STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

DOCKET NUMBER GMCB-014-15CON

IN RE: GENESIS HEALTHCARE, INC. CERTIFICATE OF NEED HEARING. PROPOSED PURCHASE OF FIVE (5) VERMONT NURSING HOMES LOCATED IN BENNINGTON, BERLIN, BURLINGTON, SPRINGFIELD AND ST. JOHNSBURY

June 2, 2016
1 p.m.
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89 Main Street
Montpelier, Vermont

Certificate of Need hearing held before the Green Mountain Care Board, at the Second Floor Hearing Room, City Center, 89 Main Street, Montpelier, Vermont, on June 2, 2016, beginning at 1 p.m.

P R E S E N T

BOARD MEMBERS: Al Gobeille, Chairman
Cornelius Hogan, Board Member
Betty Rambur, Ph.D., R.N.
Allan Ramsay, M.D.
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P R E S E N T

Jaime Fisher, GMCB Staff
Kelli Rockandel

I N D E X

MR. GOBEILLE: Good afternoon. I'll call this meeting of the Green Mountain Care Board back from recess from this morning.

Next on our agenda is the Genesis Health Care Certificate of Need hearing which is scheduled to go from 1 to 3. Just a couple of points, first is unfortunately we have an AC issue in the building. If you're feeling a little hot, it's because you are correct. I've declared it a no-coat zone. So if anybody wants to take their coat off, you can. We have the windows open. If anything flies in, jump on it; do something, and we will try to get through this. They have also been working in our back parking lot with jack hammers. If that was to happen, we will show our flexibility and come up with some alternative plan.

So all that being said, at this point I'm going to turn it over to the hearing officer, Noel, who is going to take it from here.

Are you ready? You may need to pull it close to you.

MR. HUDSON: Good afternoon everybody. My name is Noel Hudson. Can you hear me?

MEMBER OF THE PUBLIC: Is it on?

MR. HUDSON: Can you hear me now? All

right.

So my name is Noel Hudson. I'm the designated Hearing Officer in this proceeding today. I also serve on the Board's staff as Director of Health Policy. For the record today is June 2, 2016.

This is a hearing in the matter of a proposed purchase by Genesis Health Care, Incorporated and its subsidiaries. Docket Number is GMCB-014-15CON. The application review and hearing are conducted under Chapter 221 of Title 18 of Vermont statutes as well as the Board's Certificate of Need Regulation Rule 4.

We have a court reporter with us. Her name is Kim Sears. Transcript of this proceeding that she will be generating will be available within a reasonable time for anyone who wants to request one. Speaking of the record, please turn all cell phones off at this time. And Jaime, can you hear me?

MS. FISHER: A little bit closer.

MR. GOBEILLE: Can that go up a little bit at all? Can the volume on these go up a little?

MR. HUDSON: How's that? Good. Okay. So please turn all cell phones off at this time. We need a distraction-free environment for the Board, for the parties, and for the generation of the

record.

The parties to this proceeding are the applicant, Genesis Health Care, Incorporated and intervening party Jacqueline Medoros who is the state's long-term care ombudsman. She has submitted a written statement but will not be appearing as a witness today. At this time all those who are appearing as witnesses today please stand to be sworn in by our court reporter.

MS. COHEN: Can I ask a procedural question? So we have some people here that are going to be giving a presentation, but then there are representatives of Genesis who have particular subject matter expertise who may or may not speak depending upon what the Board's questions would be. Would you like me to have them all stand just in case and be sworn?

MR. HUDSON: Sounds good. Everyone who may be testifying feel free to stand now.

MR. GOBEILLE: Maybe we should have just left everyone seated.

LINDA COHEN, RICHARD RASKIN
MICHELLE COSTA, JUDY MORTON
RICHARD BLINN, KEN CULLEROT
TOM DEPOY
Having been duly sworn, testified as follows:

MR. HUDSON: Thank you everyone. The order of business today we will first be hearing from Donna Jerry, a senior analyst on the Board's staff. She will be introducing this application for any members of the public who may be here and to get the Board settled into this hearing.

MR. HOGAN: I'm having a very hard time hearing you. So crank this thing up. Let it rip.

MR. GOBEILLE: I prefer he yelled and we have no fans.

MR. HUDSON: I can yell if you want. So our first witness will be Donna Jerry, a senior analyst with the Department -- sorry -- with the Board. Apologize for that saw going behind me. Followed by the applicant, Genesis Health Care, Incorporated, represented by Linda Cohen of Dinse, Knapp & McAndrew as well as the applicant's designated witnesses, and then after that the public will have an opportunity to make statements as well.

After each witness the Board will have a chance to ask questions. And also during witness presentations the Board may be asking questions as well.

So with that, I'll call the first witness. Ms. Jerry, you may proceed.

MS. JERRY: Very good. Good afternoon all. As Noel said, the Genesis Health Care, Inc. is proposing to purchase five nursing homes in Vermont currently owned by Revera. They are located in Bennington, Berlin, Burlington, Springfield and St. Johnsbury.

On 10/16/15 we received an application from the applicant. As Noel mentioned, there is one interested party which is the Vermont state long-term care ombuds. And following completion of interrogatories, the application was closed on April 27. And just as background, the purchase price -- proposed purchase price of the five facilities in Vermont is approximately 39 million. And Genesis currently owns four homes in Vermont. They own two in Rutland, one in Newport and one in St. Albans. And that's just more background for the audience.

Very good. Thank you.

MR. HUDSON: Thank you, Donna. So we

now call Genesis Health Care, Incorporated.

MS. COHEN: Thank you. Linda Cohen. I have been introduced from Dinse, Knapp & McAndrew. It's my privilege to be here on behalf of Genesis Health Care, Inc. seeking a Certificate of Need to purchase five skilled nursing facilities from Revera.

We had spoken about this before. And our general impression is we are unsure of how much the Board knows of skilled nursing facilities. So to the extent that we are using as we are talking a term of art or something that is not immediately understandable, please feel free to interrupt us. We are happy to do whatever to make our presentation in the manner that's most suited to the Board's ability to understand.

Our agenda for today is I'm going to introduce the parties who are here and a little bit about the proposed transaction, give you some purchase details, and then go on to the criteria that the Board will be considering in granting the CON. We will talk about the Triple Aims. The HRAP and CON standards and the public good standard.

Genesis Health Care and its subsidiaries are here requesting approval to purchase five skilled nursing facilities from Revera Assisted

Living. Donna Jerry was able to tell you where those five facilities are. They are listed on the slide as well. We wanted to note for you this is part of a larger transaction. It was a 24-facility transaction between Genesis and Revera. 19 of the other facilities have already closed in eight other states on December 1 of 2015. Revera is the seller. Revera is a privately-owned Canadian company that operates over 500 properties in the United States -- in Canada at this point. And the reason that I stop myself is because Revera has plans to ceasing its operations in the United States. So they have -- this transaction is part of their planned exit from the United States' market. They're shifting their focus as you can see from this slide and they are divesting of their skilled nursing facilities and the supporting infrastructure that exists in the United States. So they are not going to be here operating skilled nursing facilities.

It's for the Board to note since December 1 of 2015 when the other facilities closed, Genesis has been under contract with the operating companies that it's formed, and I'll explain more later, to manage the facilities -- these applicant facilities. So Genesis has been on site managing the

facilities since December 1. And we informed DAIL of that and received consent for that arrangement to be entered.

I'm now going to turn the presentation over to one of my two co-presenters. The first co-presenter is Dick Blinn who is the Executive Vice President for the Northeast Region of Genesis, and he'll explain a little bit of that. He'll turn over to Michelle Costa who is the Vice President of Clinical and Quality for the Northeast Region who will then turn back to me.

MR. BLINN: Thank you, Linda. And thank you for allowing me to take my coat off. A little warm. Good afternoon.

Again my name is Dick Blinn. I'm the Executive Vice President for Genesis Health Care here in New England. I started my career as a social worker back in 1979 in a nursing home in Massachusetts. And I worked in nursing homes or supervising nursing homes ever since. Spent my entire career here in New England. I'm a New Hampshire resident. I have lived in New Hampshire for the past 25 years. Prior to that was also from the flat lands of Massachusetts.

Genesis itself was founded in 1985

actually in New England, in Massachusetts, in Agawam, and they bought six centers. They currently operate over 500 skilled nursing centers assisted living communities across 34 states. We have -- we are operating 116 skilled nursing facilities and assisted living currently in New England in all six states. We have been in the State of Vermont since 1995 with the acquisition of Mountain View in Rutland which was part of the McCurley acquisition. We are a publicly-traded holding company maintaining consolidated financial statements with subsidiaries.

We provide national, regional and facility-specific leadership, management and support to each of the skilled nursing centers which I will -- when we get into the org chart I'll try to show you a little bit about how deep our support is and where it's located. We currently own four skilled nursing facilities in Vermont with the same ownership structure, again the same regional leadership team.

Three of the four centers are -- currently have won national quality awards through our national trade association, American Health Care Association. And all four are in substantial compliance with DAIL.

We really like this transaction, and

for a number of reasons. It's a good geographic and cultural fit for us. You know, having a regional team located in New England and in the State of Vermont makes it sort of a natural fit to grow into the State of Vermont where we only had four facilities prior. The Revera buildings were unusual in that most of the times, and some of you can imagine this, when we look to do acquisitions the seller may have been looking to sell for two or three or four years, and there is little capital put into the building. So when we acquire centers oftentimes there is a lot of infrastructure, roofs, heating systems, generators, etc., major capital that needs to be done. With Revera it was quite the opposite. They have actually spent a lot of capital over the last three years, and there is very little, if any, major capital requirements in the majority of the 24 centers that we are part of this deal. So that was very attractive to us.

Also we feel like Vermont being one of the New England states is a good fit for us. Been here since '95. We have worked collaboratively with the state on other projects. Back in 2008 we took over two of the Haven centers which were problematic centers. Their company had gone bankrupt, so we

worked with the state, took those over, and have been running those successfully since 2008; difficult centers, but have done a fairly good job with those.

And the other issue that was attractive was the four existing centers quite frankly wanted us to buy more in Vermont feeling like the ability to have sister facilities locally, to exchange best practices, et cetera, is attractive to them, such as what we have in the other New England states where we have a little bit more penetration.

So if you can flip that to the org chart which you probably can't read. But at the top is George Hager who is our CEO. He's been with the company for approximately 24 years. He was our CFO prior to being our CEO. Top line is really the folks at our corporate office in Kennett Square, Pennsylvania. They do come out here occasionally. But for the most part they are located and they support our teams here in New England.

Under Mike Reitz who is the Chief Operating Officer is myself. As you can see, I have been with Genesis for the last 18 years. And again, I'm a New Hampshire resident. On the left-hand side under me is Wendy Labates who really wanted to be here today. Wendy is my Senior Vice President of

Operations. She was not able to be here because of a family issue. But Wendy is a rather unique individual in this field. She is the Senior Vice President of Operations for New Hampshire, Vermont and Maine. So we have split the region in half. Sean Stevenson on the other end of that chart has the other lower Rhode Island, Connecticut and Massachusetts.

Wendy actually started her career as an LNA working in nursing homes. She then got her nursing degree, worked in both nursing homes and hospitals. She then got an RN. She got a BSN. She then got her administrator's license so she ran a building for many years. She was then promoted to a regional administrator; ran her own home and a few other homes. She then was promoted to Vice President of Clinical Services. So she was my Michelle prior to Michelle, and was the Vice President -- VP of all the clinical services provided in New England, and is now -- at that time got her MSN. Also has a Master's degree in Health Care Administration. So unique individual. And again she wanted to be here today but was unable to be here.

As I go through this real quickly I'll ask those of you who I mentioned to stand up. Some

of them are here in the room, so you can understand who is here. Ken Cullerot is our VP and Area Controller. Ken actually came aboard with the McCurley acquisition in 1995, so he has not only his 32 years goes with -- I know he doesn't look that old, his 32 years goes back to the McCurley days. He was here and involved with the Mountain View acquisition.

Michelle Costa sitting to my left. Ken, by the way, lives in New Hampshire, so he's a local guy at our Andover, Mass. office. Michelle Costa you're going to hear from shortly. Just to let you know that Michelle also started her career as an LNA in a nursing home. And then later went and got her BSN, worked in nursing homes as a charge nurse, became a Director of Nursing, became a Manager of Clinical Operations, and a Director of Clinical Operations. And took Wendy's place when we moved Wendy into operation. So Michelle is also very well rounded and has a lot of background in the nursing home industry. She lives in Massachusetts and has been with us for 18 years.

Mary Tess Crott who is not here with us is our Vice President of Quality Improvement. Mary Tess is a nationally known quality expert. She works

extensively with both CMS and with our national trade association, AHCA, in developing quality programs working to the development of the QAPI program which is something new that's about to come out formally from CMS.

Pat Colanton is our VP of Human Resources. 14 years; lives in Massachusetts. Works with her team to support the centers in terms of recruitment, retention, leadership development. Right now major focus on both recruitment and retention; work force availability in all of the New England states right now is getting very, very tight, and Vermont is no different than any other states when it comes to trying to staff. We are seeing competition from some of the hospitals that we never saw before in terms of they are hiring LPNs and new grads which they never did before.

Doctor Rich Raskin is here today. Rich is our Senior Vice President of Medical Affairs. He's been with us for eight years. Rich brings a very unique skill and service to our nursing centers. All of the medical center directors of each center has a medical director. In the past they have operated very independently providing clinical leadership and physician leadership to each center.

With the advent of Rich Raskin and our Genesis physician services group, we have regular meetings with our medical directors. Rich will come up. He has had quarterly meetings for the last I don't know how many years, since he's been here, I guess eight years, meeting with the medical directors, making sure that there is a strategic and sort of similar approach to the care in each of the centers from a physician's perspective as well as nurse practitioners.

In many cases we actually hire our own physicians and our own nurse practitioners. Jim Noddin been with us for 16 years. Jim is the VP of Environmental and Property Management. Another New Hampshire resident. Rich, by the way, lives in Connecticut. Jim is responsible for our capital budgeting, our capital projects. So if somebody in -- Jim has a staff that works with him. If Jim -- if a center up here needed say a roof or a generator, administrator might not understand all of the details of getting specs for a roof or something like that, that's Jim's job to come up with his folks or send his folks up to help spec those type of things out. Any environmental issues Jim gets involved with as well.

Pete Middlemass. Nine years New Hampshire resident. Pete does VP of Business Development. Works very closely with hospital relationships and physician group relationships, and in Massachusetts right now a lot of the ACOs and BBCIs and all of those things that we are probably starting to hear about but not sure what they are, because I'm not sure what they are, are coming fast and furious at us in Massachusetts similar to what the One Care is in Vermont.

And Sean Stevenson who I mentioned is the Senior VP for the other southern states.

Here with us today, Tom DePoy. Tom is here. You may know Tom. He's a Vermont native. Lived here his whole life. Tom and I were talking earlier today. Tom and I actually started working together in 1982 which kind of ages us a little bit. But Tom worked with Genesis for a number of years. He left us to work with Revera in Vermont, reduce a little bit of his travel, and for some upward mobility position. And now Tom has come back to us which will provide a nice smooth transition between the centers from a Revera perspective to the Genesis perspective.

Judy Morton who is also here with us.

Judy is a senior administrator. She runs the Mountain View Center in Rutland. She is on the board of managers of One Care here in Vermont. She is I believe the only skilled nursing representative on that board. She is also a member of the board of the Vermont Health Care Association which is our trade association. She is a Vermont native.

She has led the culture change initiative in Vermont and certainly at the Mountain View Center. It's a very unique center, very progressive when it comes to making a nursing center look more like a home.

Judy also -- a little tidbit of information about her. Judy when she was a child used to take the bus to Mountain View to visit her mother who was also the administrator at Mountain View back in the day.

And then under Michelle we have Donna Babineau who is the Director of Clinical Operations who covers Vermont and some of New Hampshire.

Then we have three clinical operations managers. One educator and two managers. Also with 15, 10 years. Those two also live in the State of Vermont and oversee the buildings here in Vermont. So we have about a one to five, one to six ratio of

our operations; clinical operations managers. So that in a nutshell is our -- sort of our org chart. I'm sorry I took so long with that. I just wanted to make sure you understood there was a team here in New England to operate our centers. We are not corporate from Pennsylvania and just pop in every once in awhile. Our folks are here every day here in New England.

If anybody has any questions about the org chart? If not, I'll turn it over to Michelle.

MS. COSTA: Hi again. I'm Michelle Costa. I'm the Vice President of Clinical Operations for Genesis.

I'm just going to briefly explain to you our clinical support and our quality team that we have within the northeast region. So I have the privilege of having a very good interdisciplinary team who reports up to me. On that team is a dementia specialist, a social service specialist, I have two regulatory compliance managers who are former Department of Public Health surveyors from the state of New Hampshire. And then I have RNs who are regional clinical educators, and then I have RNs called managers of clinical operations. I'll refer to them as MCOs, who are all Registered Nurses and

who have all been directors of nurses at one point in a long-term care facility. Their responsibilities, which is what I'm going to focus on mostly, is they what we call partner with our centers. They work with the directors of nurses at the center level to find opportunities for clinical improvement, focus on regulatory compliance, do medical chart reviews, and support centers when they have their annual survey from the Department of Public Health.

They also look at any opportunities, clinical initiatives that may need some improvement, or also look at best practice that they can share with their other centers that they are covering.

I also have a staff of per diem people who work occasionally who will help go into centers that are struggling with programs, and they work solely in that one center rolling out clinical initiatives, getting staff to really understand what it is they need to get done clinically whether it's focusing on wounds or falls or whatever it may be.

They help establish our policies and procedures within Genesis too, because we have many, many different policy and procedure manuals, so as policies get updated, they provide the education. We are also very happy that we promote a two-way

communication system with the centers. So on a monthly basis the directors of nurses are responsible to report up to, not just the managers of clinical operations, but to myself, and then also to folks in Kennett Square, in-house supplied pressure ulcer rates, falls rates, weight loss, rehospitalizations, a lot of the quality measures. They do reports. And then the managers of clinical operations review those reports to see where it is that the center may need some help and some guidance.

At the same time directors of nurses will notify the managers of clinical operations and say hey, I think I need some help in wound management. I'm seeing my numbers go in the wrong direction. Can you come in, do an in-depth analysis, and help me get back on track. So there is the two-way communication that we promote at the centers.

My clinical education department, they do education in two ways. They will provide on-site clinical education in the centers. So if a director of nurses or a staff development coordinator, we call them NPEs, nurse practice educators, identify where they need some education, clinical educator will go to that center and provide education just for that center.

If it's related to CMS regulations, or changes in policies and procedures, then they hold Adobe Connect education where multiple centers and multiple folks can join in on that educational program. And all of which are videotaped. So if the center was to miss that day, they can go back and review it at a time that's convenient for them.

We have a philosophy as we do acquisitions of doing an incremental change management program. We do not take over our building on December 1 and say, okay, you're Genesis. Here's all our policies and procedures and expect them to perform like we do. We do a strategic map out monthly of programs and policies and procedures to allow the centers and the nursing staff to really understand them, grasp them, and move forward before we introduce another program.

Part of Genesis too is our Genesis physician services. Our physicians, nurse practitioners, and physician's assistants work for Genesis Physician Services led in the northeast by Dr. Raskin. They use evidence-based clinical protocols for their policies and procedures. They are available for consultation to our centers. They are obviously our direct employment of Genesis Health

Care and they support the medical directors, especially with bringing new changes from CMS that affect the medical directors. It is the Genesis Physician Services that is responsible for that.

Doctor Raskin does, as Dick said earlier, hold regular director meetings on a quarterly basis. He does them in all the different states in which we operate here in the northeast. And they get reports, that that helps the medical directors guide them in what needs they may possibly focus on. So one of them is the Flacker report. The Flacker report is a report that is taken off of the MDS, which is a special assessment we have to do in long-term care, that will trigger whether or not a patient could possibly benefit from Hospice care or end-of-life palliative care. There is certain things on the MDS that we code that may say it's time to have advanced care planning discussions, Hospice conversations with this patient.

They also get reports on the use of our telepsychiatry, how many patients they are seeing, how often are they seeing patients, and then everyone in the region not just the physicians, but I as well get an antipsychotic usage report, where are we in relation to national averages, and where are we doing

reductions where they are appropriate.

MS. COHEN: Back to me. Do you guys want to stay or go?

MS. COSTA: I'll sit in the back.

MS. COHEN: That's fine. Thanks.

MR. HUDSON: Attorney Cohen, before we proceed, are there witnesses -- can I give the Board the opportunity to ask questions?

MS. COHEN: Absolutely. Good idea.

MR. HUDSON: Do the Board members have any questions for these two witnesses?

MR. HOGAN: I'm not sure how you want to handle this. Do you want to have all questions at the end of this, or do you want to spread them out?

MR. HUDSON: If you want to wait until the end.

MR. HOGAN: Yeah, I think so. I would. I don't know about the others.

MS. RAMBUR: I have some questions, but I can do them at the end. So --

MR. HUDSON: All set.

MR. GOBEILLE: I think everybody has questions. But they want to hold them.

MS. COHEN: So this is a brief diagram of the transaction that's proposed. It's a purchase

from Revera. The buyer will assign the right to purchase the real estate through property companies which are Vermont-formed LLCs, and the right to purchase the other facility assets to operating companies also Vermont-formed LLCs.

One of the things that's interesting to note about this structure of property companies and operating companies is it's largely driven by the HUD financing program. So HUD likes to see -- and we can address questions about this more -- but HUD likes to see the property company that is taking a mortgage being a single-purpose entity with the single set of assets, so this structure that you see is again largely driven by the financing.

This is a list of what's being purchased. I don't think there is any need to read it back to you. But if the Board wants to look at it. Given just the nature of the room, the noise, the heat, I'm going to try to go quickly. If I'm going too fast, stop me. But I think everyone will appreciate me being speedy. Yes.

MR. GOBEILLE: Brilliant.

MS. COHEN: So this purchase is following a common structure of other purchases including the other Revera purchases, and as we

described, each facility is going to be operated by a Vermont operating LLC that's a member-managed LLC with common operators. Very similar to the structure of the four facilities that -- in Vermont that Genesis currently owns and operates.

Same thing with the real property. I have put in from the submission materials ownership following the purchase. The thing that I would like the Board to note is that all of the ownership ultimately goes up to Genesis Health Care, Inc. which is the publicly-traded holding company that files consolidated financial statements for all of the entities below. What that means is with the consolidated financial statements, the consolidated borrowing, Genesis Health Care, Inc. is responsible for the entities that fall below it. So it makes no business sense or common sense for them to not support the lower entities if the owning entities, operating entities and property entities have financial failure, it inures up to the parents.

So there haven't been any circumstances where Genesis has not financially supported the centers, and that's just good business sense for them.

The purchase details as asked for in

the Certificate of Need. Basically what I can say to you is Genesis doesn't intend to make any significant changes either in the facilities or in the staffing. There is one change that is helpful with meeting Vermont policy goals which is a reduction of 52 beds. That comes out of four of the five centers that we're asking for permission to purchase, and reducing those unoccupied beds will add additional private rooms. Very minimal disruption to the current residents. Maybe six. I think they are thinking maybe fewer than six, but those six that would be moved would be given the appropriate regulatory notice and the opportunity to be made comfortable and in a room, an appropriate room.

DAIL which is the Division of Aging -- Disabilities, Aging and Independent Living is supportive of the move to private rooms. They feel that it enhances quality of care and the residents' experience. There are no management changes planned for the facilities to be purchased. Although since there has been the management agreement, the two administrators and one director of nursing have changed. Again staffing would be the same. We have introduced you to Tom DePoy who is a former Senior Vice President at Revera. Genesis retained him to

help with the transition, the changed management and to facilitate the effective transition over to Genesis.

Donna had given you the purchase price information. This is a breakout by facility. It basically allocates the overall purchase price to each facility as well as an allocation of the overall project cost which includes closing costs and loan fees. Initial financing is through a bridge loan with Welltower, Inc. which was formerly Health Care REIT. There is the interest rate. It's guaranteed by first mortgage. This is the information that is used for the financial projections for the first period of time, and then the financial projections I believe assume that there will be a HUD refinancing.

There is a formal portfolio credit approval from HUD. Genesis has been accessing that formal portfolio approval to refinance other centers throughout the country. And the plan is to refinance with HUD as well.

There are some important state policy goals that this transaction would facilitate. The first is the reduction of beds and the goal of achieving a 50/50 balance between in-home care and skilled nursing care in each county in Vermont.

Genesis and its personnel who have been here in Vermont for some period of time are very active in cooperative health planning. I think we have already noted that Judy Morton is on the board of One Care. DAIL has characterized them as an active state partner, and here are some basic, some train -- OASIS has a training program. There is a list of programs that Genesis people have cooperated with DAIL with. Also Mr. DePoy and Ms. Morton are active in the Vermont Health Care Association and its board, and there are a couple of projects that they have been particularly active with that trade association.

There are some standards set forth in the statute for you to consider. And so I'm going to go through those standards now. The first is whether the proposed transaction satisfies the Triple Aim. This is Genesis's corporate tactical strategy approach to satisfying the Triple Aim. And you're well aware I think of what the three elements of the Triple Aim are. But basically strategically Genesis on a company-wide level is looking at patient engagement and care delivery models that will improve the patient experience of care. They are looking to partner with other providers in the health care

delivery system both upstream and downstream and as well as tracking key data measures in order to improve population health. And they are looking at identifying in-house capabilities to reduce lengths of stay which would reduce costs as well as helping people prepare effectively for discharge from a skilled nursing facility to be successful at home, which also reduces the per capita cost of care.

As far as improving the individual experience of care, Genesis is strongly committed to support independence and functioning of its residents. The care planning is driven by patient goals. Patients are in -- actively engaged in assessing their goals, what their activation is towards achieving those goals and engagements in achieving those goals, and what their engagement is in achieving those goals. And the care plans are drafted to reflect that patient goals.

There is dining choices. Genesis made an earlier change than expected in the dining services from when it took over the operating and actually canceled the prior Morrison contract early because it just wasn't up to Genesis's standards. There was not an emphasis on fresh food. There was not an emphasis on choice dining. And so Genesis

very strongly believes that food and nutrition is one of our basic pleasures and tries to deliver to the residents the ability to eat as closely as possible as they would if they were home. So that includes offering choices, not having tray lines; snacks being available, and on demand dining to the extent practical.

Consistent in assignments is a huge factor in Genesis's quality which means that on the actual floors try to make as few staffing changes as possible and try to make sure that the nurses who are working with residents and the aides who are working with residents are consistently assigned. That allows the staff to become familiar with residents to know preferences, to actually anticipate needs, and try to fulfill them before they actually arise. So that consistency of care staff is very important to improving a resident's experience in a skilled nursing facility. And Genesis works really hard to keep consistent assignments.

Patients are afforded some choice in schedules. The quiet -- the quiet center is also a very big concept in resident's satisfaction. So alarms are eliminated. There is no paging. There is quiet hours for sleep. Mr. Blinn noted that when he

visited some of the centers while he's up here and noted that he was jarred to hear an overhead alarm because he's become so accustomed to not hearing that in Genesis centers. And it's an important factor in the ability to live peacefully and have a happy life at the facility.

Also arranged in a neighborhood concept which means that there are resident councils within the neighborhoods established within the different centers where residents actually meet, raise concerns, discuss concerns, and the centers address the concerns of the residents.

There is also a customer service team at each center with regional support to improve the health of the populations. There is interprofessional practice. Michelle talked to you about that. There is the clinical education that she talk to you coming from the regions, nurse-to-nurse reporting. Of course partnering with hospitals and other health care providers including Home Health agencies to facilitate discharge. Data driven risk assessment. I'll show you how the data collection in a few slides.

Home Health agencies will participate in discharge planning, the clinical protocols and the

Genesis physician services. I've heard people kind of describe those as a secret sauce, and I think that they are. There are very well developed and established clinical protocols with the goal of reducing variability and improving the quality of care by reducing that variability. So there are intranet resources that are available to people at the centers. The regional staff who is here pick up the phone; talk with people. You can -- if you have the opportunity to ask questions of Judy Morton who is a center administrator she can describe the contact that she has with the regional clinical support. I think that that would be very helpful for you to understand and to hear from her. Particularly what protocols and processes are available to support the centers, so that if a problem has been encountered before and has been resolved successfully, it's not as if another Genesis center needs to figure that out again from scratch. Right. That information, that learning is shared amongst the centers.

And then also Genesis participates in learning collaboratives, the Regional Clinical Performance Committees in Vermont, the Blueprint and hospital initiatives. An example was a recent effort

in Rutland to try to address some high ED utilization.

Reducing the cost of care. Everybody practice to the top of their license and skill set. Consistent medication reconciliation across settings. Genesis does med passes twice a day. So twice a day; one helps with compliance, two helps with resident quality of life. Pretty consistent. There is not interruption of sleep or whatnot for medication passes. It's a regular scheduled activity. That seems to help a lot on many, many fronts.

There is nurse-driven care management. Oversight for high risk patients, some of whom are identified by the Flacker report. And by the way, for the reports that we are mentioning there are exemplars at the end of the Power Point in the exhibit. So if you wanted to take a look at them and ask questions, Dr. Raskin who helps work with them and Michelle Costa are here to answer your questions about those as well.

There is measuring and reporting on individual and population level data. And there is the use of the MBI which is a preparation for discharge in order so people don't just get discharged but they are provided the supports that

are appropriate and needed to have them be successful at home and avoid readmissions.

So on to the CON standards. The first standard is about monitoring and collection of data. So Genesis monitors and collects data at three levels; the facility level and the regional level and the national level. That allows for benchmarking against national peers and regional peers. At the actual center level the centers pick goals for -- amongst the pillars of excellence which includes clinical excellence, customer service excellence and others, as well as goals related to CMS mandatory reporting measures. And they make a plan about how they are going to measure and improve their performance on that. And that plan is supported by the regional -- that planning is supported and monitored at the regional level, and then there is the national data warehouse that also lets people do comparisons against their peers.

So if there is a facility that has certain characteristics, let's just say perhaps a dementia unit, you can compare against another center that has a dementia unit, and you're really able to get granular with the data in just speaking with Michelle and hearing examples. One of the things

that I have been particularly impressed with is the granularity of the data use. They are really digging down and understanding what's going on in the centers, supporting the centers to understand for themselves where there are opportunities to improve. And I think that's a very unique feature for a nursing facility operator.

The facilities have clinical Wednesdays. There are policies that are available to them on the Intranet. They can pick up the phone and call someone in clinical, get support, and they also report up on their progress of goals monitored at the regional level. The regional -- there are regional report cards, mandatory measures in addition to the self-selected measures at the center. So there is a very robust data monitoring and collection process that happens at all levels of the organization.

Standard 1.7 is about evidence-based practice. When I look at this slide it kind of reminds me a little bit about what happens with the clinical model at an ACO. You have at the top level an interprofessional clinical leadership group that's chaired by the chief nursing officer of Genesis Health Care, Inc. Their goal -- their task is to set the clinical strategy. They receive information from

others within the organization in order to try to do that effectively. There are practice councils who review the literature and standards and update the clinical standards, provide information to be used in setting the clinical strategy.

Information is also gathered from the divisional clinical leadership groups and Genesis Physician Services as well as the nurse practitioners and the physicians who are in the centers working with the residents day-to-day. The nurse practice educators, Michelle spoke a little bit about those people. And regional support as well as at the center level the interprofessional leadership groups and the materials that are available to the centers as well as anybody else who has access to Genesis intranet.

CON standard 3.12 is regarding palliative and end-of-life care. Genesis has a structure based upon compassionate care for advanced illness, training and practice. There is a philosophy to support compassionate end-of-life care and support strongly the use of a Hospice benefit by the skilled nursing facility residents. There is teaching for all center staff on competencies for comfort and respect for ill and dying patients as

well as their families, and that includes palliative care and Hospice. A lot of that education is conducted by the nurse practice educators as well as the directors of Social Services.

The Flacker score is used to identify patients who may be on the way toward being appropriate for their timing to talk about their goals for care conversations, to have family meetings, and to do advance care planning and potentially consider Hospice. But the point there is you're looking along the way to see when patients are ready to be engaged in those conversations and to encourage engagement in those conversations and in that plan.

There are contracts with local Hospice providers. And nursing staff is strongly encouraged to be in Hospice and palliative care certifications. That is not the only area where the staff of the centers are encouraged. And so very much supported in gaining additional competencies for education. There is tuition assistance, there are all kinds of educational programs that are -- that center staff are strongly encouraged to take advantage of.

And there are some statistics about in Hospice 39 percent in 2014, and in 2015 as of the

time that we had data when we did the submissions, 32.8 percent.

CON standard 4.7 is support of mental health. So there is a multi-disciplinary team of behavioral health specialists at each center. They work in collaborative and integrated patient-centered approach. Genesis will credential providers if there is a need. They prefer to use local providers on-site when it's available. That's not always available.

There is some pretty well-known shortage of psychiatrists and some other behavioral health providers in the state. So what Genesis has done to work in light of that shortage is to use Mind Care which is a telehealth supplement for regular telepsych consultations. So that's been described to me as the behavioral health interventionist appears on a very large screen that is in a patient room. And the patient has that televisit, but it's a big screen. Right? It's not a little tiny computer screen. And so there is the ability to do two-way observation and interaction.

In fact, it's been so successful that the Genesis has been asked to and has engaged with the Health Care Association in trying to expand the

Mind Care services beyond the Genesis centers in Vermont. So the behavioral health provider services are listed on there. They include in-person consultations, telephone consultations, staff education, evaluating the quality of care, and contributing to a care plan.

So for CON standard 5.1. We want to reflect the permanent values of the residents. So I think the mission statement is pretty important to that. So the mission statement is we improve the lives we touch through delivery of high quality health care and every day compassion. Try to provide the level of choice in daily life as though a person were at home. So a person-centered environment with an individual focus. Self-directed routines. And there is a very strong effort to avoid the institutionalized -- to avoid institutionalized language. So de-institutionalize the language. Try to provide recreational opportunities. Flexible food and nutrition. Therapy animals; that was another pilot project with DAIL. And ongoing discharge planning to get residents to the least restrictive level of care when they are appropriate.

DAIL wrote that Genesis has a solid track record of quality of care and partnership with

the state, Accountable Care Organizations, and with the Nursing Home Trade Association. So in their letter under this prong of the Certificate of Need they characterize Genesis as a capable owner and operator who has been in Vermont since 1995 with a solid track record of quality care and partnership.

Acknowledge -- DAIL acknowledges that Revera is leaving. The beds should stay online. That there is a need for the beds that are Revera beds at this time. The current four Vermont Genesis facilities are in substantial compliance. That's one of the terms of art that the Board understand substantial compliance, meaning that on their CMS surveys they were found to meet the survey qualifications for participating in Medicare.

DAIL has noted recognized best practice related to person-centered care. Recreation, nutritional services and therapy animals. Partnering with DAIL in person-centered dementia care. And at the end DAIL affirms its belief that Genesis can support the acquisition and will continue good quality.

5.4 is capitalization. So Genesis Health Care, Inc. has 80 million dollars in liquid or easily liquidated assets that was demonstrated in the

written materials. The liability insurance is more than adequate for any kind of potential liabilities. We will note that there is no active Vermont litigation for Genesis. And DAIL once again wrote that Genesis is adequately capitalized and insured to protect Vermont citizens against any lapses of quality of care.

Financial and quality standards. The assets far exceed the liabilities. Genesis can sustain the financial burden of this project. We have lenders finding that. We have DAIL finding that. And we have provided information that we hope the Board can find that as well. The quality performance meets DAIL's approval. Highlights there.

So at the end the Board needs to decide whether -- or how this project will serve the public good, and we believe very strongly that this project will serve the public good. There is a reasonable cost. Genesis financial position is secure. There is no undue increase in the cost of care.

The only changes to the rates would be based upon complying with the rate setting regulations. There is a step-up in basis calculation that happens whenever a skilled nursing facility is sold. So if Revera is selling its facilities, which

it is because it's going to leave the state, that step-up in basis calculation will happen. And the bed reduction does have somewhat of an impact on rates, but that's because there is a encouragement to reduce the beds by the rate setting regulations. There is an identified need. Revera will continue to operate the beds, and they are needed in each of the communities that they exist. Quality will improve.

Genesis is a strong operator. We have shown you a degree of national and regional support for clinical and quality that does not exist with other skilled nursing facilities that are operating here today. Genesis is capable of adding the facilities without impact on the services and the beds, and strong operators are needed. These are some of the reports.

I'm going to turn it over for questions, with the caveat that the ombudsman -- long-term care ombudsman did submit some written materials. I suspect strongly that some of those materials might be the subject of some questioning today. So if possible, what I would like to do is see what comes out of the questioning, and perhaps reserve maybe five minutes at the end of the hearing to respond to anything else that didn't come out in

the questioning, if that meets with the Hearing Officer's approval.

MR. HUDSON: That's fine.

MS. COHEN: And just what we plan to do as far as questioning is if it's acceptable, again, I can hear the question and direct the question to the Genesis representative who is here who is best able to address it. Does that work okay?

MR. HUDSON: That's fine.

MS. COHEN: Would you like that person to approach the table to answer or --

MR. GOBEILLE: It's really --

MR. HUDSON: The microphone will be necessary today. So turn it over to Board's questions.

MS. RAMBUR: I have a couple of questions. I believe Mr. -- I believe Mr. Blinn mentioned the work force available. And perhaps that is question for Ms. Costa. I'm curious about the vacancy rate -- the turnover rate among nursing assistants and Registered Nurses, and I am particularly interested in the Vermont-specific improvement of retention strategy for particularly nursing assistants.

MS. COSTA: So in particular for

Vermont for the licensed nursing assistants, we have developed a strategy where we have decided we need to start what we call growing our own. So we are offering LNA classes at our own centers now in the hopes so what we are doing is we are doing prescreening before they enter the class.

While they are in the class they are helping doing bed making and other things so they become part of the staff. So once they graduate and they get their license, the LNA certificate, that they want to stay at our facility. It's a challenge, staffing is a challenge. Not just in the State of Vermont, it is a challenge everywhere. As we see hospitals now that only wanted to hire RNs are now hiring LPNs. We are losing staff obviously. So we do have special recruiters throughout our organization who are going to job fairs. We go to nursing schools to try to recruit people. We have done a special -- not here in Vermont, but we did a special grant in the state of Massachusetts with the University of Lowell where we did a residency program.

So we partnered with UMass Lowell, Lowell General Hospital and Genesis Health Care, and we had brand new grads rotate through both sites. So

they can -- so that long-term care is not what they think long-term care is. People have a misnomer about what we do every day at the center. So we have a lot of different recruitment events happening. We do recognize our turnover rate was high. And we are not satisfied.

MS. RAMBUR: You mentioned encouraging supporting education. If I'm a nurse in your facility, what does that encouragement and support look like?

MS. COSTA: So we have different levels of our education. So we have basic levels of education that, you know, for new grads we have a licensed nurse orientation program. So a brand new graduate nurse will go through an eight-week orientation program where we teach them different things, and they work with a preceptor hand in hand throughout their orientation. We do the same thing for LNAs. Two -- they have a two-week LNA program where they work with a preceptor.

We have formalized education for basic things like how do you recognize what a pressure ulcer is. How do you stage -- what is the right treatment. And then we offer what we call our clinical development program. So as a nurse, whether

it be an LPN or an RN, you want to get a certification. You have a passion for something whether it be Hospice or palliative care or rehab nursing, we support and promote the certification, and we do pay for their certification program.

MS. RAMBUR: So -- I just wanted to clarify that financial support.

MS. COSTA: Yeah. There is financial support for their education.

MS. RAMBUR: Then I also started my career as a nursing assistant when I was in college. So help me understand how the Mind Care telehealth works. I'm imagining that I'm a Registered Nurse or a nursing assistant, and there's a person with dementia. You have the big screen. What happens after the big screen experience?

MS. COSTA: So there is a lot of prep work before the big screen comes in. So if we have a patient resident who is in need of psychiatric consultation, whether it be for dementia behaviors or someone who has truly a mental illness diagnosis, we send -- obviously get the order from the physician -- consult with the primary care physician first, we would like a psychiatric consultation. They say yes.

We send the Mind Care solutions, the

history and physical, a list of what medications they are currently on. And then the resident, if capable, will be in a room privately with the psychiatrist for that consultation. If the patient resident has dementia that they can't really speak to or answer the psychiatrist's questions, then either the primary care nurse or the social worker will be in that room answering the psychiatrist questions. We try to keep it as private as possible in the best interest of the resident.

After they see the patient they write up their consultation, and they either develop a behavioral plan for us, what works, what doesn't work, or they will make different recommendations regarding medication. But our philosophy is meds last if at all possible.

MS. RAMBUR: If there is medication prescribed, is it the psychiatrist who prescribes it and monitors or the primary care?

MS. COSTA: The psychiatrist recommends it. The primary care physician must order it. Yes. That's the rules in long-term care.

MS. RAMBUR: I may have some more questions, but I'll let somebody else go.

DR. RAMSAY: I guess since we are kind

of on the clinical side of things, I will ask -- I have a few questions.

One of them just as a matter of full disclosure I've spent about 10 years as the medical director of a long-term care facility in Vermont. So -- and most of my career is -- has focused on end-of-life care. So just so you know, that's where I'm going to move my questions.

First on the medical director side, you know in Vermont you will -- and Dr. Raskin, I'm sure you know, you will contract with hospital-employed physicians, FQHC physicians or independent physicians to provide those medical director services. Do you have some kind of formula for what percentage FTE is the appropriate amount of time for a medical director position in your facilities? Is it by number of beds, is it by the number of patients the medical director actually has primary responsibility for? How do you do that?

MS. COSTA: Do you want Dr. Raskin to answer that?

DR. RASKIN: Should I use the microphone?

DR. RAMSAY: Yes please. I think the medical director position is a very important one,

and I bet Dr. Raskin will agree with me on that.

DR. RASKIN: I do agree. So for our employed physicians --

DR. RAMSAY: When you say -- you mean hospital employed, FQHC?

DR. RASKIN: Genesis employed.

DR. RAMSAY: You don't employ any Vermont physicians.

DR. RASKIN: Right, but I was trying to answer your question relative to the people we do have employed. So typically an employed physician can be a medical director of two buildings, maybe 200 beds altogether. 200-bed building. So that's kind of a rule of thumb.

DR. RAMSAY: That's one FTE.

DR. RASKIN: Right. In Vermont we do in fact have a relationship with the FQHC in Rutland and the medical director of both our buildings.

DR. RAMSAY: I know him. Brad Barryhill.

DR. RASKIN: And that relationship has worked very, very well.

DR. RAMSAY: You have a percentage of FTE of Mr. Barryhill; a percentage of their time you contract for.

DR. RASKIN: Right.

DR. RAMSAY: What percent?

DR. RASKIN: I see what you're saying. The way we figure that out is we assess -- we sort of grade each building based on size, complexity, number of beds. And you know, the characteristics of the building. We have some buildings that are almost exclusively long-term care dementia, and we have other buildings that are very active skilled rehab admissions coming in.

And then we level them, one, two, three or four, and then we base the number of hours that we want to contract with the physician based on the leveling of that building. So for a complicated building it might be the expectation would be 12 or 16 hours a week for a very large busy building. And for a small, sleepy nursing facility it might only be four hours a week that they would be serving as medical director.

DR. RAMSAY: So specifically, for Burlington Health and Rehab, a building that I know really well, is that a big complex building, or is that a little kind of not --

DR. RASKIN: It's about a hundred beds?

DR. RAMSAY: About a hundred beds.

DR. RASKIN: Probably be a level two building. We would probably want Dr. Kellogg who is the medical director there. Contracted for --

DR. RAMSAY: No. Kellogg or Picher?

DR. RASKIN: I'm sorry. Picher.

DR. RAMSAY: Mark Picher. How much time for an FTE would you ask from doctor --

DR. RASKIN: I would guess about four hours per week. So we would contract for that rate. However, we have not contracted with any of them up to this point.

DR. RAMSAY: Okay. So getting back to the mental health issues that Dr. Rambur brought up and the Mind Care versus direct person-to-person counseling, those are your -- those are the two models that you have.

Do you have any patient or family experience of that care model to determine whether it's really meeting the needs of the patient or family? This is -- okay. So and I always am going to say patient and family. Because with severe depression, with cognitive disorders, it is a matter of how the patient and the family experience the care.

Do you have any information, any

outcome measures, any quality indicators about patient experience from Mind Care versus person to person?

DR. RASKIN: Yes. I think Mind Care does satisfaction surveys on the patients that they have seen. I don't have any of that data. I don't know if any of us does right now.

DR. RAMSAY: What do you think the percentage of Mind Care teleconsult versus person-to-person consult would be in Vermont? You've managed the five -- you've got your own facilities, and then you manage the other five.

Do you have any kind of breakdown? Is it 50/50, 70/30?

DR. RASKIN: I think if there are local resources, we would use those almost exclusively. So the places where Mind Care is most embedded are communities that don't have any psych, any behavioral health services, and then it's really pretty much a hundred percent. You know, all of the consultation is done tele.

DR. RAMSAY: But in Vermont it looks like from the record you will have mental health -- behavioral health personal services available.

DR. RASKIN: Right. That's our

expectation, so this would be a backup, I think, if needed.

DR. RAMSAY: Yeah. The last one I have, and I'll let my colleagues go on, has to do with, as you might expect, I know the Flacker severity index, Flacker ratio, whatever you want to call it. I've known -- I know about that one, and this is a question of the process that you use meaning go to your MBS, go to your Flacker, get a score, versus the actual outcome you achieve in assuring that people at the end of their life actually get the best quality of care basically by enrolling them in Hospice.

So do you have any information about those people who have gotten that score? Seven makes them automatically Hospice eligible, that actually have been enrolled in Hospice? In let's say in the Vermont facilities. This is really important to me. We underutilize a vibrant, high quality Hospice system, mission-driven Hospice system throughout Vermont. We underutilize, and part of that utilization is people living in long-term care facilities don't always get the benefit.

So do you have any outcome information?

DR. RASKIN: I think we agree with you

completely. We have been tracking Hospice enrollment across all of New England for years; three, four, five years regularly, and our goal is to, you know, offer Hospice services as early as we possibly can. There are in Vermont -- I understand some issues with availability of Hospice service. We have one building that really doesn't -- not any of the Revera buildings -- but really doesn't have local Hospice services available. So that's a problem. But I think we are --

DR. RAMSAY: Where does that number -- that 39 percent, is that all your Genesis facilities you've got? I mean -- you've managed -- now you are managing almost 900 patients since December 15 because you've already taken over management of these five facilities plus your own.

Have 39 percent of those, whatever I saw on that one, actually gone into Hospice?

DR. RASKIN: That's 39 percent of patients who died on Hospice.

DR. RAMSAY: So they were enrolled in a Hospice program.

MS. COSTA: At the time of their death.

DR. RAMSAY: In Vermont.

MR. BLINN: In the four centers.

MS. COHEN: In the four centers, that statistic is the four Genesis centers in 2015.

DR. RAMSAY: This only goes up until mid '15.

MS. COHEN: Right.

DR. RAMSAY: You only took over in late '15. So tell me about your contract with the Home Health agencies for Hospice or with Bayada for Home Health services, what kind of contracts do you have? In other words, do you have any contracts for respite care, so they are caring for someone in the community that needs to move into respite care for a short period of time? Do you have a contract where you can take them on?

MR. BLINN: Judy could answer that better.

MS. COHEN: Could we ask Judy Morton to come up?

MS. MORTON: Yes. We have contracts with the VNAs and with Bayada for each of our nursing centers. We do respite care as well if that's needed. They can call us quite quickly, and we can make arrangements for someone to come in. Absolutely.

DR. RAMSAY: You can make arrangements.

So when Bayada or RAVNAH come in, you have a model for integrating their services with your services that has worked pretty well.

MS. MORTON: Absolutely. Yes. So we have an entire section of our chart where the communication flows back and forth. The Hospice providers will attend family meetings, care plan meetings, we have a great relationship. And I think Mountain View in particular has had quite a good use of Hospice. We always offer choice, if someone would prefer Bayada, Hospice or the VNA, they can make that determination, and then we invite them in.

As we said, we started doing palliative care resident surveys. When we did our resident satisfaction survey previously we didn't send them to folks that had passed away in our centers. That just started in the last two months. Mountain View was a pilot for that process. So we have seen very high satisfaction from families that have been on Hospice. And that's just coming -- like I said, it's only been I think two or three months that those surveys have been going out. So we will have certainly more data about that.

DR. RAMSAY: Which includes the six months of bereavement care.

MS. MORTON: Exactly.

MS. COHEN: Mr. Blinn can address the question as well.

MR. BLINN: I personally share your passion for end-of-life care in a nursing home having experience from the personal perspective as well. We have established goals of 80 percent. We believe --

DR. RAMSAY: By when?

MR. BLINN: 80 percent of our deaths that occur in the nursing home should occur with their Hospice benefit in place. I know that sounds extremely high.

DR. RAMSAY: No.

MR. BLINN: But I don't believe so. And we have some buildings, believe it or not, who are in the 90s, where we have, you know, a chaplain on staff, and it's just been ingrained into their culture over the years. But we have moved that needle over the last three years from around the mid low 30 percentages, and as a region right now for all of New England we are at 60 percent. So we are moving towards that goal.

DR. RAMSAY: So you're on the record.

MR. BLINN: Yes, sir.

DR. RAMSAY: Your goal in Vermont is 80

percent.

MR. BLINN: Goal in New England is 80 percent.

DR. RAMSAY: What's your goal in Vermont?

MR. BLINN: I don't know that for sure. I can't really answer that, because of you know, there is some pockets where it's lower than others, like I said, and some of it has to do with availability. Some has to do with physicians. Unfortunately we have some physicians in Massachusetts who won't refer to Hospice, and we have been working on them for a couple of years now to the point where I'm ready to move on from them. So that can be a barrier as well. And I don't really know what to expect up here with the five buildings.

DR. RAMSAY: I understand.

MR. BLINN: We do have that goal. And we have to track that manually because our systems don't -- we can't get that by pushing a button, so we manually track that every month.

DR. RAMSAY: Sounds like since you're already ahead of the curve in New England that you might be willing to accept a condition on this CON that did suggest a percentage goal of the best

end-of-life care as possible meaning Hospice, by a certain time in Vermont.

MR. BLINN: I would certainly commit to working towards that goal, yes. I don't know what it would be. But yes. That is a personal commitment from me related to that. And I think when I saw the numbers at 39 percent, I thought they were pretty low for four centers. And what I found out was -- at least we think what's accurate here is it was 39 percent or 33 percent in four of our buildings with one of them being zero.

DR. RAMSAY: That's always the case.

MR. BLINN: I don't know what I would commit to in terms of the number, but I would commit to you personally that we will increase that number.

DR. RAMSAY: Thank you.

MR. HUDSON: If I could just interrupt the questions for a second. Are folks in the back able to hear these exchanges? Yes? Good.

MS. HOLMES: Okay. Thank you so much. I'm going to leave the clinical questions to my colleagues who have more experience, but I will just share that I had some concerns about Mind Care not knowing much about this. But seeing a really high rate of patients with depressive symptoms in some of

the nursing homes they already operate in Vermont, Rutland and Mountain View, in particular, way above the national average and way above the Vermont average. So I just am going to throw that out there as something that struck me as a big red flag. I don't know if that's something that can be solved with Mind Care or whether there is some other solutions there. But it's really high and troubling.

I'm going to switch gears a little bit and talk about or ask you about financial sustainability. And a couple of questions regarding -- so you're shrinking -- reducing the beds about 10 percent. It looks like 52 beds out of five hundred something. This was a little bit surprising to me given what we are hearing about with our big population -- the growth rate of people over 65. So I would love to just hear a little bit about that decision with projections going forward. And then realizing in some of the materials that you provided for us the revenues projected to grow at two percent a year. Costs are projected to grow at two to three percent a year. So in terms of financial sustainability if costs are growing at three percent a year and revenue's growing at two percent a year, that's problematic for the long run.

And even just looking at some of the income statements of projections going out, I would love to hear a little bit from you all about some of the nursing homes -- the projections three years out. You know, there is a doubling of net income which is great. And some of them it likes look there is a shrinking of net income.

In fact, Berlin looks like even after three years is going to be negative margins. I would love to hear a little bit more about that from whoever might be able to answer some of those questions.

MS. COHEN: First bed reduction, can you speak to that?

MR. BLINN: Sure.

MS. COHEN: When we get to the financial tables, I'll ask Ken Cullerot.

MR. BLINN: Sure. I think overall really nationally we are seeing a reduction in occupied beds. Certainly in New England we are seeing a reduction in occupied beds despite the fact that lots of folks think that because of the babyboomers coming of age they are going to fill up our nursing homes. It's just simply not accurate. In Massachusetts where they are really sort of

leading the way with sort of the managed care organizations and the ACOs and the BBCIs which we are participating in nine sites with, which they are really looking at avoiding SNF utilization, if possible. And two, length of stays are getting much shorter, so -- and three, the attractiveness of a private room versus a semi-private room is very significant.

So you know, I think when we look at all of that -- and four when we looked at the track record of Revera, most of those beds weren't occupied over the past year or two anyway. So it wasn't like we were eliminating occupied beds. It was really run rate. And I think that -- I personally think that you're going to continue to see on the short-stay side of the nursing home care as opposed to the long-term care side you're going to see a reduction in length of stay. That's the whole aim of the government, and it's just happening very quickly in Massachusetts and Connecticut. Not so much up in our northern states, but we know it's coming. So that's sort of from the bed perspective if that answers your question.

MS. HOLMES: If there is no staffing changes, well if they haven't been occupied -- I'm

just thinking about some of the quality ratios or quality measures in terms of staffing ratios should improve I would think; right? Well I guess if they weren't occupied in the first place.

MR. BLINN: They really haven't been occupied.

MS. COHEN: But do you want to talk about the actual staffing measures? Did you want to --

MS. COSTA: Yeah.

MS. COHEN: Let's let Ken and maybe we will get back to the staffing measures.

MR. CULLEROT: Good afternoon. My name's Ken Cullerot, Vice President, Divisional Controller for Genesis. And we worked on the financial projections and tables back last summer and into the fall. We had 2014 actual Revera financial statements prior for these facilities. And they were well run, efficiently operated centers. So it was no real expectation of operational performance changing much since.

MR. BLINN: Cannot hear you. Speak up.

MR. HUDSON: If you would speak directly into the mic.

MR. GOBEILLE: It would be great if you

two coached each other on that.

MR. CULLEROT: So generally speaking the financial projections were based on the 2014 Revera financial statements. Inflated, as you said, annually with census being consistent, and rates essentially increasing two percent per year. In operating expenses, salaries, benefits, other expenses, the same about two percent per year. There were some other capital costs that are included in the financial presentation -- financial tables. For example, Linda mentioned the financing approach, and what was assumed in the financial statements is six months of operations under the bridge loan that averaged roughly seven and-a-half percent annualized interest expense. But under the HUD loan scenario we estimated a four and-a-half percent increase -- I'm sorry, four and-a-half percent interest rate. Which you know, hopefully is closer to four percent at the time in 2012.

We closed a HUD loan from Massachusetts facilities at 2.47 percent. You know, it depended on market conditions and such. But that's what was included. So the interest expense in year one is six months of the higher seven and-a-half percent and six months at the four and-a-half percent. And then year

two and three are assumed at that four and-a-half percent.

So interest expense should be decreasing over time in the tables. So that was -- those are the assumptions that are included. There was no expectation that operating income would be decreasing under that scenario, although you can see that played out in some of the scenarios. But the assumptions were consistent amongst the five facilities.

MR. GOBEILLE: Can I follow up on that? Why would you buy Berlin? It's a one, it's 6.1 million dollars, and you're going to lose money. If you were my kid I wouldn't take too kindly to your idea.

MR. CULLEROT: It's a fair question, but the portfolio that -- Revera by exiting U.S. operations it was all or none.

MR. GOBEILLE: Okay.

MR. CULLEROT: So 24 centers involved nationwide. It was important enough to Genesis to proceed with the transaction without the ability to exclude as you said.

MR. GOBEILLE: So my concern is, and realize this is a financial question. But they're

immediately not going to want you to answer it. How do you take a one and bring it up to where you want it to be if it's not making money? I mean is this a death spiral?

MR. CULLEROT: I would not say so.

MR. GOBEILLE: Okay. I knew you weren't going to let him answer it.

MS. COHEN: No, I think Michelle is going to talk to you. For example, they hired a new administrator. Changed the Director of Nursing. But Michelle can talk to you a lot more about that. But it is that regional support for clinical and policy gives resources that aren't otherwise available and does help turn facilities around.

MR. GOBEILLE: So let me be really clear in my question. None of these facilities that you're purchasing will be run on their income statements or balance sheets alone.

MR. CULLEROT: Correct.

MR. GOBEILLE: Decisions will not be made as to quality or any programmatic based on how they perform for the company.

MR. CULLEROT: Never.

MR. GOBEILLE: That's what I was getting at. I wanted to get that on the record.

Thank you.

MR. CULLEROT: Thank you.

MS. COHEN: Can Michelle talk about the staffing measures.

MS. COSTA: So for staffing measures, obviously when we staff a building, we obviously don't staff for empty beds or beds that we are taking out of service. But when the Department of Public Health -- well they call it DAIL. DAIL. Sorry.

MS. COHEN: DAIL.

MS. COSTA: I'm in Vermont. When the surveyors come in, we have to give them a two-week snapshot of what staffing was like within the two weeks usually prior to the surveyors coming in. Sometimes depending on when your survey falls, it could be during Christmas week, it could be during summer vacation. So our staffing levels may not be what we want them to be because of vacations, sick calls, or whatever it may be, and we are stuck with those staffing levels on our record until we have our following survey which could be anywhere from nine months to 15 months later of when we reported it.

When you look at the CMS five-star rating though, our four centers all have either a four or three-star on overall staffing. And when you

look at the Vermont minimum staffing for LNAs in the centers where we may fall a little short because that's what we reported, we, Genesis, have licensed nurses fulfilling those roles. It's not that the residents are going without care. It's someone else, whether it be an RN or an LPN, providing that hands-on bathing, dressing, feeding; whatever care that be needed to take care of that resident.

MR. GOBEILLE: And what could be a higher expense.

MS. COSTA: Could be a higher expense, but it's all about taking care of the residents.

MR. HOGAN: You already testified that turnover is high. First I want to know how high.

MS. COSTA: I'm going to be honest with you. I don't have those numbers.

MR. HOGAN: Will you provide that?

MS. COSTA: We can provide that.

MR. HOGAN: And in a state that has the lowest employment rate in the country, unemployment rate in the country, and a business that's tough on people and nurses particularly, how do you do this? How do you stay staffed in this environment?

MS. COSTA: In some instances we have had to use agency and travelers. So we contract with

the outside agency where a nurse may be from Colorado, wants to come to Vermont for the winter because maybe they enjoy skiing. I don't know. They come and they will spend 16 weeks at the center so it is consistent. They get oriented into our systems and what our expectations are. And they will be part of our staff.

So that's kind of a Band Aid approach. It's not what we want as we continue our recruitment efforts. Like I said earlier, with the LNAs we are trying to grow our own.

MR. HOGAN: In the current environment, what percentage of these increased costs are of your total staffing cost?

MS. COSTA: That's a question for Ken.

MR. BLINN: Ken, do you know the question is -- oh, did you hear it?

MR. CULLEROT: I think I did; what the percentage is.

MR. HOGAN: In other words, I want to know how large the -- you're going to see it, these increased costs in the environment that we are in today are in relation to your total staffing costs.

MR. CULLEROT: Currently for these five facilities I believe only Berlin is the center that's

using external nursing agency to supplement their staff due to the staffing needs.

MR. HOGAN: You don't see that changing over the next months at your other facilities?

MR. CULLEROT: It can. You're right. It's a difficult market. We have relationships to be able to pull in those resources, if needed. We would prefer not to. The consistency and quality of internal staff has many more benefits even than the financial impact. So --

MR. HOGAN: What is -- I'll keep asking. What is the largest you could envision -- the largest increase in these special costs?

MR. CULLEROT: It's tough to say.

MR. BLINN: I don't know that we could make that, you know, guess. But I mean at the worst case, you know, you could run 40 percent of your staff with agency. I mean I don't know that I've seen that lately in any of our centers anywhere. But in the 1980s I did unfortunately.

And I think -- I don't know if you're getting at this other question, Mr. Hogan, but I believe that the nurse agency premium over an in-house nurse comparing wages with benefit cost versus an agency nurse which has no benefit cost, is

probably about 25 to 30 percent.

MR. HOGAN: And all I'm trying to get at is what is it you can expect, and are they included in your financial protections.

MR. BLINN: I think that in the projections it is essentially run rates.

MR. CULLEROT: Yeah.

MR. BLINN: So you know, and if there is -- we have had -- we are having such problems in many of the states that we actually have petitioned both in Connecticut, in Massachusetts, in Rhode Island over the last six months, Massachusetts is just about to come out. Connecticut was done where we are asking for direct wage pass-throughs from the legislature to be able to guarantee higher wage rates for the nursing home staff. That -- we have been successful at that in those three states. And I think quite frankly it may be necessary up here. I haven't seen that yet.

MR. GOBEILLE: What's interesting is Central Vermont Medical Center, Washington County Mental Health have been in and also Central Vermont testified that they are paying more, and that's what their CFO was talking about affecting that. So there is a nursing shortage in the Berlin area.

MR. BLINN: In the country.

MR. GOBEILLE: In the Berlin area.

MR. BLINN: You're seeing it in a hyper.

MR. GOBEILLE: The question for the Board is -- really is we are not the rate setting division for this. But what --

MR. BLINN: Right.

MR. GOBEILLE: How realistic, how -- what's your crystal ball as to how realistic, you know, this is? And then what if it goes awry, and how do we look at that?

MS. COSTA: So some of the things that we are looking at with a higher level with the Chief Nursing Officer at the Vice President of Clinical Operations levels, because I have other counterparts throughout the country, is looking at nursing care delivery redesign. So really focusing on working at the top of your license. Where do we really need an RN to do stuff that only an RN can do? Where do we need LPNs now with the -- especially with the State of Vermont is now allowing medical technicians.

MR. BLINN: Techs.

MS. COSTA: And BelAir had the first graduate, had one of their staff members as the first

graduating medical technician who passed, so she will be providing meds. Mountain View and Rutland will be having a graduating class. So through the crystal ball we are seeing we need other folks to help provide nursing care and working at the top of their license.

One of the other things we do when we talked about earlier the pillars of excellence, one of them is staff excellence. So we have a lot of things in place that focus on retention. What can we do to make the employee see Genesis as the employer of choice? We want to stay with Genesis because we are dedicated to our residents and to the company because we are a good company to work for. And there is a lot of different programs that the centers do to focus on staff excellence.

MR. HOGAN: Al, I have a few more small. Okay. I'll keep going. Shift here.

I notice that your food per day cost felt low. Why?

MR. BLINN: Well I mean I think that having 500 nursing facilities nationally we buy and have contracts for a lot of food in the contracts. Every time we acquire more buildings that cost goes down. I think that, you know, our menus, are very,

very carefully done. You know, we use as much fresh food and fresh local ingredients as we possibly can. And you know, when we looked at the Revera, they subcontracted their dietary complete services, their food purchasing and labor, to a subcontractor thinking that it was going to cost less, which it didn't cost less from what they were doing. But the product and the service was not to our standards at all. It was actually -- one of the buildings we had actually move in and actually take it over.

So I think it really is a matter of fact -- we have corporate people who actually develop menus that change. We have choice, and we have buying power. I mean we have had numerous letters from the centers related to food since we took over, I mean so in terms of better service especially at Berlin. So I think that is the primary reason.

MR. HOGAN: Okay. And there was testimony about that you were somehow connected to the Blueprint. I would like to hear more detail about that.

MS. COHEN: Judy?

MS. MORTON: I think that our connection is that we have been working collaboratively with some of the learning

collaboratives. There was five communities that participated; right? The first roll out about reducing ER usage. So I think the nursing homes have been coming to the table with those groups and letting them know how we can assist with some of those projects.

MR. HOGAN: Thank you.

MS. MORTON: You're welcome.

MR. HOGAN: And then you said that the 52 beds were essentially unoccupied, or how many were unoccupied, how many were occupied?

MR. BLINN: I can ask Tom. Tom?

MR. DEPOY: The 52 beds that we talked about, what's happened in most of our centers is we have been reducing beds in Revera.

MR. HOGAN: Can you speak up? We are having a hard time.

MR. GOBEILLE: And say who you are and what you do.

MR. BLINN: Where you live.

MR. GOBEILLE: Where you live. What your favorite flavor of Ben & Jerry's is.

MR. DEPOY: Cherry Garcia.

MR. GOBEILLE: Well played.

MR. DEPOY: My name's Tom DePoy. I'm

a regional Vice President for Genesis.

MR. HUDSON: Speak up.

MR. DEPOY: Back to my broadcasting days. My name is Tom DePoy. I'm a regional Vice President for Genesis; worked in the business a long, long time. I've previously worked for Genesis. And then went with the Revera company because they promised I would have to travel less, which didn't turn out to be true, but was thrilled when Genesis was able to purchase the facilities.

In the Revera model that they have been using for the last five years or more, their plan was to slowly take beds out of service. A good example of that is Burlington Health and Rehab. That was a 168-bed building. We went to the state and worked out an arrangement to drop 42 of those beds years ago and then replace them with a skilled therapy department, that was a very, very aggressive therapy department. So that kind of thing was going on in Revera for the last five or six years including at Berlin Health and Rehab where we have taken one wing that was formerly a 30-bed unit, and now it's a 16-bed private unit.

So some of those changes that you're seeing where the beds weren't occupied have been

started before. And I think what a lot of people see is that there is much more demand by the elderly population now to come in to a different setting, like a private room, be able to get their therapy quickly and intensely, not like, you know, a months in therapy program, and then be discharged. So that's kind of what's led to --

MR. HOGAN: My question was, how many of the 53 beds were unoccupied?

MR. DEPOY: Well as of today, I would say all those beds are unoccupied. That would be the total.

MR. HOGAN: Okay.

MR. DEPOY: Give or take a bed in four different buildings.

MR. HOGAN: Okay. But these are all unoccupied beds?

MR. DEPOY: Yes. Yes. Yes.

MR. HOGAN: My other thought was I noticed that you have a list of types of people or diseases or issues that you won't accept in your nursing homes. I have that list in front of me if you want it.

MR. DEPOY: I haven't seen it. Michelle could probably answer that for you.

MR. HOGAN: What happens to those people -- well I have two questions. And you can't answer the first because we need the same information for the other nursing homes that you don't own, and we don't have that. So I would really like to ask our staff to get that information so we can see if there is a difference. If there is no difference, there is no problem.

But the other question would be what happens to those people that fall out because you will not admit them?

MS. COHEN: So those criteria are generally based on medical criteria and the ability to safely deliver care to those patients. So for example, Judy can correct me on this, but there is a skilled nursing facility that has a ventilator unit, so the patients who are ventilator-dependent would go to that skilled nursing facility because there they have the clinical ability to care for the patient.

So essentially because most of those criteria are related to scope of practice or ability to safely care for the patient, the patient would go to a setting that has the practice to meet his or her needs.

MR. HOGAN: That's in that -- how many

patients like that might you have in a year where that's the case?

MS. COHEN: So we did give those figures, and maybe someone can help me find those figures of how many people were turned down, and we have -- or not admitted, and we have those reasons. But those reasons are actually combined with other reasons such as -- thank you.

MR. GOBEILLE: Found that way too fast.

MS. ROCKANDEL: Practice.

MS. COHEN: Not having an appropriate gender bed or being related to another skilled nursing facility, so we did not have that broken out. But in the response to December 12 questions at Exhibit M we have a chart for 2015 year-to-date referrals, admissions and non-admission reasons grouped in the top 10, which is what we were asked to produce.

So some of the reasons that you mentioned are in there, but overwhelmingly there are change of location to home or Home Health agency, referral cancel, female bed.

MR. HOGAN: But they are all placed somewhere. That's the issue; right?

MR. BLINN: Yeah. A lot of times the

referrals go to multiple nursing homes. Somebody takes it.

MR. HOGAN: Right.

MS. COSTA: Or as the patient improves they may be referred back to us, and then we would accept them once --

MR. GOBEILLE: From a hospital.

MS. COSTA: -- from a hospital once that they are stable. In our scope of practice.

MS. RAMBUR: Can I ask a quick follow up on that? So I certainly understand, you know, for example, if the individual has unstable signs, if they are too ill to be managed in that setting, but if this purchase is approved, basically means that 30 percent of the nursing homes in the State of Vermont will not accept them. Is that --

MS. COHEN: We did talk about that. Michelle can address that just briefly to say there are bariatric patients at the facilities. It's a 500 count, and that's basically an equipment and staffing concern. Michelle, would you add anything to safety?

MS. COSTA: So when a referral from patient who is 500 pounds and over is referred to us, I'm contacted to review that patient. I have accepted patients who have been over the 500-pound

mark in different states. And I could have here too, I just don't remember what state, depending on the mobility status.

If the resident requires more staff than I have on a level seven, we can't safely care for that patient, because if everyone is in that room caring for that one resident, no one is watching the rest of the residents in that building, or I may not have enough staff on the night shift. Maybe that person who is 600 pounds requires six or seven people to turn and reposition them.

So it's based on do I have the staff. And I look at really the night shift on 11 to 7, do I have enough staff to safely meet the needs of this resident and all the rest of the residents in my center.

MS. RAMBUR: Thank you. I have one other sort of micro question. CPAP rules people out. It seems like --

MS. COSTA: 24-hour a day CPAP.

MS. RAMBUR: Okay.

MS. COSTA: We will take someone 12 hours or less, but if they require 24 hours, they need to be on a ventilator unit. And Genesis doesn't have any in Vermont. We have them in four other

states.

MS. RAMBUR: Thank you.

MR. HOGAN: I want to go back to Jess's question where she identified a couple of the homes that have a couple really lousy outcomes. And I'll identify them if you want, but I probably shouldn't today. But they are in the record.

Okay. I would like to go further on that. I would like to see a written plan on how you're going to change them. That they were very, very serious indicators and need to be dealt with. Is that possible?

MS. COSTA: So we do have a process --

MS. COHEN: Let me just give you --

MR. GOBEILLE: This is fun watching you be put in the position you can't see them.

MS. COHEN: I can't.

MR. GOBEILLE: You don't know whether they are going to answer before you can stop them.

MS. COHEN: I'm not trying to stop anyone. I'm just trying to -- so this gets a little bit towards what the ombudsman has proposed as conditions. So Genesis is extremely committed to quality. And quality is --

MR. HOGAN: This is not related to the

ombudsman's letter. This is my view of your outcome. That's what I'm interested in.

MS. COHEN: Yes, sir, I'm sorry. I guess I wasn't tying the two together from what you were saying, but from the way that I was responding with regard to the written plan on changing. If you would like me to separate them, I would be happy to.

MR. HOGAN: Well I asked my question. Is it possible for you to give us a written plan and how you're going to fix several very serious outcome indicators?

MS. COHEN: So the response that I have to that is that Genesis is working diligently at improving quality, and we have described the general quality here as well as the program to improve quality. It's an ongoing effort with support at the regional level.

There is a very vigorous measurement process that is developed at the federal level by CMS. There are criteria that are surveyed with very lengthy survey guidance that is provided to the Department of Disabilities, Aging and Independent Living or the Licensing and Protection. They go in and they survey. When they find deficiencies they require written plans of correction that are

basically addressed at resolving deficiencies that are found in the survey process. And Genesis engages in that process.

The concern is that because that process is so comprehensive, that having conditions that are also coming from the CON Board as an additional regulatory authority, provides a likelihood or opportunity for conflicting regulatory guidance and an inability as a regulated entity --

MR. HOGAN: I've got to tell you, I don't want to hear this. At BelAir your falls or major injuries were three times the state average; three times. Your need for help with daily activities a third higher than the state average. Lost too much weight, three times the state average. These are general. I could go on. And I could find these for each of these facilities. This is serious stuff.

MR. BLINN: Can I just say, Mr. Hogan, and we would be happy to provide what you want, but we could also stand here and defend a lot of that. I don't want to do that. For example, BelAir is a very small facility, so if you have one fall divided by a small number of residents, percentages go up. But if you want us to report some sort of on -- there is a

lot --

MR. HOGAN: How about --

MR. BLINN: There is a lot of indicators.

MR. HOGAN: How about Mountain View?

MR. BLINN: We have the executive administrator here.

MR. HOGAN: The depressive symptoms are four times the state average.

MR. BLINN: What was it?

MS. MORTON: I can certainly address that, because we do a very thorough assessment where we ask the patient specifically to try to identify those patients who have depression. Depression in the elderly is one of the diagnoses that is under reported. So while our numbers are high, it's because we go and we ask the residents routinely and then provide the services that they need.

MR. HOGAN: How about Rutland Health Care? Pressure ulcers twice the state average.

MS. MORTON: The thing that you have to recognize is MDS these criteria change on a monthly basis, so whatever period of time that you're referring to, I don't know the period of time on that report, it changes every month. If the facility, for

example, has a very specific program where they admit patients because they do wound care, they are going to have a higher percentage of patients with wounds.

MR. HOGAN: How about in Rutland, depressive symptoms at 52 percent versus the state average of 12 percent? I'm sorry. Your answers are not working for me.

MS. COSTA: Could I just describe what the process is, our process is? So my managers of clinical operations get those same reports, the public quality indicators. Even when I was an MCO you would go in, you would print the quality indicators. I would ask for a six-month report and a one-month report. On those quality indicators when we really break it down it's more than just the numbers you're seeing, but we have it by resident. Who is triggering for those numbers that are making you go, oh my God, this is not good. We do a thorough chart review. So we look at different things. Is it true? Did we code the MDS incorrectly? Have we left the MDS coded too long that it's making our numbers obscure or do we really have a system breakdown. If we do, the MCO requires a written action plan from the center. What are we going to do to fix this broken system? And the MCO

monitors that system everytime he or she visits the building. If it's really serious like --

MR. HOGAN: Could we see these reports for these?

MS. COSTA: They are QA. They are -- the MCO reports are under the quality improvement.

MR. HOGAN: You're not being clear.

MS. COHEN: The first -- they contain patient identifiable information.

MR. GOBEILLE: The answer is no.

MR. HOGAN: The answer is no for that. Could you give it to us in summary fashion?

MS. COHEN: That would vitiate the quality assurance privilege.

MR. HOGAN: Say that again.

MS. COHEN: They are privileged.

MR. HOGAN: I don't want it by person.

MS. COHEN: Correct.

MR. HOGAN: I want it summarized.

MS. COHEN: In addition to the privacy concern, there is a legal privilege of non-disclosure for quality improvement activities. The intention is to foster the health care providers to do critical self analysis with the expectation that it won't be used against them in a liability or some kind of

future proceeding.

MR. HOGAN: Allan, do you understand this?

DR. RAMSAY: Yes, I understand it. It's privileged information. It's been a statute for over 25 years to encourage providers to openly discuss errors basically without feeling at risk of being held accountable in a litigation. It is clearly privileged. We all understand that. And it's not -- there is nothing we can do to change that.

It has nothing to do with patient identification to tell you the truth, very little to do with that.

MR. HUDSON: I'm not sure everyone in the room understands that. Can we identify what, for the sake of the record, what the legal basis for this privilege is?

MS. COHEN: It was the peer-reviewed quality assurance provision. I don't have a statutory cite right now. I do think that one of the things, Mr. Hogan, that it might be helpful for you to recognize is that there were some changes, and there have been some changes in Rutland recently, and when Mr. Blinn gave you the organization chart he

showed there were two Genesis centers in the Rutland area. They have now been -- there has been some coordinated management with Judy, and maybe Judy can talk to that.

But basically there is a new administrator; correct? And new Director of Nursing at Rutland with the goal of achieving quality improvement. My understanding is that the overall quality score has improved since the information --

MR. HOGAN: Okay.

MS. COHEN: Judy is coordinating efforts to work collaboratively between the two centers in Rutland. They are historically with the Rutland and the St. Albans building. They were -- they came out of the Haven bankruptcy. They had not been managed very effectively in light of that. They had to -- they were in need of really concerted effort in order to make improvements. It has taken some time. It's not easy to turn a building around overnight.

MR. HOGAN: I understand that.

MS. COHEN: And Genesis has continually evaluated the improvement methods that they are using, has looked at the individuals in -- individual patients as well as the management and has become

pretty creative as far as having -- you know, Judy, who is running an excellent facility, have some collaboration with the other facility or the other center in her area to try to make the improvements that everybody is interested in seeing happen.

MR. HOGAN: Let me be clear that we want to work with you. We really do. Because you're coming in to play a very important role in Vermont. As Betty said, you're going to end up with 30 percent of all the beds. That's a big deal. And we really want to work with you.

So trying to be open about this stuff is important. And even though we don't want to violate any federal rules about this, there has got to be a way to improve the communication. Now that brings me to my last question, and I don't want it to sound acrimonious, but in your -- let's see, what was the date? I don't have it in front of me. I think it was May 16 responses to the questions -- reasonable questions --

MS. ROCKANDEL: March maybe?

MR. HOGAN: -- reasonable questions that our staff asked, there were an entire series of responses that basically said, I'm paraphrasing in a major way, that we are not going to give you this

because our relationship is with the Division of Rate Setting. And there were question after question after question where that was the answer.

Now, Rate Setting doesn't work for us. We are an independent agency, completely independent. I think the burden is on you to be able to answer those questions that the staff asked, one. The criteria includes public good, plus no adverse effects on health care costs, that is an essential for us to make a decision. Yes, Rate Setting does its thing, but we are not Rate Setting. And the questions actually relate to your rates. And those are a series of questions regarding the rates, and you just did not answer directly. You said in effect it's Rate Setting's issue. That's not working together.

MS. COHEN: So I appreciate your concern. It harkens back to the concern that I tried to state -- to voice before which is a regulated entity needs a single set of rules to follow. Can't really follow different rules for different processes that are promulgated by different agencies. So essentially with regard to the Rate Setting, the cost report for 2013 was settled with Rate Setting. The information that was requested by the Board wasn't

requested by Rate Setting. The same with 2014.

But let me tell you for 2015 the cost reports were filed, and they do use actual cost for the insurance programs that were pointed out in these questions. So Rate Setting did not ask those of Genesis for 2014, and because they were in the desk review process, and Rate Setting was not asking for the materials, and Rate Setting is making the determination of the rates based upon the regulations, there was a bit of a disagreement about what the regulations required, whether it was GAAP or actual costs.

Just you know, thought it was most prudent to take the guidance from the regulatory agency with primary jurisdictions for the reporting rules that promulgated --

MR. HOGAN: Put yourself in our shoes. Can't do it without the information.

MS. COHEN: I believe that DAIL had given an impact on -- preliminary impact on rates. And that once the cost report's settled by Rate Setting, they are settled. The information is there, and that's what the rates are derived from.

So to the extent that there were questions about 2014, I need to confirm with the

Genesis people, but my understanding is those cost reports are, if not at final desk review, but they are settled, without the questions that were raised by the CON staff being raised by the Rate Setting agency, and for 2015, Genesis heard what was happening and did report the actual costs for the program to Rate Setting. So --

MR. HOGAN: I'll stop.

MR. HUDSON: Sounds like there is no further questions from the Board at the moment. Are there any further witnesses that you would like to speak to the Board?

MS. COHEN: No, sir. There are no further witnesses, and just at the risk of belaboring, just wanted to reiterate the concern about putting conditions on a CON that relate to survey issues or concerns that are within the primary jurisdiction of another regulatory agency like DAIL or Rate Setting.

Because again, as a regulated entity, to have different sets of rules it makes it very difficult to operate in compliance.

MR. HUDSON: Thank you. We will open for public comments.

MS. HENKIN: We take public comment at

this time. And people can submit written comments for 10 days from the day of this hearing.

MR. HOGAN: There is a question in the back of the room.

MR. GOBEILLE: Ken. I'm going to say this to you, I've never been able to say this to you in my life. I can't hear you. Stand up. That would be great. Maybe come to the middle of the room.

MR. LIBERTOFF: There are a lot of factors obviously that go into the CON decision. Certainly financial concerns, and quality of care concerns. But I was a little bit curious, and I may have missed it. But in talking within the presentation when it talks about why the project would serve the public good, one of the statements is that there is really no alternative plan. And I'm just sort of curious if that could be addressed a little bit more. Because is there no alternative that could be considered or would be considered or is it just that nobody else has expressed interest? Because it ends up becoming a factor.

MR. GOBEILLE: So you know, Ken, from the Board perspective, we don't look at it that way. Meaning we look at it as this is a CON. This is an entity requesting to purchase another entity. And

that's, you know, could these things be sold some other way or done -- that's not -- we don't do if then else. So to me that's not material to this would be my direct answer.

Other comments or questions? I see a hand, but I don't know who that is. Oh man. Where were you this morning?

MR. CARPENTER: I was busy.

MR. GOBEILLE: Okay. How are you, Walter?

MR. CARPENTER: Can't come to these meetings all day long. My season's pass is only good for the afternoon.

MR. GOBEILLE: That's true.

MR. CARPENTER: Walter Carpenter. Just want to pick up on Con's queries about staffing. I'm just kind of curious about management-staff relationship, because the high turnover is not usually indicative of good management-staff relations. And so I'm just curious how that would affect Vermont and how that would play into the acquisition in the CON process. Raise that question.

MR. GOBEILLE: Well Walter, there is probably two PhD term papers in employee-management relations in your question that I'm not going to get

to this afternoon.

MR. CARPENTER: Do you want me to write them?

MR. GOBEILLE: You take labor's side; I'll take management. I think the point is, Walter, we are seeing a problem with medical staffing in the state, particularly in the Berlin area. And you know, from testimony today we are seeing that nationwide. I don't think it's as simple as management and labor relations. I think it's a lot more going on there.

And I think if you go back to the Howard Center's budget and their testimony of how hard it is to hire, when your folks are hired away by hospitals that can pay more, you know, it's not just, you know, as linear as relations between the two.

I'm going to leave my doctoral thesis there.

MS. RAMBUR: If I can just add a brief comment. For full disclosure of the record I've done lots of work for research on nurse recruitment, retention, turnover, et cetera. And this is an industry overall that tends to have more turnover and partially salaries, partially the challenge of the work. So it is an industry just like designated

agencies that tends to have more churn in the work force.

MR. GOBEILLE: Did you have a follow up, Walter? Are you all set?

MR. CARPENTER: I'm all set.

MR. GOBEILLE: Other comments or questions?

(No response.)

MR. GOBEILLE: All right. Seeing none, I'll turn it back over to you.

MR. HUDSON: So just as a reminder to the audience, the public comments will be taken in by the Board for the next 10 days. They can be submitted by Web site, phone or the U.S. mail, whatever channel you choose.

And unless there are any further comments or questions from the Board, I'm going to adjourn this hearing.

MR. GOBEILLE: Thank you. And so at this point the only thing left on the Board's agenda is to adjourn. Is there a motion?

MS. HOLMES: So moved.

DR. RAMSAY: Second.

MR. GOBEILLE: All those in favor?

THE GROUP: Aye.

MR. GOBEILLE: Thank you very much.

(Whereupon, the proceeding was adjourned at 3 p.m.)

C E R T I F I C A T E

I, Kim U. Sears, do hereby certify that I recorded by stenographic means the Certificate of Need hearing re: Docket Number GMCB-014-15CON, at the Second Floor Hearing Room, City Center, 89 Main Street, Montpelier, Vermont, on June 2, 2016, beginning at 1 p.m.

I further certify that the foregoing testimony was taken by me stenographically and thereafter reduced to typewriting and the foregoing 100 pages are a transcript of the stenograph notes taken by me of the evidence and the proceedings to the best of my ability.

I further certify that I am not related to any of the parties thereto or their counsel, and I am in no way interested in the outcome of said cause.

Dated at Williston, Vermont, this 5st day of June, 2016