IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF CONNECTICUT

CONNECTICUT ASSOCIATION OF HEALTH CARE FACILITIES, INC.,

Plaintiff,

v.

M. JODI RELL, in her official capacity as Governor of the State of Connecticut,

Defendant.

CASE NO. 3:10-CV-136 (RNC)

DECLARATION OF JOSEPH M. LUBARSKY IN SUPPORT OF PLAINTIFF'S MOTION FOR A PRELIMINARY INJUNCTION

I, JOSEPH M. LUBARSKY, declare under penalty of perjury as follows:

1. I am an individual residing in Louisville, Kentucky.

2. The facts set forth herein are based on my personal knowledge, and, if called upon to testify thereto, I could and would do so competently under oath.

PROFESSIONAL BACKGROUND

3. I earned a Bachelor's degree in accounting from the University of Wisconsin-Milwaukee in 1974.

4. I am currently employed by Eljay, LLC, which consults with and represents nursing home associations and providers when States design or modify their nursing home payment systems. This involves rate modeling and negotiation relative to payment design, budgetary parameters, and identification of funding sources. Eljay, LLC also consults with nursing home associations and States on the design and implementation of provider tax programs.

5. I was a partner and the National Director of Long-Term Care Services for BDO Seidman, LLP ("BDO"), a national professional services firm providing assurance, tax, financial

advisory, and consulting services to a wide range of publicly traded and privately held companies. I was employed at BDO and a predecessor firm that merged into BDO's practice in 1986 from 1974 to 2006, when I retired from the firm.

6. I have been actively involved in financial management and Medicaid reimbursement issues related to nursing facilities for over 35 years. I have worked with providers in all aspects of financial management, including acquisition and due diligence, feasibility and construction, budgeting, planning and payment. I have been involved in the design or redesign of Medicaid payment systems in 10 States over the past 10 years. This involves identifying goals and objectives of the new system; comparison of the current system against the goals; development of acuity-based models; development of cost centers, payment ceilings, price levels, incentive payments, and inflation factors; phase-in methodology development; and extensive modeling relative to the proposed system to determine payment adequacy, variation in payment against the existing system and budgetary requirements.

7. I have extensive knowledge and expertise relative to cost structures and Medicaid payment for nursing facilities. I have conducted eight formal studies over the past eight years examining the relationship between Medicaid rates and allowable costs, and the factors that influence rates and costs, on a State-by-State basis. These studies, done annually for the American Health Care Association (a national nursing home trade association), identify the differences between Medicaid payment for nursing facilities and their Medicaid allowable costs on a facility-specific basis in each State. This extensive process involves obtaining provider-specific payment rates and cost reports in as many States as possible and comparing the differences between payment rates and Medicaid allowable costs for each Medicaid-certified provider in that State. The results for all the providers in a State are compiled to determine a statewide

difference between rates and Medicaid allowable costs with a summation of the statewide findings into a national report. These studies have been referenced and relied upon by numerous persons and entities, including the Connecticut General Assembly's Legislative Program Review and Investigations Committee. *See* Legislative Program Review & Investigations Comm., Conn. Gen. Assembly, *Nursing Home Medicaid Rate-Setting System* (2001).

8. I have opined on the adequacy of nursing home payment in legislative as well as judicial forums and in formal, State-specific studies in nine States.

9. A true and correct copy of my *curriculum vitae* is attached as Exhibit A.

PURPOSE OF ENGAGEMENT, DATA SOURCES USED AND METHODOLOGY

10. I was engaged by Plaintiff Connecticut Association of Health Care Facilities, Inc. to determine whether existing rates are consistent with efficiency and economy.

11. In order to make that determination, I examined the relationship between Medicaid rates and Medicaid allowable costs of nursing facilities in Connecticut, focusing specifically on the differences between the Medicaid rates paid to nursing facilities and the Medicaid allowable costs incurred by them in state fiscal year ("FY") 2010 (i.e., July 1, 2009 to June 30, 2010).

12. Medicaid allowable costs do not include all costs incurred by nursing facilities to deliver care. Instead, Medicaid allowable costs include only those costs recognized by the Connecticut Department of Social Services ("DSS") as reasonable and directly or indirectly related to patient care and typically exclude necessary operating costs including, but not limited to, advertising, marketing and public relations, bad debts, income taxes, contributions, certain legal and professional fees, and property costs related to purchases of facilities. Based upon my 35 years of experience preparing and analyzing cost reports, these costs typically constitute 2% to 3% of total costs. In the case of Connecticut, that would represent $4.00 to $5.00 per patient

day, meaning that if all costs were considered, not just Medicaid allowable costs, our findings would reflect shortfalls between Medicaid rates and costs that were $4.00 to $5.00 more per patient per day than what we indicate.

13. In addition, Connecticut determines the nursing home's cost per day based on the assumption that the facility has an occupancy rate of 95%. Based upon the data provided to me (see paragraph 15, below), the actual average occupancy of Connecticut nursing homes in 2007 was 92.7%. The effect of presuming 95% occupancy for most nursing homes is to further reduce Medicaid allowable costs by $16.8 million.

14. To understand the Medicaid payment system for nursing facilities in Connecticut, I was provided with, among other things, a copy of Attachment 4.19-D of Connecticut's State Medicaid Plan, entitled "Methods and Standards for Establishing Payment Rates for Nursing Homes"; the "State Medicaid Plan Amendment Transmittal (TN) 09-012"; and a document prepared by the Connecticut Department of Social Services, Office of Certificate of Need and Rate Setting, entitled an "Overview of Nursing Facility Rate Setting" in Connecticut. I also had discussions regarding the details and history of the payment system with the accounting firm of Anquillare, Ruocco, Traester and Company, who are reimbursement consultants to the Connecticut Association of Health Care Facilities, Inc. and to many nursing homes in Connecticut.

15. To conduct the analysis, I obtained a spreadsheet reflecting the "2007 Medicaid allowable costs by facility." If a facility had more than one licensure type—there are two in Connecticut, chronic and convalescent nursing homes ("CCNH") and rest homes with nursing supervision ("RHNS")—the spreadsheet detailed the Medicaid allowable costs for each licensure type. I also was provided Medicaid rates by facility by licensure type for the FY 2010 rate year

of July 1, 2009 to June 30, 2010. The data was provided by the accounting firm of Anquillare, Ruocco, Traester and Company, who obtained the information from DSS.

16. At my request, to insure data integrity Anquillare, Ruocco, Traester and Company analyzed the spreadsheet of "2007 Medicaid allowable costs by facility" and another spreadsheet obtained from DSS identifying "expenses for each facility utilized in computing rates." In some instances, the "expenses for each facility utilized in computing rates" were significantly higher than those reported in the file of "2007 Medicaid allowable costs by facility." Anquillare, Ruocco, Traester and Company indicated that the disparities related to unidentified and unknown factors, possibly including amendments to cost reports. However, to be conservative, we ignored the higher costs found on the spreadsheet identifying "expenses for each facility utilized in computing rates." Instead, we based our analysis on the facility-specific allowable costs reflected on the "2007 Medicaid allowable costs by facility" spreadsheet. This approach was conservative because, in most cases where there were disparities, the costs were far lower on this spreadsheet than those reflected on the "expenses for each facility utilized in computing rates" spreadsheet. If we would have used the latter spreadsheet, the disparities between the Medicaid rates paid to nursing facilities and the Medicaid allowable costs incurred by them would have been significantly greater.

17. In calculating Medicaid property rates in Connecticut, a fair rental value system is used. That system pays a facility a "rental" amount in lieu of reimbursing a facility's actual allowable property costs (depreciation and interest expense on property plant and equipment). In simple terms, the rental amount is based upon the historical cost of the facility's property multiplied by a debt service factor which amortizes the historical cost over the property's life

(like a mortgage payment would). The average fair rent payment per resident day is approximately $11.

18. Since a facility's actual depreciation and interest expense for the rate year in question is not used by DSS to calculate the rental payment, the "2007 Medicaid allowable costs by facility" spreadsheet does not include actual Medicaid allowable property costs for all facilities. The spreadsheet did include "reported property costs," but the reported property costs for some facilities might have included expenses that might not be recognized as allowable by DSS. Therefore, to be conservative and to assure that unallowable costs did not affect the accuracy of our analysis, we assumed that the fair rental payment was equal to each facility's actual Medicaid allowable property costs. As a result, our findings reflect no shortfall or inadequacy of payment relative to reimbursement of a facility's property costs.

19. To properly compare current FY 2010 Medicaid rates to costs, the non-property costs from the "2007 Medicaid allowable costs by facility" spreadsheet had to be inflated from the 2007 cost report year (October 1, 2006 through September 30, 2007) to the FY 2010 rate year (July 1, 2009 through June 30, 2010). Under the State Medicaid Plan, the costs are to be inflated from the cost year to the rate year using the Northeast Regional Consumer Price Index-All Items (CPI). *See TN 94-011-The Connecticut Medicaid Agency Assurances and Findings Applicable to Medicaid Payment for Long-Term Care Facilities.* We made this calculation using the same inflation index, the Northeast Regional Consumer Price Index-All Items (CPI), to inflate costs from the 2007 cost report year (October 1, 2006 through September 30, 2007) to the FY 2010 rate year (July 1, 2009 through June 30, 2010). Using that index, the inflation rate applicable for this 33-month period was 5.51%. This inflation factor was calculated by comparing the CPI indices from which it was determined that between the four quarters ending September 30, 2007

(cost report year) and the four quarters ending June 30, 2010 (rate year), the CPI had increased from 218.85 to 230.9, a change of 5.51%.

20. In calculating payment rates, the State has often adjusted costs utilizing an inflation factor lower than the inflation rate determined using this index. However, the inflation factor must be generally reflective of cost increases nursing facilities would likely incur between the cost report year and the rate year—in our calculations using 2007 cost reports, almost a three-year time frame. Failure to utilize an inflation factor reflecting actual cost increases experienced by nursing facilities assumes that services can be delivered for less than cost and causes payment rates to be inadequate to cover the cost of care. Moreover, when inadequate inflation factors are used repeatedly year after year, and the last cost reports DSS used for rate setting were from 2003 (now seven years old), the inadequacy is compounded.

21. Anquillare, Ruocco, Traester and Company indicated that 2008 was the latest year that cost report data was available, although the data only reflected "as-filed" cost reports (i.e., before any adjustments by the State). Anquillare, Ruocco, Traester and Company provided us spreadsheets reflecting these "as-filed" cost report expenses by facility for both 2008 and 2007. From the spreadsheets for these two years, we calculated the average percentage increase in costs per patient per day for all facilities from 2007 to 2008. The average percentage increase in per diem costs for that one year alone was 5%.

22. In our calculations, we used 5.51% as the projection of inflation for a 33-month time period from 2007 to FY 2010. A 5.51% inflation rate for a 33-month time period is equivalent to an inflation rate of just under 2% per year. Using an annual 2% inflation rate to project costs from cost year 2007 to FY 2010 is extremely conservative, especially when the

analysis indicates that costs for Connecticut nursing facilities during the first 12 months of that 33-month period have increased by 5%.

23. As a routine convention, it is common to compare nursing home costs and Medicaid payments on a per patient day—or per diem—basis. Calculating the difference between a nursing facility's Medicaid rate per patient per day and the facility's projected FY 2010 per diem cost (cost per patient per day) requires that the total 2007 allowable Medicaid costs be inflated to FY 2010 for each facility and divided by the patient days for the 2007 cost report period. However, the State Medicaid Plan requires, in most circumstances, that the cost be divided by the higher of the actual patient days or patient days calculated based upon the assumption that the facility was occupied to 95% of its total capacity throughout the year. This assumption penalizes facilities with occupancy less than 95% occupancy. It lowers their per diem cost by spreading their total allowable costs not over the actual number of patients and the actual number of days of patient care the nursing home provided in that year, but by a higher number of patient days based upon the inaccurate assumption that a nursing home has excess capacity and should be 95% occupied every day of the year.

24. There are at least two major problems with an across-the-board assumption that every nursing facility operates at 95% occupancy for the entire year.

25. First, different facilities serve different geographic areas, different demographics and different patient populations. A facility in an urban area near hospitals and other referral sources, for example, may operate at a different occupancy level than one located in a more remote or urban setting. Moreover, a facility specializing in short-stay rehabilitation will experience substantially higher numbers of admissions and discharges than a facility providing predominantly long-term care. More frequent discharges and admissions may suppress the

overall occupancy rates because of turnover. However, for both the non-urban facility and short-term rehabilitation, the existence of an empty bed is not indicative of an inefficient or uneconomical operator, but a legitimate characteristic attributable to the facility's market.

26. Second, using the State's methodology in deriving per diem costs assumes that a nursing facility with less than 95% occupancy has excess staff (including nurse staff), supplies, and food to provide care and would not need to incur any incremental costs if occupancy increased to 95%. For example, consider a facility that, on average, cares for 70 patients but has the bed capacity to serve 100 patients. The State's methodology assumes that the facility would not incur "one nickel" of additional cost if the census increased by 25, so that 95 of the facility's 100 beds were occupied. This makes the false assumption that every cost in a nursing home is fixed and does not vary based upon the number of patients cared for by the facility. In fact, the majority of costs in a nursing home increase as resident census increases. More patients require more care and services, which translates to more care givers, housekeepers, laundry, supplies, food, etc. All nursing home departments, for example, set staffing budgets and provide actual staffing based upon a given number of staff per a given number of residents. As patient census changes, so does the number of staff.

27. Application of a minimum 95% occupancy threshold in determining per diem costs is totally unrealistic and inconsistent with the variable nature of most costs in a nursing home. Nevertheless, rather than calculate another minimum occupancy percentage to apply based upon the percentages of nursing home costs that are variable rather than fixed, we used the State's 95% minimum occupancy methodology, dividing 2007 expenses by the same patient days used by the State in determining per diem costs for rate setting. Once again, by doing it this way, we err on the conservative side in favor of the State by understating facility per diem costs

for those facilities where the 95% minimum occupancy threshold was applied. Using cost year 2007 data, the 95% occupancy factor was applied to 83 facilities. In the aggregate, application of the 95% occupancy factor eliminated $16.8 million in costs, or $2.70 per Medicaid patient day, from the rate calculation.

28. From the data provided to us, we were able to compare Medicaid FY 2010 rates to projected FY 2010 Medicaid allowable per diem costs for 221 facilities. Eleven facilities had both a Nursing Facility-CCNH license and a Nursing Facility-RHNS license. Therefore, in total, we were able to compare Medicaid FY 2010 rates to projected FY 2010 Medicaid allowable per diem costs for 232 licensed providers. The results of our analysis follow.

29. Eighty-nine percent of Connecticut facilities, or 207 of the 232 licensed nursing facilities, were paid less than the allowable cost of providing services to Medicaid patients. The Medicaid day-weighted average rate of these nursing facilities was $219.07 but their projected allowable Medicaid day-weighted average cost was $239.99. These 207 entities incurred a Medicaid day-weighted average loss providing services to Medicaid residents of $20.92 per Medicaid day.

30. The Medicaid day-weighted calculation weighs the rate, per diem cost and short-fall of each entity by their Medicaid days as opposed to computing a simple average of all providers' rates, costs and shortfalls. As the Connecticut General Assembly's Legislative Program Review and Investigations Committee has acknowledged, using a Medicaid day-weighted approach is preferable "because a straight average would result in an overall mean by facility, and not consider the number of Medicaid clients in each facility . . . . A weighted average adjusts the Medicaid rate by volume to account for the difference in Medicaid days

among facilities." Legislative Program Review & Investigations Comm., Conn. Gen. Assembly, *Nursing Home Medicaid Rate-Setting System* 12 (2001).

31. A simple example illustrates the purpose of using a Medicaid day-weighted average computation as opposed to calculating a simple average. Assume Facility A has a shortfall of $60 per Medicaid day but provides only 100 days of service to Medicaid patients annually, while Facility B with a shortfall of $20 per Medicaid day provides 10,000 annual Medicaid days of service. A simple average loss for the two facilities is $40 [($(60) + ($20))/2] but that does not represent the average loss on services to Medicaid patients. However, if each facility's shortfall is weighted by their days of service to Medicaid patients, the end result is the average loss for the two facilities relative to serving Medicaid patients. The computation would be [(($60) x 100) + ($20) x 10,000))/10,100] which, in this example, equals an average shortfall from serving Medicaid patients of $20.40.

32. On average, Medicaid residents represented 67% of the total patient census of these 207 nursing facilities with the average number of beds for these 207 providers being 116. For a 116-bed facility that is 95% occupied with two-thirds of the census being Medicaid residents, a $20.92 shortfall per Medicaid day equates to an annual loss of $563,800 relative to the provision of Medicaid nursing facility services.

33. Even those licensed providers with the lowest costs (and thus arguably considered the most efficient) are incurring substantial Medicaid shortfalls. Of the 116 providers with costs at or below the median of all providers, 94 of them (81%) incurred a shortfall between FY 2010 rates and projected FY 2010 Medicaid allowable costs. Their Medicaid day-weighted average rate was $205.53 while their projected allowable Medicaid day-weighted average cost was $217.10. The Medicaid day-weighted average shortfall for these 94 providers was $11.57

per Medicaid day. The average number of beds for these 94 providers is 110 with Medicaid residents representing, on average, 72% of the total patient census. For a 110-bed facility that is 95% occupied with 72% of the census being Medicaid residents, an $11.57 shortfall per Medicaid day would equate to an annual loss of $317,700 relative to the provision of Medicaid nursing facility services.

34. Obviously, no nursing facility can sustain such losses and remain in business without offsetting those losses with other revenues or assets. Thus, Medicaid losses are either passed on and subsidized by non-Medicaid patients (or their families) who pay for nursing home care out of their own funds, by private insurance or other payers, or by being absorbed by the nursing facility. The Connecticut General Assembly's Office of Legislative Research discussed the impact of such cross-subsidization on rates charged private pay patients. *See* Office of Legislative Research, Conn. Gen. Assembly, *Nursing Home Provider Tax—Potential Cost to Private-Pay Residents*, Rep. No. 2005-R-0369 (Apr. 11, 2005). Whatever the actual amount of such cross-subsidization, it is clear that it occurs and that private individuals and/or payers must subsidize the shortfall in Medicaid payments in almost 90% of Connecticut nursing homes, if those nursing homes are to remain viable.

CONCLUSIONS

35. As a result of our analysis of the relationship between Medicaid rates in FY 2010 and projected allowable costs for the same time period, along with our review of the payment methodology for both the current and prior years, we conclude the following.

36. The Medicaid rates in Connecticut bear no relationship to the Medicaid allowable costs that providers are incurring. The data that is being used for rate-setting is from 2003 nursing home cost reports; cost data that is now 7 years old. While the costs were inflated to the rate year, an absolute ceiling on the per diem rates ultimately paid to facilities was imposed (a

stop-gain provision) in disregard of facilities' actual Medicaid allowable costs. In fact, for the past two fiscal years (FY 2009 and FY 2010), the stop-gain was 0%, which meant no rate increases for nursing facilities in the past two years and no recognition of allowable cost increases providers were incurring, regardless of how economical and efficient they were.

37. In essence, the system has become what is commonly called a "rate-on-rate" system. The rates are derived from out-dated cost information (in the case of Connecticut, 2003 data) and then rolled forward by a factor that is driven by state budgetary considera-tions and not necessarily representative of cost increases nursing facilities incur between the old base year (2003) and the current rate year (2010). This de-coupling of the relationship between the Medicaid allowable costs that nursing facilities are incurring and the rates they are paid has been duly noted by the Connecticut General Assembly's Legislative Program Review and Investigations Committee. In their 2001 report entitled "*Nursing Home Medicaid Rate-Setting System*," the committee found that "adoption of flat percent increases for rate reimbursement has eliminated the relationship between facilities' allowed costs and the Medicaid rate ultimately issued." The committee also concluded that, "since FY 00, the stop-gain provision has made this calculation [referring to the rate-setting calculation based upon recent cost reports subject to certain cost ceilings] pointless, since a flat increase percentage is merely applied to the prior year's rate to yield the new per diem issued to a facility. In other words, the rate ultimately established has no connection to the costs submitted by the facility [in their annual cost reports]." Legislative Program Review & Investigations Comm., Conn. Gen. Assembly, *Nursing Home Medicaid Rate-Setting System* 26 (2001).

38. DSS's own analysis relative to the cost of rebasing demonstrates that there is no relationship between Medicaid allowable costs that providers are now incurring and the

Medicaid rates they are paid. When using more current cost report data from 2007 for each facility and basing rates on these more current costs, DSS's own figures indicate that FY 2010 rates would have increased by 9.64% or by approximately $114 million. These rates were simply not implemented due to state budgetary considerations.

39. A determination that rates are consistent with efficiency and economy requires defining the terms efficiency and economy and then insuring that the rates are consistent with the costs being incurred by those providers meeting that definition or standard. As it relates to nursing facility care, efficiency is commonly defined as rendering care and services with a minimum waste of time and/or resources, with economy meaning that the prices paid for those resources are prudent and reflective of market conditions. The standard of efficiency and economy is most commonly applied using a "zone of reasonableness" concept. Rather than attempting to drill down into nursing home operations relative to facility-specific staffing, wage and benefit levels and inventory and purchasing, States commonly consider economic and efficiently operated to mean incurring cost levels that are reasonable in comparison to industry norms. Those norms are typically established at or within some reasonable percentage (zone) above industry median cost levels.

40. The State's definition of efficiency and economy has historically been consistent with the methodology just described, defining efficiently operated as a cost level that ranks at or below the median cost in each cost center. *See TN 94-011-The Connecticut Medicaid Agency Assurances and Findings Applicable to Medicaid Payment for Long-Term Care Facilities*. That same document defines economically operated by comparing each facility's current performance to its prior performance to determine if the facility is operating in an economical manner.

41. However, the cost levels that providers are now incurring and their actual year-over-year performance relative to cost increases are not taken into account in the current rate setting process. Instead, regardless of providers' current spending levels and their actual cost increases, the per diem rates continue to be based upon out-dated cost data with increases capped by stop-gain provisions, which for the last two fiscal years alone have been 0%. As a result, the current rates bear no relationship to actual Medicaid allowable costs that providers are incurring. Even those providers with current cost levels within the State's own efficiency standard (the industry median) and are economical in terms of reasonable cost increases would not have rates consistent with their costs, again because the rates bear no relationship to their costs. As such, it is impossible for existing rates to be consistent with efficiency and economy.

42. Our analysis of the relationship between FY 2010 rates and Medicaid allowable costs further supports this contention that payment rates are not consistent with efficiency and economy. A table that summarizes our findings is attached as Exhibit B.

43. As stated previously, our analysis reveals that almost 90% of providers lose money from providing services to Medicaid patients, the average shortfall being $20.92 per Medicaid patient day for these providers. A shortfall of $20.92 per Medicaid day for a facility with an average daily Medicaid census of 75 patients would result in an annual loss of more than $550,000 annually.

44. More than 80% of the providers whose Medicaid allowable costs are within a reasonable efficiency standard (those with costs at or below the midpoint of all providers), and arguably the most efficient providers, incur substantial shortfalls as well. For these providers, the average loss is $11.57 per Medicaid day. A shortfall of $11.57 per Medicaid day for a facility with an average daily Medicaid census of 75 patients would result in an annual loss of

more than $300,000 annually. This shortfall analysis also factors in an economy standard consistent with the State's definition of reasonable cost growth by inflating the latest cost report data (cost year 2007) to FY 2010 for all providers by an extremely conservative inflation rate of less than 2% per year.

45. It is not possible for Medicaid payment rates in Connecticut to be consistent with efficiency and economy when:

A. An extremely high percentages of all providers, regardless of their level of cost efficiency, incur substantial losses from providing Medicaid services; and

B. The State's own analysis indicates that Medicaid funding is short $114 million in FY 2010 if more current actual allowable Medicaid costs of nursing facilities are considered.

46. It is evident that Medicaid payment rates for Connecticut nursing facilities bear absolutely no relationship to the actual Medicaid allowable costs providers are incurring. Under such circumstances, current Medicaid rates cannot be consistent with efficiency and economy.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on February 12, 2010

/s/ Joseph M. Lubarsky
JOSEPH M. LUBARSKY

EXHIBIT A

Joe Lubarsky was the National Director of Long-Term Care Services for BDO Seidman, LLP until his retirement from the firm in 2006. Joe has worked exclusively consulting with long-term care providers for the past thirty-four years. He has specific hands-on experience in all aspects of financial management for long-term care facilities, including budgeting, planning, reimbursement, acquisition and feasibility. He continues to work extensively with both national and state nursing home associations in development and refinement of reimbursement systems and funding mechanisms. He has been involved in the design or refinement of Medicaid payment systems in 10 states in the last 10 years.

Professional Profile

Directed the firm's Medicare consulting practice; conducting research projects, handling Medicare appeal issues, providing litigation support services, developing Medicare cost accounting systems and conducting workshops on Medicare PPS issues. Wrote the *Medicare Exception Manual* for the American Health Care Association (AHCA) based upon new exception requirements as well as a manual for AHCA on cost accounting under the Medicare Prospective Payment System.

Managed the firm's health care due diligence practice managing and conducting agreed-upon procedures engagements relative to the acquisition or refinancing of numerous long term care companies

Conducted eight formal studies for AHCA on Medicaid shortfalls in nursing homes throughout the country; the first study of its kind identifying the Medicaid shortfall on a national basis

Served as lead consultant to state nursing home associations on redesigns of Medicaid payment systems in Kentucky, Idaho, Colorado, Virginia, New Jersey, Nevada, Pennsylvania, Louisiana, Hawaii, Rhode Island, California, Tennessee, Utah and North Carolina

Worked with Arizona Health Care Association on payment issues relating to 2005 rate rebasing

Worked with provider associations and state agencies on the design of provider tax programs and strategies including development of provider tax waiver programs and corresponding rate system modifications in California, Colorado, Connecticut, Florida, Georgia, Idaho, Indiana, Kentucky, Maryland, Michigan, Nevada, New Hampshire, North Carolina, Oregon, Pennsylvania and Utah. Participated in numerous calls and meetings with CMS on provider tax waiver programs and hold harmless interpretations.

Served as lead consultant to Washington Health Care Association and Washington Association of Homes and Services for the Aging relative to Medicaid property payment system redesign

Conducted formal studies in nine states (Montana, Minnesota, Kentucky, Oklahoma, Louisiana, New Mexico, Pennsylvania, Arkansas and Tennessee) on the cost impact of federal legislation (OBRA) on nursing homes in those states.

Conducted formal studies in eight states (Wisconsin, Oklahoma, Tennessee, Florida, California, Pennsylvania, Louisiana, and Montana) on the adequacy of their Medicaid reimbursement plans identifying problems with their systems and providing recommendations for improvement.

Provided litigation support services in Boren Amendment lawsuits in Wisconsin, Oklahoma, Montana, and Arkansas

Directed the development of nursing home databases in Wisconsin and Texas consisting of information on cost reports for over 400 homes in Wisconsin and over 900 in Texas. This comparison report, done annually, has been an excellent management tool for facilities for operational analysis and rate negotiation.

Directed the development of pricing models for managed care contracts including full costing and incremental costing models and options. Developed practical cost accounting models to identify margins under the Medicare PPS program.

Consultant to thirty-two state nursing home associations.

Education
B.B.A. (Major in Accounting) University of Wisconsin - Milwaukee, (1974)

Affiliations
American Health Care Association (AHCA)
American Institute of Certified Public Accountants (AICPA)
American Health Lawyers Association (AHLA)
Wisconsin Health Care Association (WHCA)
Wisconsin Institute of Certified Public Accountants (WICPA)

Publications
- Wrote numerous articles for nursing home trade publications on issues related to reimbursement and financial management.
- Wrote the *Medicare Exception Manual* for the American Health Care Association.
- Wrote *Cost Accounting Under PPS* manual for the American Health Care Association.

Presentations

Frequent speaker on long-term care issues conducting approximately 10-15 workshops or presentations each year for such organizations as:

American Health Care Association (AHCA)
American Society of Consultant Pharmacists (ASCP)
American Health Lawyers Association (AHLA)
Numerous state nursing home associations

Other

Recognized as one of the top 100 most influential people in the long-term care industry in the country by *McKnight's Long-Term Care News.*

EXHIBIT B

Exhibit B

	Number	Number of "Losers" (Rate<Cost)	Percentage Incurring Losses	Medicaid Day-Weighted Average Shortfall for These Providers	Medicaid Day Weighted Average Rate	Medicaid Day Weighted Average Cost
All Providers	232	207	89.20%	$ (20.92)	$ 219.07	$ 239.99
Facilities with Medicaid Allowable Costs at or Below the Median	116	94	81.03%	$ (11.57)	$ 205.53	$ 217.10
Facilities with Medicaid Allowable Costs at or Below the 25th Percentile	58	42	72.41%	$ (10.29)	$ 191.97	$ 202.26