imposed immediately when a serious (Immediate Jeopardy) deficiency exists, when a provider fails to achieve full compliance after a follow up visit, or when there is a history of serious deficiencies or recurrent problems exist. Once imposed, the DPNA remains in effect until the provider is found in full compliance.

- Termination – All providers are subject to termination from Medicare or Medicaid if they fail to correct all deficiencies and achieve full compliance in 180 days, however, an expedited termination period may be established for the most serious violations. This is the most serious federal nursing home sanction and few nursing home terminations occur.

- Special Focus Facility Designation – Although not a "sanction", state survey agencies assist CMS in identifying a small number of nursing homes that receive more frequent inspections (average every six months) due to their regulatory history. A nursing home remains a special focus facility until compliance can be sustained for a period of time. There are currently six Special Focus Facilities in Florida.

Standard of Proof for Federal Sanctions – If a provider challenges a federal sanction case, the burden of proof lies with the provider to show substantial compliance with the cited provision of law.

State Enforcement

- Fines – Florida Statutes provide specific fines for deficiencies based upon their classification and scope. Fines are doubled for recurrent problems. Fines are generally imposed per deficiency and range from $1,000 to $30,000 per violation. Fines may be challenged and payment is required only after a Final Order is entered by the Agency Legal Clerk.

- Conditional License and Watch List – When a nursing home is cited for Class I, Class II or uncorrected Class III violations, a conditional license is issued until the licensee is in full compliance. The intent of the conditional license is to alert residents and the public of the non-compliance at a nursing home. However, since a conditional license is considered a sanction, licenses are not issued until a legal charging document is drafted. It is not unusual that a nursing home has corrected the deficiencies and eliminated the grounds for the conditional status prior to issuance of the conditional license. Although expedited correction of violations is the goal, the conditional license seldom serves its intended purpose as notice of existing concern. There is an opportunity to review the conditional license history through the Nursing Home Watch List, which displays historical information about conditional license status over the prior 30-month period.

- Six-Month Survey Cycle – If a nursing home is cited for Class I or Class II deficiencies within a specific period, it will be inspected more frequently; on average every six months for a two year period. The nursing home licensee must pay for the costs of this inspection, so a fee is levied. This is one of the most valuable tools to provide greater regulatory oversight of those nursing homes that have met the threshold based on significant deficiencies. The six-month survey fee was designed to offset the additional costs of a second inspection each year for two years. There are 29 nursing homes on a six-month survey cycle at this time.

- Moratorium – If a nursing home is found to have serious violations that represent ongoing concerns for resident health, safety or wellbeing, the Agency may impose an emergency order placing a moratorium prohibiting any new admissions.

- License Denial or Revocation – The Agency may initiate action to deny a renewal or revoke a license for serious violations, a pattern of deficient practice, and other criteria in statute. There are also grounds for mandatory revocation for certain repeated violations which may be mitigated if appropriate.

- Emergency Suspension Order – If conditions exist that present an immediate, serious danger to the health, safety, or welfare of the residents of the facility, the nursing home license may be suspended on an emergency basis. An emergency suspension of licensure removes the licensee's ability to perform any activities requiring licensure. Such an action is an extraordinary remedy and necessitates the immediate relocation of all residents.

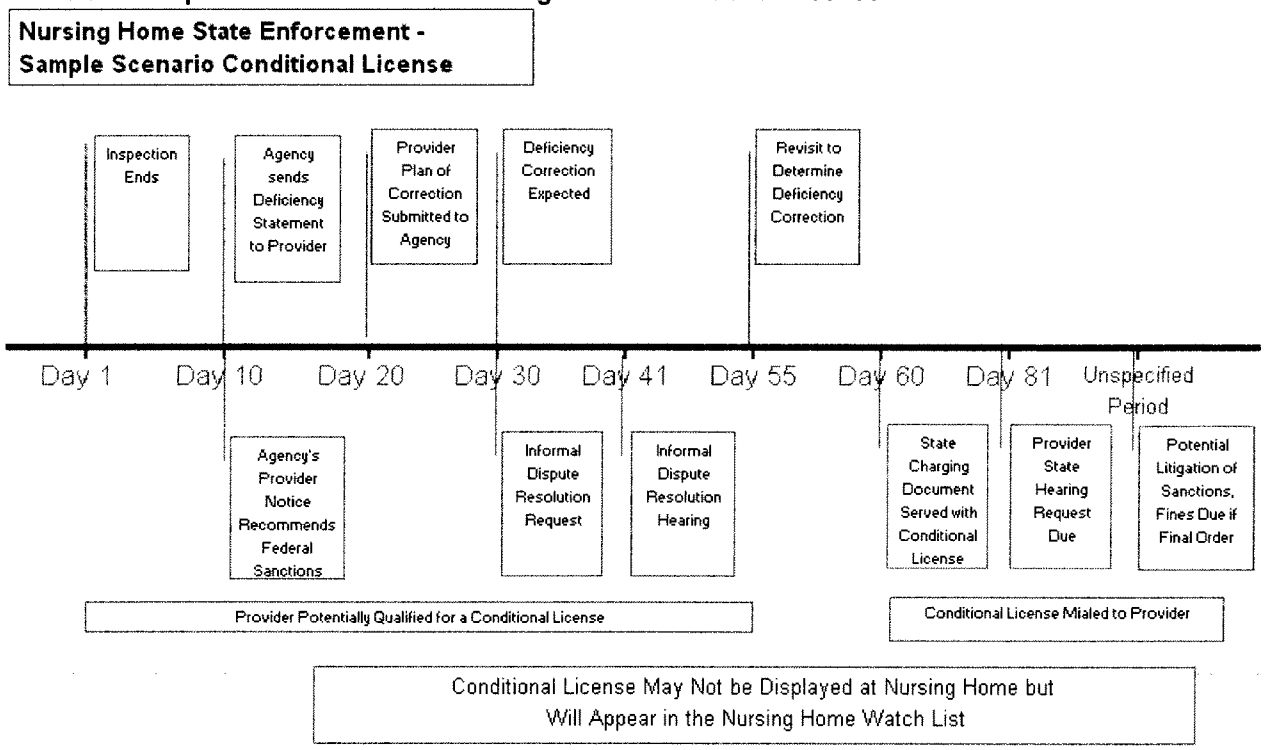
Standard of Proof for State Sanctions – All state sanctions are subject to the Florida Administrative Procedures Act, which places the burden of proof on the regulatory agency to show by clear and convincing evidence that the violation occurred, and that the "severity" or classification of the violation is appropriate. The state burden of proof standard is significantly higher than the federal standard for nursing home sanctions. ***Appendix C*** addresses the legal burden of proof issues that exist when faced with a clear and convincing standard and points out the potential challenges of witness credibility when a case is based upon information obtained from a nursing home resident. Given the vulnerability of nursing home residents, consideration should be given to the appropriateness of this burden of proof in regulatory cases involving nursing homes and other similar settings.

> The state burden of proof standard is significantly higher than the federal standard for nursing home sanctions.

Timing of Sanctions

The administrative process to impose sanctions creates a delay between the citation of the violation and the implementation of the sanctions. For nursing home fines paid in 2006, the time between the inspection and the date fines were paid averaged 266 days for state fines and 174 days for federal fines. Based on the Florida Administrative Procedures Act, a state sanction must take the form of a legal case and include a formal "charging document" such as an Administrative Complaint or Notice of Intent from the Agency. Charging documents for non-emergency actions such as a conditional license, a fine or a six-month survey cycle are typically not generated until after the federal Informal Dispute Resolution process. An example of the service of a conditional license is displayed below.

Exhibit 3: **Sample Scenario for State Nursing Home Conditional License**



The nursing home and assisted living reforms passed in 2001 sought to create a balance in oversight by limiting the reliance upon the civil courts to seek restitution for wrong doing through increased regulatory oversight and sanctions. Now, with several years of experience since these reforms, the Agency has identified the following barriers to achieving this goal from a regulatory perspective:

- Mechanisms designed to alert residents and/or the public such as the conditional license may not be visible in a timely manner to serve their intended purpose. Because a conditional license is considered a sanction, it is served with a legal order.
- The clear and convincing burden of proof for state sanctions creates a barrier to identification of deficiencies and upholding regulatory sanctions when imposed.

Recommendations - Enforcement

Require a conditional license be issued and displayed regardless of any administrative challenge as a matter of public transparency and timely notification.

Evaluate the appropriateness of the clear and convincing standard for regulatory violations in long term care facilities. Given the vulnerability of the residents in nursing homes, an altered level of proof may be prudent, similar to the federal standard.

Quality Initiatives

Quality of Care Nurse Monitors

In 1999 the Nursing Home Quality of Care Monitoring Program was created, with significant expansion in 2001. The program was designed to create a positive partnership between the Agency and nursing homes and ultimately yield improved quality of care to residents. Monitors are registered nurses employed by the Agency and are trained and experienced in nursing home regulation, standards of practice in long-term care, and evaluation of patient care. Their primary role is to visit nursing homes and monitor care being given to residents; they do not function as regulatory agents. When serious concerns with a facility exist, an immediate referral is made to nursing home inspectors for regulatory investigation. Each nursing home is visited at least quarterly, although some homes may be visited more frequently if regulatory concerns exist. Monitors seek to identify, at an early stage, any conditions potentially detrimental to the health, safety, and welfare of nursing home residents. They use tools in preparation for a visit that help target areas for improvement including regulatory violations, quality indicator reports, adverse incident reports, and staffing information. They interpret and clarify state and federal rules and regulations governing the facilities as well as offer educational resources and performance intervention models designed to improve care. The monitors work closely with nursing homes to improve resident care outcomes and focus additional efforts on facilities demonstrating higher resident restraint use and pressure sores. The monitors link providers having difficulties in these areas with quality improvement resources that can provide additional training and assistance.

One of the most effective regulatory methods to improve compliance appears to be a greater regulatory presence in those nursing homes with histories of regulatory violations. Quality of Care Nursing Monitors and the Six-Month Survey Cycle are effective tools to increase oversight where appropriate.

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Quality Measures

The nursing home Quality Measures come from resident assessment data that nursing homes routinely collect on all residents at specified intervals during their stay (referred to as the Minimum Data Set). The information collected pertains to the residents' physical and clinical conditions and abilities, as well as preferences and life care wishes. This assessment data is converted into quality measures that provide information about the nursing home residents' conditions and are displayed as part of the CMS Nursing Home Compare website as indicators to provide information about the care at the nursing home. Quality Measures are not benchmarks, thresholds, guidelines, or standards of care. They are based on care provided to the population of residents in a facility, not to any individual resident. The Quality Measures are listed in ***Appendix D***.

The 1993 Government Performance and Results Act (GPRA), holds federal agencies accountable for using resources wisely and achieving program results. GPRA requires agencies to develop plans for what they intend to accomplish, measure how well they are doing, make appropriate decisions based on the information they have gathered, and communicate information about their performance to Congress and to the public. The Centers for Medicare and Medicaid Services (CMS) has focused on identifying a set of meaningful outcome-oriented performance goals that include reduction in pressure sores and restraint use in nursing homes.

CMS established baseline values for certain Quality Measures including restraint use and pressure sores and is measuring improvements in these areas. CMS is working with the Agency and the Quality Improvement Organization (QIO) to make improvements. The QIO in Florida is the Florida's Medicare Quality Improvement organization that operates under contract with CMS. Florida has demonstrated improvements relative to the baseline data for restraints which was established using statistics collected on nursing home residents in 1996. At that time, the restraint use was 17.2%. Restraint use in Florida was 8.6% in the fourth quarter of 2006 and had improved to 7.7% and in the second quarter of 2007. Florida has not demonstrated such marked improvement relative to pressure sores. The baseline data for pressure sores was selected by CMS from information collected on residents in 2002. At that time, the score in Florida was 9.3%. Pressure sore prevalence in Florida was 9.7% in the fourth quarter of 2006 and the second quarter of 2007.

In October 2006 the Quality of Care (QOC) nurse monitors began extended visits at nursing homes that were in the GPRA top 20% percent for pressure sores and/or restraints (136 nursing homes for each measure). During the first quarter of 2007 the monitors addressed implementation of action plans for pressure sores and restraints with these nursing homes. Between the two most recent report periods, 38 of these facilities improved in the area of pressure sores and 25 in the area of restraints such that they are no longer in the top 20%. The nurse monitors also refer nursing homes to the QIO for additional assistance with pressure sores and/or restraints reduction when needed.

Multiple entities are collaborating to improve resident outcomes in these areas. The Agency for Health Care Administration is partnering with the nursing home industry, quality improvement agency and the hospital industry to identify the underlying issues related to these areas and develop strategies for improvement.

Staffing

Federal regulations require nursing homes have adequate staff to meet the needs of residents. Many evaluations have been conducted over the past decade regarding the "appropriate" level of nursing assistants and licensed nurse staff in nursing homes. Each recognizes the variation in resident needs as a factor and most stress that increased numbers of staff alone will not necessarily improve care. In December 2001, the Centers for Medicare and Medicaid Services released Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Report to Congress: Phase II Final, December 2001. Excerpts from the 2001 CMS report is highlighted below.

> Data review of ten states, 5,000 facilities to identify thresholds below which quality of care was compromised and above which there was no further benefit with respect to quality. Staffing data was obtained from Medicaid cost reports.
>
> Quality measures:
> - Short-stay Medicare admissions with hospital transfers for potentially avoidable causes, e.g.: urinary tract infections, sepsis, and electrolyte imbalance.
> - Long-stay residents (in facility at least 90 days) with select quality of care issues, e.g.: functional improvement, incidence of pressure sores or skin trauma, resisting care improvement and weight loss.
>
> Staffing threshold ranges (depending on the nursing home population):
> Nurse aides: 2.4 – 2.8
> Licensed nurses (LPN and RN): 1.15 – 1.3
> Registered nurses: .55 -.75
>
> Other Results:
> There is a strong relationship between nursing assistance retention and quality.
> Additional costs of increased staffing requirements will affect Medicare and Medicaid expenditures on nursing home care.

Incremental increases in minimum staffing standards were implemented in Florida beginning in 2002 and fully implemented January, 2007. Florida licensure regulations require specified staff-to-resident ratios for certified

nursing assistants (CNAs) and licensed nurses providing direct care are among the highest mandatory staffing ratios in the country.

Florida mandatory staffing ratios are:

- A weekly average of 2.9 hours of CNA care per resident per day, with a minimum of 2.7
- A minimum of 1.0 hours of licensed nurse care per resident per day, which includes licensed practical nurses (LPNs) and registered nurses (RNs)

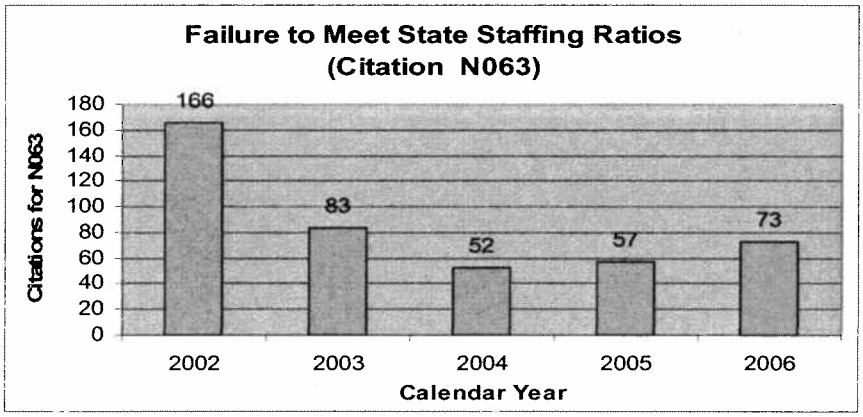
Staffing levels are monitored and reported to the Agency in several ways including:

State Staffing Reports - Reports must be filed with the Agency providing the average staffing levels for CNAs and licensed nurses in the nursing home. The report also requires information about staff turnover and stability of nursing staff, the administrator and the director of nursing. This information is self-reported but is shared with Quality of Care nurse monitors for review during their quarterly nursing home visits, and is reviewed prior to inspections. See ***Appendix E*** for the Semi-annual Staffing Report which is used to report staffing data to the Agency. Evaluation of the most recent report indicates 99% of nursing homes report meeting the minimum required staffing ratios. Deficiencies are discussed below.

Federal Staffing Reports - Actual staffing hours for nursing staff are reported for the two week period immediately before a full federal recertification inspection. This information is posted on the CMS Nursing Home Compare website but is limited in that it only represents a two-week period. See the federal staffing report document, ***Appendix F***.

Staffing Deficiencies – During inspections, surveyors cite deficiencies for failure to staff at required state minimum ratios, a quantitative deficiency (State Tag N063) or failure to have adequate staff to meet the needs of residents, a qualitative deficiency (Federal Tag F353). Staffing ratios are evaluated at each full inspection and whenever there is a complaint that may involve staffing issues. Not only are the minimum ratios monitored, but if a nursing home failed to meet minimum requirements for two consecutive days. Florida law requires the nursing home to self-impose a moratorium on new admissions until ratios are met for six consecutive days. If the nursing home licensee fails to impose this moratorium, the Agency will issue a Class II deficiency; there was one citation for this deficiency during 2006. The following chart represents trends in nursing home staffing deficiencies.

***Exhibit 4*: Nursing Home Deficiencies for Failure to Meet the State Staffing Ratios**



Risk Management and Adverse Incident Reporting

Federal regulations have required nursing homes to have quality assurance programs and committees for many years. However, in 2001 Florida regulations were enhanced to require nursing home to expand these quality assurance committees to include risk management with adverse incident reporting. The Agency produces an annual report of nursing home and assisted living facility adverse incident statistics. Adverse incidents are those events over which facility staff or personnel could exercise control, rather than occurring as a result of the resident's condition, that resulted in:

- Death;
- Brain or spinal damage;
- Permanent disfigurement;
- Fracture or dislocation of bones or joints;

- A limitation of neurological, physical, or sensory function;
- Requiring medical attention to which the resident has not given his or her informed consent including failure to honor advanced directives; and/or
- A transfer of the resident, within or outside the facility, to a unit providing a more acute level of care.

Or any event (regardless of facility control) that resulted in:
- Abuse, neglect, or exploitation;
- Resident elopement; and/or a report to law enforcement.

When an incident occurs, the facility risk manager must be notified within three days of the occurrence, and the Agency must be notified within one business day after the risk manager receives the report. The Agency is authorized to investigate any such incident as appropriate and may prescribe measures that must or may be taken in response to an incident.

Nursing homes must submit a complete adverse incident report to the Agency for each adverse incident within 15 calendar days of the occurrence. The reporting facility also indicates if the incident was determined to be an adverse incident.

By law, the adverse incident report is confidential and is not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the Agency or the appropriate regulatory board. The Agency reviews pertinent reports for each facility in conjunction with inspections and monitoring visits and each report is given the to Department of Health for review of potential practitioner involvement.

Highlights from the July 2007 annual report include the following statistics for fiscal year 06/07:
- 4,728 reported adverse incidents occurring with associated outcome
- 38 on-site visits to nursing homes specifically in response to adverse incidents requiring investigations; these surveys resulted in findings of Class I & II deficiencies in two nursing homes

The small number of serious violations found during investigations of adverse incident reports suggests prompt response by facility licensees.

Nursing Home Gold Seal

The Gold Seal Award was implemented in 2002 as a way to recognize Florida nursing homes that exhibit excellence in care management and quality of life for their residents. While the vast majority of nursing homes in the state adhere to laws requiring high quality of care, the Gold Seal program was designed to reward those facilities with exceptionally high standards and quality of care. Each Gold Seal recipient must be in operation a minimum of 30 months prior to the date of application. Additional performance criteria include:
- Evidence of financial soundness and stability
- High quality of care ranking among other nursing homes in their region
- An excellent record with the State Long-Term Care Ombudsman Program
- No "conditional" licenses or Nursing Home Watch List appearances in the past 30 months
- Demonstrated evidence of community involvement

There are 14 nursing homes that current hold the Gold Seal award, ***Appendix G*** provides the current list of these nursing homes.

Consumer Information and Choice

Selecting a nursing home is an important, personal, and often difficult decision. Sometimes the selection is the result of deliberate planning, but often the decision happens during a crisis situation. A nursing home selection involves many people including the resident, the resident's family, and health care professionals. First, the medical needs of the resident must be evaluated. Not only do the needs of a resident vary greatly between individuals, but the nursing care services available vary greatly between facilities. Along with medical needs, it is important that other factors such as location, proximity to family and friends, distance from busy streets, special amenities, room sizes, noise, odors, and compatibility with other residents are considered. Ideally, a potential resident or their family would research a few of the nursing homes that meet their initial criteria. Research may include, the Agency's Nursing Home Guide and Watchlist, the CMS Nursing Home Compare, and announced/unannounced visits to the nursing homes to observe the residents, the nursing home personnel, and the general condition of the facility. Interviewing the staff regarding inspection information, medical doctor availability, continuing education for

staff, and visiting hour information is also recommended. Lastly, after the research is done, options should be discussed with other family members, friends, and the prospective resident's doctor before making the decision.

Nursing Home Guide and Watch List

The Nursing Home Guide is designed to provide information to consumers about how to choose a nursing home and includes a ranking of nursing homes based on regulatory deficiencies cited by the Agency. The Guide was originally authorized in 1999 and first released in 2000. Originally designed to include a component of customer satisfaction and quality measures, subsequent legislation changed the Guide to limit the scope of the comparative information to regulatory deficiencies. The Nursing Home Guide provides specific information about the nursing home including location, contact information, profit status, occupancy, forms of payment accepted, languages spoken, special services offered, an indication if the nursing home currently holds the Gold Seal award or is currently operating under bankruptcy protection.

The Nursing Home Watch List is also part of the Guide and provides information about each nursing home that has had a conditional license during the past 30 months, including the number and percentage of days of the conditional status. See ***Appendix H*** for a sample of the Nursing Home Guide.

The Guide provides detailed regulatory history using a star ranking which is updated each calendar quarter and considers all deficiencies cited during the last 30 months. Each deficiency cited is given points based on the "severity" and "scope" of the deficiency. Points are totaled and used to compare nursing homes within the same inspection region. Nursing homes are ranked from one to five stars, one representing the worst performance or lowest 20% (highest deficiency points) up to five representing the best performance or highest 20% (lowest deficiency points). Deficiencies are grouped in categories including Overall (all deficiencies), Quality of Care, Quality of Life, Administration, Nutrition and Hydration, Restraints and Abuse, Pressure Ulcers, Decline and Dignity. A complete list of deficiencies during the last 30 months and the date of citation is also provided. Because all deficiencies have a point value, a nursing home with a large number of minor deficiencies may appear worse than a nursing home with fewer, more severe deficiencies. Because the current methodology will always provide a relative ranking, it is difficult for a licensee to know the impact of inspection results until the ranking is calculated each quarter. Public measures of quality should be predictable and empower nursing home licensees to strive toward excellence.

The Nursing Home Guide and methodology for the "stars" in the Guide were developed eight years ago. Significantly more information is now available about nursing homes and a discussion about revisions to the Guide to provide additional valuable information is warranted.

Federal Nursing Home Compare

Nursing Home Compare includes information only on nursing homes that are Medicare or Medicaid certified. The site is a resource for information about nursing homes to assist consumers when making choices about nursing home placement. Nursing Home Compare includes the following information:

- Demographic information about nursing homes similar to the Nursing Home Guide
- Federal deficiencies
- Quality Measures for each the nursing home
- Staffing levels based on a two week period

Inspection Reports

Florida law requires that each statement of deficiencies be provided to the Long Term Care Ombudsman office and the local public library for pubic inspection. The Agency also responds to voluminous requests for inspection reports for nursing homes and other health care providers. Inspection reports are an important consumer tool to identify areas of concern at a nursing home or other health care provider. Efforts to make these reports more accessible though the Internet are in process.

Quality Analysis

There are many areas to evaluate when considering relationships between nursing home characteristics and quality. Simple reviews may appear to compare factors but a detailed analysis is warranted if true comparisons are desired. For example, a simple analysis of the characteristics of nursing homes based upon the Nursing Home Guide Stars indicates that nursing homes with lower levels or no Medicaid tend to have higher rankings (fewer points based on the number and severity/scope of deficiencies).

Analysis of the Nursing Home Guide Stars by Characteristics

Overall Stars by Medicaid Proportion

Overall Guide Stars	Average Medicaid %	No Medicaid Residents	Nursing Homes
★★★★★ (5)	54.21	19	145
★★★★ (4)	58.18	9	132
★★★ (3)	60.15	7	135
★★ (2)	60.14	2	131
★ (1)	65.60	1	129

Quality of Care Stars by Not-For-Profit and For-Profit Status

Not-For-Profit			
# QOC Stars	# Facilities	Avg. % Medicaid	# with No Medicaid
★★★★★ (5)	47	53.74	16
★★★★ (4)	45	57.82	4
★★★ (3)	35	59.76	3
★★ (2)	34	66.63	5
★ (1)	34	64.66	0

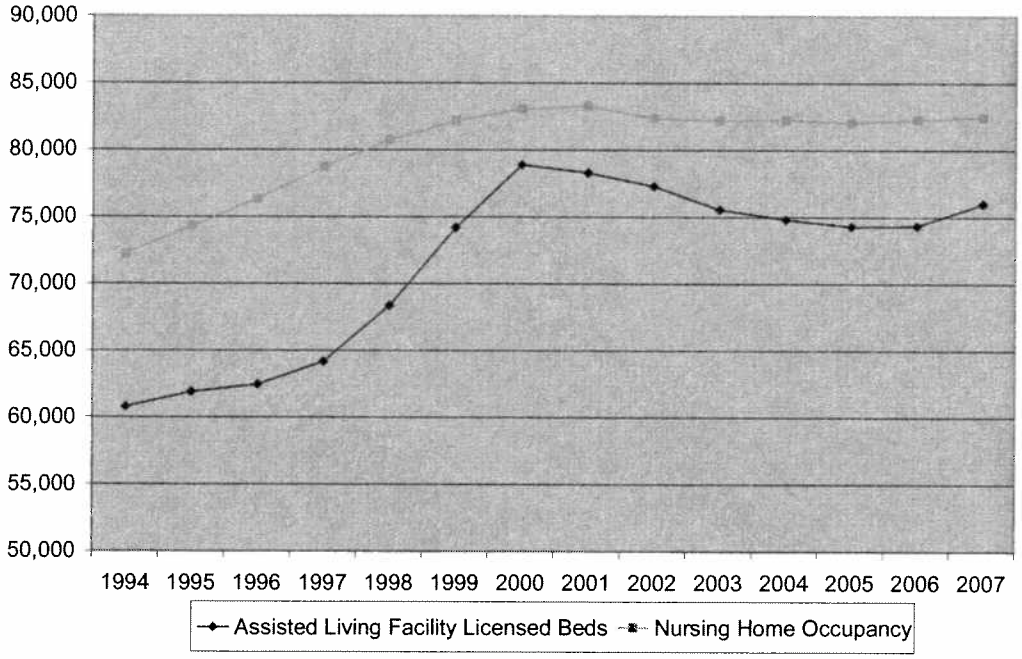
For-Profit			
# QOC Stars	# Facilities	Avg. % Medicaid	# with No Medicaid
★★★★★ (5)	98	57.22	3
★★★★ (4)	90	57.76	2
★★★ (3)	101	59.60	3
★★ (2)	93	57.61	1
★ (1)	95	64.85	1

The charts above review one single factor, deficiencies cited, and present simple averages and do not account for statistical variations and outliers. In order to draw stronger comparisons between nursing home quality and other characteristics, a more extensive analysis is recommended that would review criteria including ownership, corporate support, Medicaid and overall occupancy levels, Medicaid reimbursement rates, and ideally other non-regulatory factors including Ombudsman complaints, community involvement and satisfaction surveys. ***Appendix I*** displays other simple analyses between nursing home characteristics and potential indicators of quality.

Nursing Home Alternatives

Given the high dependence on public funds to pay for long-term care services, policy makers and planners must strike a balance between sufficient supply to offer consumer choice and the underlying need to control the expansion of publicly funded long-term care. The limited availability of alternative placements should a nursing home close is a significant factor in managing regulatory matters. Alternatives exist in some areas of the state where nursing home occupancy is lower, but in other areas, alternatives are few or non-existent. There is a growing concern about the sufficiency of regulatory oversight of alternative programs that care for persons who meet nursing home level of care guidelines, especially in assisted living facilities and adult family care homes. The exhibit below show the continued growth of home and community based care programs over the past decade while the nursing home growth has remained relatively flat.

***Exhibit 5*: Florida Nursing Home Occupany and Assisted Living Facility Beds**



Recommendations - Consumer Information

Review components of the Nursing Home Guide including staffing information, quality measures, satisfaction results, and the methodology for comparing deficiency results for nursing homes.

Improve the availability of staffing information and inspection reports to the public.

Recommendation – Quality Analysis

Commission a statistically sound analysis to evaluate correlations between nursing home quality and characteristics.

Recommendation - Alternatives

Review the sufficiency of regulatory oversight of nursing home alternatives providing care to persons who qualify for nursing home placement including assisted living facilities and adult family care homes.

Nursing Home Ownership

A company or organization must have a license to operate a nursing home in Florida. The licensee obtains the license to operate but may not be the owner of the actual physical property/building. The licensee must have a legal right to occupy the property such as a lease, 481 Florida nursing homes are leased, 394 for-profit and 87 not-for-profit. The licensee may also contract with a management company to run the day-to-day operations of the nursing home, but the licensee remains responsible for the operation, 480 nursing homes have a management company, 393 for-profit and 87 not-for-profit.

Organizational Structure of Nursing Home Licensees

Beyond the requirement to meet standards of licensure and certification described above, there are no limitations on the type of entity that may become the licensee of a nursing home or any type of health care provider in Florida. A not-for-profit organization is an entity from which no part of the income or profit is distributed to its members,

directors, or officers. A not-for-profit organization may be established for any purpose including charitable, benevolent, educational, historical, civic, patriotic, political, religious, social, fraternal, literary, cultural, athletic, scientific, agricultural, horticultural, animal husbandry, and professional, commercial, industrial, or trade association purposes. Not-for-profit organizations may be exempt from certain taxes. A not-for-profit organization may or may not be a "charitable" organization. Florida allows both for-profit and not-for-profit ownership of nursing homes. Nursing home licensees may be classified into the business organizations described below.

- Corporations - A corporation is a legal entity created through the laws of its state of incorporation. A Florida business corporation is required to have and continuously maintain in Florida both a registered office which may, but need not, be the same as its place of business, and a registered agent. The law treats a corporation as a legal "person" that has standing to sue and be sued, distinct from its stockholders. The legal independence of a corporation prevents shareholders from being personally liable for corporate debts. It also allows stockholders to sue the corporation through a derivative suit and makes ownership in the company (shares) easily transferable. The legal "person" status of corporations gives the business perpetual life; deaths of officials or stockholders do not alter the corporation's structure.

- Limited Liability Companies - Under a Limited Liability Company (LLC) structure, similar to a corporation, members have limited personal liability for the debts and actions of the LLC. Florida Statutes expressly limit the liability of members. Generally, members are not personally liable for breaches of contracts or torts, except for their own torts. The LLC is liable for torts committed within the scope of its business and contracts executed by an agent acting with authority. Other features of LLCs are more like a partnership, providing management flexibility and the benefit of pass-through taxation.

- Limited Partnerships - A limited partnership is a separate legal entity created by statute. A limited partnership has the powers to do anything necessary to carry on its activities, including the power to sue, be sued, and defend in its own name and to maintain an action against a partner for harm caused to the limited partnership by a breach of the partnership agreement or violation of a duty to the partnership. Limited partnerships are made up of limited partners and general partners. General partners may be individuals or a legal entity. A limited partner is not liable for the obligations of a limited partnership unless he or she is also a general partner or participates in the control of the business. However, a limited partner who participates in the control of the business is liable only to persons who transact business with the limited partnership. With few exceptions, general partners are liable for all the limited partnership's obligations.

- Limited Liability Partnerships - Partners in an LLP are not personally liable for the obligations of the partnership. However, unlike a limited partnership, all partners have limited liability even though they have the right to actively manage the business.

- General Partnership - A General Partnership is an association of two or more persons to carry on a business for profit as co-owners. The existence of a partnership requires an oral or written agreement and partners in a general partnership have unlimited personal liability for the obligations and debts of the partnership.

- Trusts - A business trust is a business organization which holds and manages property for holders of transferable certificates indicating an interest in the trust. A business trust is created by a declaration of trust by which investors agree to create a governing group of trustees, which holds the property of the enterprise and manages the business. Usually, members or shareholders are not liable to third persons.

- Government Owned - Government entities include the Florida Department of Veteran's Affairs, counties, cities and public health care districts.

***Exhibit 6*: Florida Active Nursing Home Licensees by Organization Type**

Licensee Owner Type	For-Profit	Not-For-Profit	Total
Corporations	162	130	292
Limited Liability Companies	288	51	339
Limited Partnerships	13		13
Limited Liability Partnerships	9	1	10
General Partnership	3		3
Trusts	2	2	4
Government Owned		11	11

Equity and Investment Firms

According to the US Securities and Exchange Commission, an investment company is a company (corporation, business trust, partnership, or limited liability company) that issues securities and is primarily engaged in the business of investing in securities. An investment company invests the money it receives from investors on a collective basis, and each investor shares in the profits and losses in proportion to the investor's interest in the investment company. The performance of the investment company will be based on (but it will not be identical to) the performance of the securities and other assets that the investment company owns. There is no requirement to report information to the Agency that would distinguish a licensee as an investment company.

There is no requirement to report information to the Agency that would distinguish a licensee as an investment company.

Disclosure of Ownership and Controlling Interest for Licensure

Licensure laws for all health care providers regulated by the Agency (ss. 408.803 and 408.806) require disclosure of "controlling interests" defined as "the applicant or licensee; a person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the applicant or licensee; or a person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider. The term does not include a voluntary board member." Controlling interest disclosure does not reach beyond interest in the licensee or management company therefore it does not reveal extended relationships to other entities that may be several layers beyond the nursing home ownership level.

In addition to the uniform licensing requirements for all provider types, nursing homes must disclose (s. 400.111) any financial or ownership interest that a controlling interest has held within the last 5 years in any entity licensed by the state or any other state to provide health or residential care which entity has closed voluntarily or involuntarily; has filed for bankruptcy; has had a receiver appointed; has had a license denied, suspended, or revoked; or has had an injunction issued against it which was initiated by a regulatory agency. This would not require a controlling interest to disclose a relationship that does not involve "ownership". For example, if a controlling interest serves as an officer or board member of another health care provider, but does not have ownership interest, disclosure is not required.

Actions of Controlling Interests

The Agency may deny or revoke a license for certain actions by a controlling interest including false representation or omission of a material fact on an application; an intentional or negligent act materially affecting the health or safety of a client; a demonstrated pattern of deficient performance; exclusion, suspension, or termination from any state Medicaid or Medicare program; or a violation of the section of licensure regulations.

Liability Beyond the Licensee / Corporation

Corporation shareholders, members of LLCs, limited partners of Limited Partnerships, members of LLPs, and business trust members are not personally liable for actions against the legal entity. Courts may make an exception only if the corporation was a mere device or sham to accomplish some improper goal such as misleading or defrauding creditors, hiding assets, evading the requirements of a statute or some analogous betrayal of trust. When the corporate veil is pierced, the corporation and the persons who dominate the corporation are treated as one person under the law.

Recent Changes in Nursing Home Licensees

The U.S. Department of Health and Human Services (HHS) released a report in June 2006, The Nursing Home Liability Insurance Market: A Case Study of Florida that provides details of the liability insurance crisis and the subsequent divestiture of nursing homes by large national chains, ***Appendix J***.

The report summary states:

> "Some five years after enactment, the impact of S.B. 1202 on stabilizing the nursing home liability insurance market remains inconclusive. The available data, on the whole, suggest that the frequency of nursing home lawsuits in Florida is declining. However, some attribute this decline in claim frequency to the lack of insurance coverage among many nursing home facilities, thereby reducing the incentive for plaintiffs to litigate. The divestiture of large national chains of their Florida facilities has had the same effect of limiting opportunities for plaintiffs to target nursing home operators with "deep pockets." Thus, in addition to the legislative impacts of S.B. 1202 itself, it is reasonable to conclude that the dramatic increase in nursing home litigation during the late 1990s planted the seeds of its own demise by decimating the insurance market which fed it. Should the liability

insurance market again stabilize, it will be interesting to observe whether increased insurance coverage for Florida's nursing home facilities might spark another increase in litigation activity in the future."

There has been a transition of nursing home ownership over the past decade to shift from a model of a common licensee for all related facilities, to separate smaller organizations (corporations or LLCs) for each facility. If a licensee's relationship to other facilities is limited by the establishment of multiple smaller corporations or LLCs, the definition of controlling interest may prohibit Agency consideration of poor health care provider operations by related subsidiaries.

Recommendation – Controlling Interest

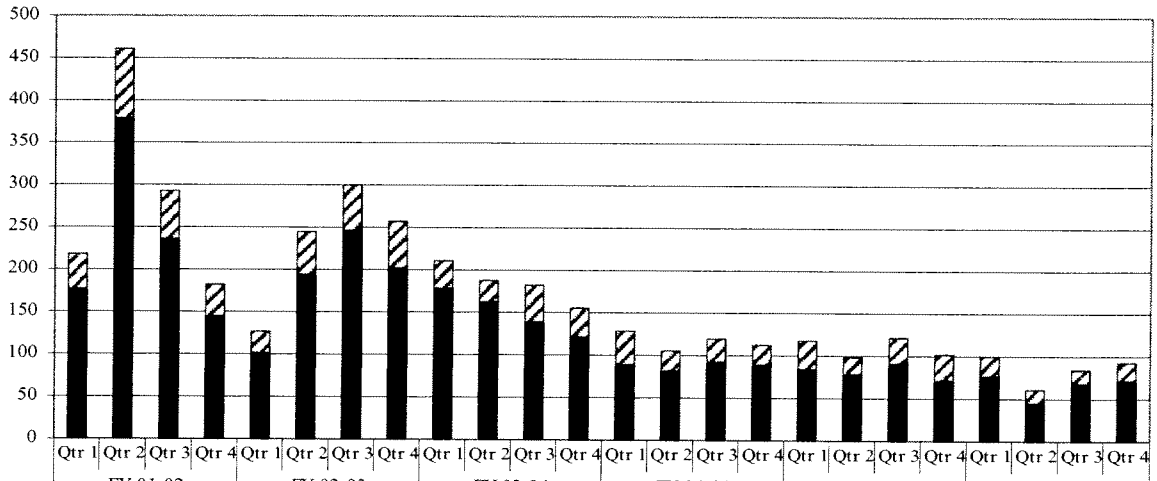
Expand the definition of controlling interest based on shifts in ownership structures to include all subsidiary operations. Controlling interest information should also be readily available to the public. In order to effectively manage the volume of information and changes in relationships it is critical that all health care licensees maintain current controlling interest information using an online reporting mechanism.

Civil Litigation Reporting

The Agency began collecting information from nursing homes regarding civil litigation in May, 2001. Initial reporting included notices of intent (NOI) to litigate for civil cases. Generally an NOI serves to notify the facility licensee of a plaintiff's intent to sue for some cause of action. In 2002 the requirement to also report civil complaints filed with a Clerk of the Court was added to the statute. Generally, civil cases include an NOI to initiate action. Once initiated, cases may be withdrawn, settled or move forward to litigation as represented by a civil complaint.

The following charts provide information about the NOIs and civil complaints reported to the Agency. Data changes over time if reports are submitted late or in error.

***Exhibit 7*: NOIs Received by AHCA by Nursing Home Profit Status**



	FY 01-02				FY 02-03				FY 03-04				FY 04-05				FY 05-06				FY 06-07			
	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4
NOI Not For Profit	40	82	58	38	25	50	53	56	31	24	43	34	38	22	26	24	33	20	31	30	24	16	17	21
NOI For Profit	177	379	235	144	101	194	247	201	179	163	140	122	90	83	93	89	84	78	91	71	76	44	67	72

Exhibit 8 displays the total NOIs and civil complaints reported to the Agency by active nursing homes by profit type with relative numbers based on proportion of beds.

***Exhibit 8*: Nursing Home Litigation by Profit Status and Corporate Affiliation**

July 1, 2006 through June 30, 2007	For-Profit	Non-Profit	Total
Licensed Nursing Homes	477	195	672
Lic NH Submitting NOI	148	46	194
Total # of Lic NOI Submitted	259	78	337
Total # of Lic Beds	58,982	23,458	82,440
# of NOI per 1000 Lic Beds	4.39	3.33	4.09
Total # of Civil Complaints	52	10	62
Civil Complaints per 1000 Lic Beds	0.88	0.43	0.75

Exhibit 9 displays the number of nursing homes receiving multiple NOIs during each fiscal year. The number of nursing homes that reported at least one NOI fell from 60% to 29% between 01/02 and 06/07.

***Exhibit 9*: Nursing Homes by Numbers of Notices of Intent Filed**

# NOI Reported	FY 01/02	FY 02/03	FY 03/04	FY 04/05	FY 05/06	FY 06/07
1	146	145	160	142	146	111
2 to 4	180	171	156	112	99	77
5 to 9	69	48	23	7	7	6
10 or more	8	3	3	0	0	0
All NOI	403	367	342	261	252	194

Licensure and Change of Ownership

Certificate of Need

To establish a new nursing home in Florida requires a Certificate of Need (CON). Although there is currently a moratorium on the issuance of any new nursing home CONs through June of 2011, the CON process includes an evaluation of the need for new nursing home beds in the region based on the extent of the utilization of existing beds and the projected need for additional beds due to anticipated growth. If a need is identified, prospective nursing home licensees may apply to establish new nursing home beds either through the development of a new facility or the addition of beds to an existing facility. Existing and prospective nursing home licensees may also apply in the absence of numeric need if access problems are alleged.

The Agency makes a decision as to which applicant is awarded a CON to establish new beds and other applicants or existing providers in the area may initiate litigation regarding the decision. Such litigation delays the CON award. Once litigation is complete, which generally takes 18 months to two years, the CON holder proceeds to architectural and engineering review by the Office of Plans and Construction. A CON that has been issued to an entity that does not intend to license the project may be transferred to another entity. Although a CON transfer is rare, it involves an expedited CON review (non-competitive) of the proposed transferee using the standard CON review criteria.

Once the new nursing home facility nears completion, an application for licensure is submitted. In addition to the CON, initial nursing home licensure requirements must be met including an onsite inspection prior to admission of residents. During the inspection, information submitted in the application is verified in conjunction with staffing, policies and procedures, administration, contracts, and a complete tour is conducted that includes observations of resident rooms.

Change of Ownership

Once a nursing home is licensed, a change of ownership application may be submitted at any time. A change of ownership occurs when the licensee changes to a different legal entity or 45% or more of the ownership, voting

shares, or controlling interest in a corporation whose shares are not publicly traded on a recognized stock exchange is/are transferred or assigned, including the final transfer or assignment of multiple transfers or assignments over a two-year period that cumulatively total 45 percent or greater. This definition has been problematic to implement due to the exclusion of a 45% change in a non-corporate entity such as an LLC, and the difficulty in tracking and managing a cumulative change of 45% over a two-year period.

The criteria for a nursing home license change of ownership include:

- Proof of financial ability to operate
- Compliance with Medicaid leased facility requirements
- Registration of the owner/licensee with the Division of Corporations
- Submission of Articles of Incorporation or organization
- Surety bonds for patient funds held by the facility
- Proof of general and professional liability insurance
- Quality assurance plans
- Disclosure of controlling interests as defined by law
- Documentation of the change of ownership transaction which includes proof of ownership or right to occupy the property in the form of warranty deeds and leases

Exhibit 10 describes the requirements of a Certificate of Need versus those associated with a licensure change of ownership application.

Exhibit 10:

Certificate of Need Criteria	**Change of Ownership for Licensure**
The need for the project being proposed and the availability, accessibility, and extent of utilization of existing facilities and services	Not applicable
Evidence of the ability to provide quality of care and the applicant's record of providing quality of care	Objective review of serious non-compliance
The availability of resources, including health personnel, management personnel and funds for capital & operating expenditures, for project accomplishment and operation	Key staff are required: Administrator and Director of Nursing. Expectation that all other resources are present, however no review until next regular inspection.
The immediate and long-term financial feasibility of the proposal	Proof of financial ability to operate including funding for current operation and three months reserves
The extent to which the proposal will enhance access to health care for residents of the service district	Not applicable
The extent to which the proposal will foster competition that promotes quality and cost-effectiveness	Not applicable
The costs and methods of the proposed construction, including the costs and methods of energy provision and the availability of alternative, less costly, or more effective methods of construction	Not applicable
The applicant's past and proposed provision of care to Medicaid patients and the medically indigent	Must maintain any prior CON commitment
No outstanding fines due to the Agency	Same requirement
Evidence of proper corporate registration	Same requirement
Proof of fictitious name registration with the Division of Corporations	Same requirement
Registration of the owner/licensee with the Division of Corporations	Same requirement
Designation as a Gold Seal Program if requesting additional nursing home beds at an existing facility	Not applicable

Financial Status

Financial requirements for nursing home licensure expect applicants to have access to sufficient funds to begin and sustain operations until profitability can be achieved. ***Appendix K*** provides a side-by-side comparison of the financial requirements of licensure versus Certificate of Need. The proof of financial ability to operate must be demonstrated at the time of initial and change of ownership licensure, and may be required by the Agency any time

there is evidence of financial instability. In the late 1990's and early 2000's, a significant number of nursing home licensees operated under bankruptcy protection: as much as 20% of Florida nursing home licensees. However, the financial situation has improved and at this time only one nursing home currently operates under bankruptcy protection.

A significant number of nursing homes changed ownership between 1999 and 2002: on average 21% per year, however, this turnover has decreased since to an average of 7% per year between 2003 and 2006. Although specific reasons for the high volume of changes of ownership prior to 2003 are not known, factors may include corporate restructuring to limit liability, reorganization due to financial difficulties in the industry including bankruptcy, and the opportunity to increase Medicaid reimbursement.

Recommendations - Change of Ownership

Revise the definition of Change of Ownership to include a 45% change in any licensee type (not just a corporation), and replace the two-year cumulative period with a requirement that a licensee must report any change in controlling interest to AHCA within 21 days.

Authorize a Provisional license for Change of Ownership applicants to allow a brief period for the new licensee to demonstrate its ability to operate the facility before final licensure is determined, similar to the assisted living facility statute.

Consider increasing the qualifications for a Change of Ownership applicant including financial, quality and resources.

Medicaid Reimbursement

Nursing homes are paid by Medicaid in Florida based on the costs of operation but may not exceed certain limitations. Costs are divided into five components: Operating, Direct Patient Care, Indirect Patient Care, Property, and Return on Equity (ROE). See ***Appendix L*** for a complete explanation of Medicaid nursing home reimbursement, and ***Appendix M*** for a list of the historical changes to the Medicaid Nursing Home Reimbursement Plan.

Provider Direct Patient Care costs have steadily risen since 2002 in part to accommodate state requirements for increased staffing. Inflation and recruitment and retention of staff have also contributed to increased costs. The Agency continues to implement changes to accommodate additional reimbursement in the Direct Care Component.

Related party transactions (e.g.: supply purchases from an affiliated vendor) may only be reimbursed at the actual cost within Medicaid component limitations. Actual costs must exclude any profit margin.

As of July 2007 the average Florida Medicaid per diem is $178.77 per resident per day. ***Exhibits11*** and ***12*** display information related to Medicaid reimbursement versus cost in the Patient Care Component and the Operating Cost Component indicating Medicaid reimbursement growth keeping closer pace with increasing costs of Patient Care than Operating. ***Appendix N*** provide details by profit status and Medicaid proportion including the percentage of providers whose costs exceed Medicaid reimbursement.

Exhibit 11: **Medicaid Nursing Home Patient Care Component**

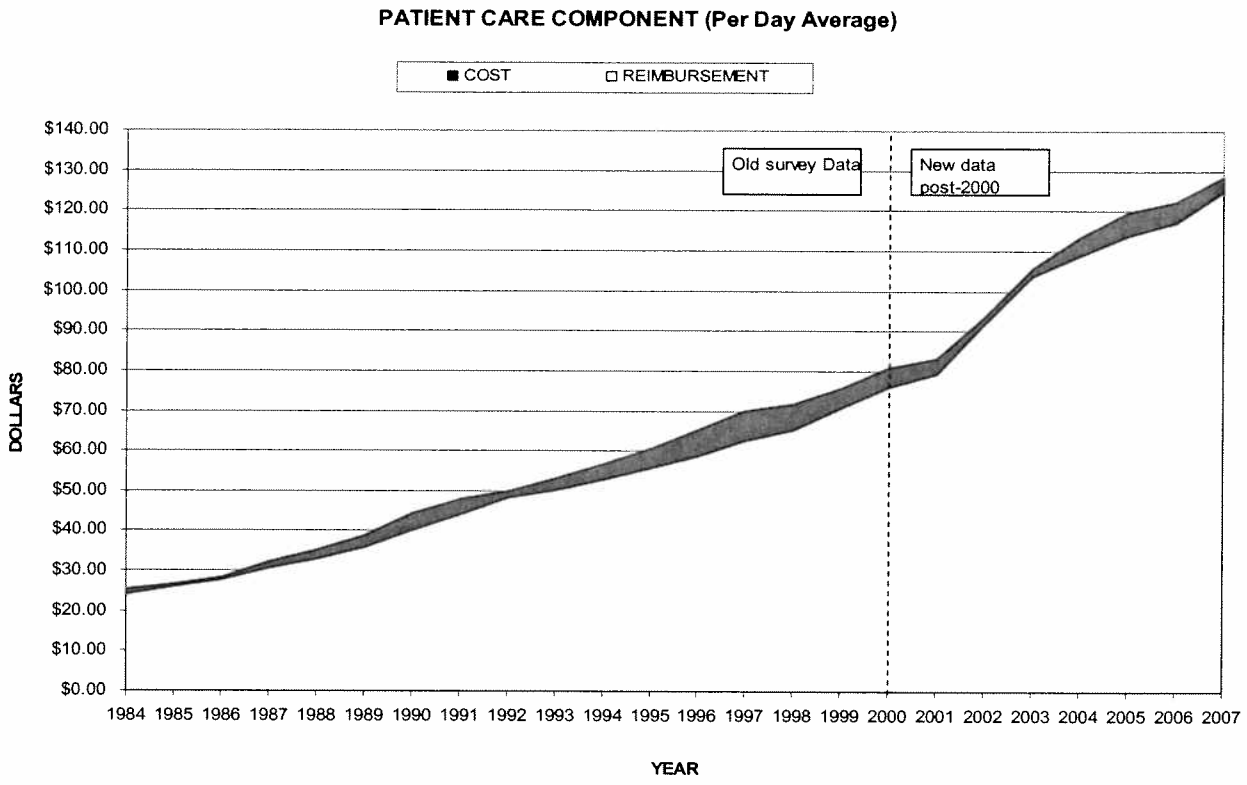
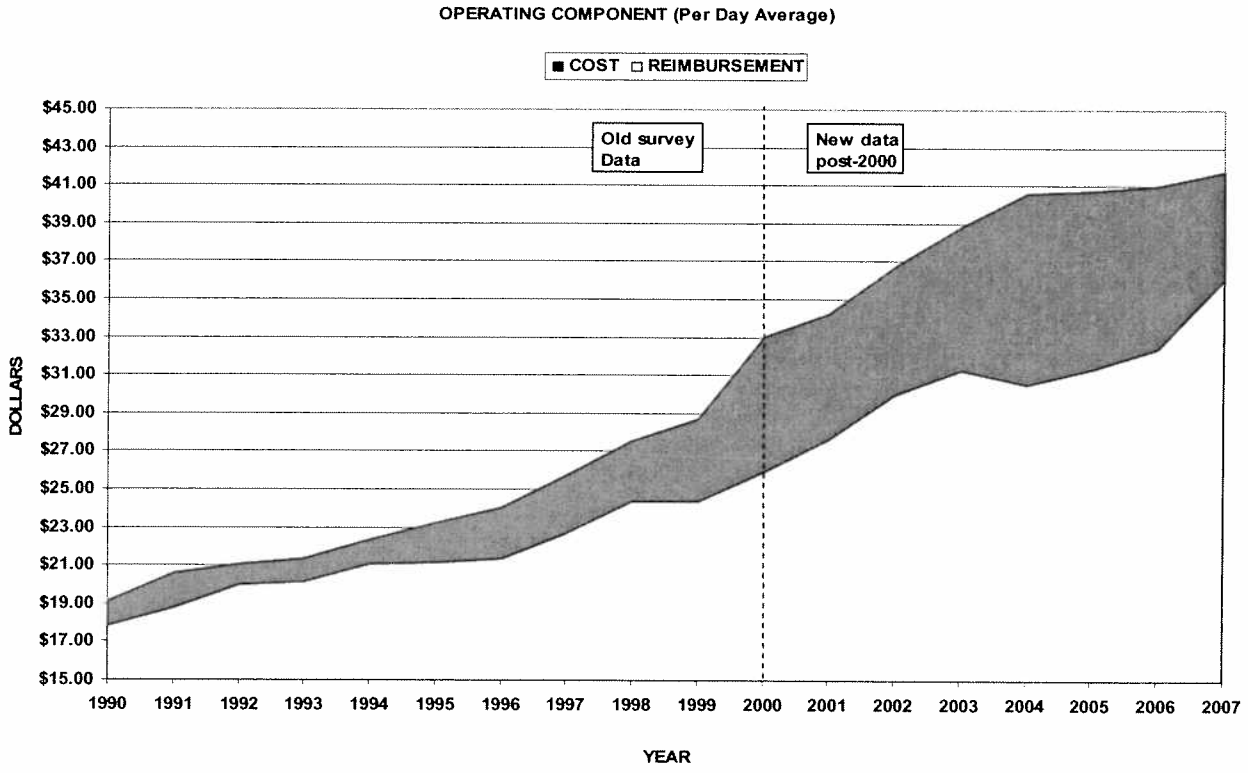


Exhibit 12: **Medicaid Nursing Home Operating Component**



Medicaid Staffing Reimbursement and Change of Ownership

As mandatory staffing ratios became law in Florida, the Medicaid reimbursement was adjusted. The Patient Care component of Medicaid nursing home reimbursement was split into Direct and Indirect components effective with initial staffing increases on January 1, 2002. Increases in reported Direct Patient Care after January 2002 reflect the two subsequent increases in the minimum staffing:

1/1/2002 CNA hours increased from 1.7 contact hours per resident per day to 2.3 hours.
1/1/2003 CNA hours increased from 2.3 contact hours per resident per day to 2.6 hours.
7/1/2007 CNA hours increased from 2.6 contact hours per resident per day to 2.9 hours averaged weekly.

Indirect Patient Care and Operating costs reported and the associated per diems reflect the legislatively mandated funding reductions.

In the event of a change of ownership of a Medicaid certified nursing home, the new provider may be reimbursed at the higher Medicaid reimbursement rate for increased costs subject to limitations.

Effective July 1, 2007, the Medicaid Nursing Home Reimbursement Plan was modified, restoring the ability to obtain an increase in rate due to a non-related change of ownership; an increase that had been eliminated in 2001. The incentives to change ownership for a rate increase have been mitigated for the near future due to rebasing of limitations and inclusion of an increase in recurring inflationary multipliers. The rebasing allows providers to receive their actual inflated costs or the class ceiling, whichever is less. The current method will allow providers to recapture increases in cost to a greater extent than in the past.

When a change of ownership is proposed, the Agency has 90 days to identify any outstanding liabilities owed to Medicaid by the transferee. There is limited opportunity to collect liabilities of the transferee identified after the change of ownership, especially if the transferee was an independent corporation or LLC formed solely for operation of one nursing home. Because nursing homes are paid based on actual costs, there is generally a delay in excess of a year before costs are reconciled with Medicaid payments. Medicare has established successor liability for nursing homes which may be adopted for Medicaid to avoid any collection issues after a change of ownership.

Recommendation – Medicaid Change of Ownership

Revise Medicaid provisions to assign successor liability when a Change of Ownership occurs.

Focused Analysis and Review

Manor Care Change of Ownership Applications

Concerns have been expressed regarding the purchase of Manor Care nursing homes by The Carlyle Group. The Service Employees International Union (SEIU) and others have expressed concern regarding future operation and the negative affects on patient care, ***Appendix O***.

Regardless of who owns or operates a nursing home, it will still have to meet regulatory requirements or be subject to state and federal sanctions. Representatives of The Carlyle Group have pledged to maintain the Manor Care quality health services to residents under the new organization, ***Appendix P***.

Manor Care is affiliated with 29 nursing homes in Florida, those licensed as Manor Care and those licensed as Heartland Healthcare. In the last fiscal year, July 1, 2006 through June 30, 2007, these 29 nursing homes were cited for 350 deficiencies, an average of 12 deficiencies per facility. The statewide average deficiencies per nursing home are 11.5. The majority of deficiencies cited in the Manor Care nursing homes were not classified as serious violations, six of the deficiencies were classified as serious deficiencies (G or higher, refer to ***Appendix B***) and involved three facilities. Staffing information reported to the Agency shows Manor Care facilities meet current required staffing levels and none of the deficiencies cited were in the area of staffing at the state or federal level.

The Agency has received several requests to conduct public hearings related to the change of ownership applications for the Manor Care nursing homes. Hearings requests have been made pursuant to Chapter 120, F.S., based on the "substantial interest" of third parties. ***Appendix Q*** describes related legal issues. This request has been forwarded to the Agency Clerk in the Agency's Office of the General Counsel, which is standard protocol. The Agency Clerk is reviewing the request and will issue a formal decision in the near future. However, based on

past decisions on similar requests, there does not appear to be an opportunity under Chapter 120 for the public or any external party to intervene in licensure matters. The Agency has contacted all those who have inquired about the Manor Care change of ownership applications and will continue to respond to questions and provide information.

Private Equity Firms

Staff of the Agency's Inspector General and Medical Program Integrity offices used the State Department's website to conduct research of Florida nursing home corporate affiliates. Conclusions reached found "Complex corporate relationships make it difficult to impossible to unravel the ownership stakes and corporate affiliations for any Florida skilled nursing facility....We were unable to determine if these corporations were connected with any known private equity firms such as The Carlyle Group or Warburg-Pincus."

A review of Warburg Pincus' website lists FHO Investments (FHP) among its portfolio. FHP is located in Tampa and focuses on the skilled nursing home sector – specifically lease hold interests. When Beverly Enterprises left Florida in 2001; FHP purchased its leased properties. FHP is not the license holder or operator of any of these facilities. Nationwide it has leasehold interests in some 127 long term care facilities.

Specific to the Carlyle Group, no evidence was found that it is currently or was historically affiliated with any skilled nursing facility or any affiliates of those facilities in Florida.

Also reviewed was information relative to corporate owners of facilities receiving a one-star overall rating in the most Nursing Home Guide. This information alone did not reveal a correlation between the low ranking and ownership.

Habana Health Care Center

Based on allegations for investment firms that cut staff after purchasing nursing homes, a specific review was conducted for the Habana Health Care Center. ***Appendix R*** provides details of the Habana Health Care Center cost report analysis.

Analysis of Habana Medicaid Cost Reports for the period between 1/1/2002 to 7/1/2007 shows:

- Direct Patient Care per diem rates steadily increased from $65.31 to $80.16 and reflect a 22.7% increase
- Indirect Patient Care per diem rates basically remained flat from $39.26 to $38.92 and reflect a less than 1% decrease
- Operating per diem rates increased slightly from $29.28 to $30.69 and reflect a 4.8% increase

A review of the regulatory history of Habana Health Care Center shows no serious deficiencies have been cited in the past three years and the only citation for staffing deficiencies occurred in February 2003 (Class 3 state deficiency). Habana Health Care Center has not had any deficiencies in the past three years that resulted in state sanctions, no fines, and no conditional license. It did have a federal civil monetary penalty for a citation in July 2004 related to protecting residents from hazards - the fine was $3,250.

The Nursing Home Guide indicates a ranking of "one star" in several areas for Habana Health Care Center. The stars represent how the facility compares to other facilities in the inspection region using the CMS federal deficiencies (see Nursing Home Guide discussion). All deficiencies have a point value, even a Class 3 (lower level), so a facility can have a high score (few stars) based on a large number of lower level deficiencies even if none resulted in sanction. That is the case with Habana Health Care Center.

Sea Crest Health Care Management

Although the nursing homes formerly operated by Beverly Enterprises do not have common ownership at this time, the majority are managed by Sea Crest Health Care Management, LLC (Sea Crest), including Habana Health Care Center. Sea Crest is affiliated with 56 nursing homes in Florida. During the fiscal year, July 1, 2006 through June 30, 2007, these nursing homes were cited for 734 deficiencies, an average of 14 deficiencies per facility. The statewide average deficiencies per nursing home are 11.5. The majority of deficiencies cited in the Sea Crest nursing homes were not classified as serious violations; however 18 of the deficiencies were classified as serious deficiencies (G or higher, refer to ***Appendix B***) and involved ten facilities. Staffing information reported to the Agency shows Sea Crest facilities have generally met current required staffing levels. Since July 2005, 18 facilities were cited staffing deficiencies; two facilities had staffing deficiencies classified as serious violations.

Conclusions

The quality of a nursing home depends upon the adequacy of funding available to provide care; the adequacy of regulatory oversight and enforcement authority; and the willingness and ability of the service provider to attend to the details of staff and patient care management. Although it would be helpful to understand the ultimate connection between a nursing home and other related organizations and affiliates, the Agency has significant regulatory authority within the current licensing and certification framework. Remedies are available to take action when a nursing home licensee does not meet minimum standards. Based on the number of complaints submitted to the Agency and outreach efforts, there appears to be good public knowledge of how to report concerns to the Agency for investigation. There is no evidence to support that the quality of nursing home care suffers when a facility is owned by a private equity firm or an investment company. Nevertheless, there are several recommendations for changes the regulatory system that would enable further improvements.

Review of Recommendations

Several recommendations are reviewed through out this report and are re-stated below.

- Require a conditional license be issued and displayed regardless of any administrative challenge as a matter of public transparency and timely notification.
- Evaluate the appropriateness of the clear and convincing standard for regulatory violations in long term care facilities. Given the vulnerability of the residents in nursing homes, an altered level of proof may be prudent, similar to the federal standard.
- Review components of the Nursing Home Guide including staffing information, quality measures, satisfaction results, and the methodology for comparing deficiency results for nursing homes.
- Improve the availability of staffing information and inspection reports to the public.
- Commission a statistically sound analysis to evaluate correlations between nursing home quality and characteristics.
- Review the sufficiency of regulatory oversight of nursing home alternatives providing care to persons who qualify for nursing home placement including assisted living facilities and adult family care homes.
- Expand the definition of controlling interest based on shifts in ownership structures to include all subsidiary operations. Controlling interest information should also be readily available to the public. In order to effectively manage the volume of information and changes in relationships it is critical that all health care licensees maintain current controlling interest information using an online reporting mechanism.
- Revise the definition of Change of Ownership to include a 45% change in any licensee type (not just a corporation), and replacing the two-year cumulative period with a requirement that a licensee must submit any change in controlling interest to AHCA within 21 days.
- Authorize a Provisional license for Change of Ownership applicants to allow a brief period for the new licensee to demonstrate its ability to operate the facility before final licensure is determined, similar to the assisted living facility statute.
- Consider an increase in the qualifications for a Change of Ownership applicant including financial, quality and resources.
- Revise Medicaid provisions to assign successor liability when a Change of Ownership occurs.

Fact v. Fiction:

The Truth about the HCR Manor Care/Carlyle Transaction

Fiction: *"...the New York Times investigated what happens to nursing home quality of care when one chain of nursing homes in Florida was bought out by private equity firms...among other concerns, there have been serious quality of care deficiencies and staffing cuts, sometimes below federally recommended levels."*	**Fact:** The New York Times story had nothing to do with HCR Manor Care. Furthermore, none of the claims in the New York Times story apply to the Carlyle/HCR Manor Care transaction. Moreover, the Florida Agency for Health Care Administration, the government agency that regulates the nursing home industry in Florida, recently issued a report which found that: "There is no evidence to support that the quality of nursing home care suffers when a facility is owned by a private equity firm or an investment company."
Fiction: *"...private equity buyout firms operate virtually free of oversight and public accountability, their profits and practices largely hidden from view.... buyout firms operate behind a veil of secrecy that allows them to conceal virtually all aspects of their business from regulators, affected stakeholders, the general public, and their competitors."*	**Fact:** Under Carlyle ownership, HCR Manor Care will continue to be heavily regulated by federal and state authorities in each of the 32 states in which Manor Care operates. HCR Manor Care will comply with the same regulations after the transaction is completed as it does now. In fact, the long-term care industry is one of the most heavily regulated industries in the world. Moreover, Manor Care will continue to be fully accountable and responsible for compliance with these regulations, and Manor Care's structure and operations will be completely transparent to patients, family members, regulators, lawmakers and the general public.
Fiction: *"...violations of basic patient care standards at Manor Care nursing homes have increased by 23 percent....Eighty-one percent of Manor Care facilities reported nursing staff levels below 4.1 hours per resident per day – a figure recommended in a government-commissioned study."*	**Fact:** For its facilities across the nation, HCR Manor Care has a 96 percent compliance rate with the nearly 200 federal regulations with which each nursing home facility must comply. While it's true that a study (i.e., the Schnelle report) made recommendations to the Centers for Medicare & Medicaid Services, CMS never agreed with nor accepted those recommendations. Saying that the recommendations were unrealistic, CMS told Congress that 97% of the nursing homes across the nation would not be able to meet the proposed recommendations. CMS also told Congress that there was no correlation between increased staffing and improved quality. Bottom line: HCR Manor Care meets and exceeds all staffing guidelines set by the government.
Fiction: *"...Manor Care's massive debt obligations could affect staffing and resident care if Manor Care decides to cuts costs in order to make its interest payments. Among other costs, Manor Care could cut its long-term operating expenses, more than half of which were attributable to staffing and other labor-related expenses in 2006."*	**Fact:** As a public company, HCR Manor Care spent more in expenses related to share buybacks, quarterly dividends, buying down debt and paying interest over the past five years than it will for its future debt obligations. As a private company, HCR Manor Care will no longer be engaged in share buy-backs, and Manor Care's pre-existing debt is part of the Carlyle debt assumption. In fact, Manor Care's new annual debt servicing obligations will be less than the average annual amount spent on share buybacks, quarterly dividends and payments on its existing debt. Moreover, the equity on the books post-transaction will double to $1.3 billion. To the question of quality care, both HCR Manor Care and Carlyle have publicly committed that no adverse changes to clinical operations will result from this transaction. In truth, Manor Care will be the most financially solvent long-term care company in the U.S., owned by one of the most financially strong sponsors in the world.
Fiction: *"Public documents indicate the Carlyle Group is planning changes to the corporate structure of nursing home chain HCR Manor Care....Applications for nursing home licenses in Maryland, Michigan, Washington and West Virginia lay out a four-tiered structure for Carlyle to shield Manor Care's assets and distance itself from liability for poor care...."*	**Fact:** HCR Manor Care will remain the owner and operator of all assets including real estate. Nursing homes will not be separated from the operations as has been reported by the New York Times and as in other transactions. HCR Manor Care's new structure – and accountability – will be completely transparent to regulators and other stakeholders. Moreover, HCR Manor Care will maintain exactly the same professional liability and property insurance after this transaction as it did previously.

In its recent "report," *Equity and Inequity: How Private Equity Buyouts Hurt Nursing Home Residents,* the SEIU makes a number of fictional or erroneous statements, the most significant of which are outlined above. With more than 500 facilities in 32 states, HCR Manor Care was first in the industry to broadly measure care outcomes, with a continuing emphasis on meeting patients' care goals. Because of its record of quality, HCR Manor Care will receive strong financial backing from this investment. And with a strong financial position, HCR Manor Care will be able to execute its strategy for the future, which includes: sustaining and enhancing staffing levels; providing training for nurses and caregivers; and investing at least $100 million every year in renovations, expansions and improvements at care centers, including expanded therapy space, clinical programs, new equipment and information technology. This is not only the other side of the story, but these are the facts of the HCR Manor Care/Carlyle transaction.

HCR·ManorCare

October 1, 2007

To All HCR Manor Care Employees:

Recently, it was announced that our parent company, Manor Care, is being acquired by The Carlyle Group. Carlyle is a private equity firm that makes investments in a wide variety of leading companies and industries, and they are investing in our company precisely because we are the widely recognized leader in providing quality long-term care and post-acute rehabilitation for about 250,000 patients each year. Most importantly, Carlyle recognizes and appreciates the role that our caregivers and support personnel have played in our success, and that we will continue to rely on your capabilities and performance to meet the needs of our patients and residents in the future.

With the completion of this transaction expected to occur before year-end, the names of our shareholders will change, but almost everything else will remain the same. In fact, Carlyle and our senior management team have reconfirmed their commitment to continue managing the company with the same dedication to quality care, staffing levels, employee benefits, capital investment and the caring culture that has made our organization the most uniquely successful and respected provider in our industry.

Over the years, HCR Manor Care and many of you have been widely recognized and honored for our capabilities, performance and professionalism. Because of our long record of excellence, it is hard to understand why some misinformed union activists have recently chosen this moment to spread ridiculous and inaccurate comments about what they think this change in our ownership means for all of us and the patients we care for. Suffice it to say, there is no basis for their offensive and potentially slanderous comments, and you shouldn't be distracted by their desperate attempts at union organizing.

Carlyle joins us in embracing our Circle of Care philosophy and the HCR Manor Care Vision Statement which reflects our aspirations, both personally and professionally. As you know, our Vision begins with, "We, the employees of HCR Manor Care, are dedicated to providing the highest quality in health care services." We have been guided by this vision since our company's beginning, and it will continue to reflect our priorities as we grow in the years ahead. Our success will also continue to be dependent on the skills and commitment of our caregivers and their support organization, to work together in a respectful and collegial manner to meet the needs of those who are entrusted to us for their care.

I invite you to join me as we all look forward to this new partnership with Carlyle and the opportunities we have to grow and provide quality care to our patients and residents throughout the country. I sincerely thank you, our caring employees and the organization that supports them, for your commitment to our patients and residents and their families, and I am proud that because of your dedication, we will continue to strive to provide the best care and caring in our industry.

Sincerely,

Stephen L. Guillard
Executive Vice President and Chief Operating Officer