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Executive Summary

Complete HealthCare Resources-Eastern, Inc. was contracted by the county of Lehigh Pennsylvania to conduct a study of the Cedarbrook Nursing Facilities, Allentown and Fountain Hill (collectively, the "Facilities"). The purpose of the study was to determine available options for the future operation of the county nursing facilities. The Facilities operated at a loss of $3,773,600 in 2012 and approximately $4,674,000 in 2013, prior to the transfer from the Operating Fund. Lehigh County realizes the escalating losses are not sustainable long term.

Current operations were assessed at both facilities to identify opportunities for financial improvement through expense reductions and revenue enhancements. Both facilities have implemented strong expense controls and continue to focus on census development and revenue enhancements. The assessment has identified some areas that could achieve additional savings and revenue enhancements. The barrier to obtaining a break even budget is the impact on census generation related to the marketability of the physical plant at the Allentown facility.

We reviewed several options for Lehigh County to consider as part of the long term planning for the Cedarbrook nursing facilities. The aged physical plant at the Allentown facility is the primary issue that must be addressed under all options. Census revenue is the key factor negatively impacting the operations. The Allentown facility which houses the majority of the licensed beds, is outdated and lacks basic amenities expected by the current and future generations seeking nursing facility care. When the facility was originally constructed, the population expectations were very different than they are today. Cedarbrook Allentown is the only facility in the market with 3 and 4 bed rooms with no bathrooms in the resident rooms. This, along with

appearance and layout, make this facility increasingly undesirable when there are many other options available within the market. As such, most options explored include replacing the existing Allentown building.

Further detail identifying specific findings is located in the Options and Departmental Sections of this report. The following is a summary of options.

OPTIONS

Continued County Ownership

Option 1: Continue existing operations under County Ownership

The county always has the option to continue with the existing operations without any changes. As the County is well aware, this option continues the county burden of providing continued financial support to maintain the current operations.

If the county elects to continue existing operations with no changes, the following table shows the 2012 and 2013 operating results and the projected three year losses with the continued decline in census. The required transfer from The County Operations funds will increase from approximately $4.7 million required for break-even operations noted in the 2013 county financials to approximately $7.1 million in 2016 if no operational changes are implemented. The increasing losses over the period are the result of:

- Declining census due to the physical plant limitation and changes in consumer demand
- Flat or slowly increasing reimbursement, particularly Medicare and Medicaid
- Increasing employee wages and benefits (including health and pension) at levels higher than reimbursement increases

Table 1

Lehigh County Facilities Summary Financial Trend **Option 1 - No Changes**	Actual 2012	Actual 2013	Projected 2014	Projected 2015	Projected 2016
Revenue	$63,449,309	$59,963,860	$61,163,137	$62,386,400	$63,634,128
Operating Expenses					
Wages and Benefits	43,973,459	43,921,403	45,239,045	46,822,411	48,695,308
Other Operating Expenses	17,117,239	15,021,809	15,322,245	15,628,690	15,941,263
Management Fee - Admin & Dietary	631,373	615,572	627,884	640,441	653,250
Total Operating Expenses	61,722,072	59,558,783	61,189,173	63,091,542	65,289,821
Net Operating Income Before County Indirec	1,727,237	405,077	(26,036)	(705,142)	(1,655,693)
County Indirect	3,624,733	4,038,923	4,477,943	4,612,281	4,750,650
Net Operating Income	(1,897,496)	(3,633,846)	(4,503,979)	(5,317,424)	(6,406,343)
Capital, Bond Debt and Other	1,876,104	1,039,870	1,837,319	961,926	679,600
Net Income before Transfer from Operations	(3,773,600)	(4,673,717)	(6,341,298)	(6,279,350)	(7,085,943)
Transfer from Operations	(3,438,230)	(6,376,755)	(6,341,298)	(6,279,350)	(7,085,943)
Net Income	($335,370)	$1,703,038	$0	$0	$0
Census Days	239,806	230,612	229,459	228,312	227,170
Average Daily Census	657.00	631.81	628.65	625.51	622.38

Option 2: Implement revenue enhancement – expense reductions

If the county elects to make operational changes to improve efficiency noted in this report, and the operational improvements were fully in place by July 1, 2014, the operational losses will be decreased from those noted in Table 1 for the period 2014 to 2016, but county contributions would still be required. The losses would continue to grow due to the factors noted above. The CHR-E review identified operational improvements that would achieve annual improvements of approximately $2,806,000. The following table shows the financial impact:

Table 2

Lehigh County Facilities Summary Financial Trend **Option 2 - Implementation of Recommendat**	Actual 2012	Actual 2013	Projected 2014	Projected 2015	Projected 2016
Revenue	$63,449,309	$59,963,860	$61,478,200	$62,707,764	$63,961,919
Operating Expenses					
Wages and Benefits	43,973,459	43,921,403	43,338,039	42,887,330	44,602,823
Other Operating Expenses	17,117,239	15,021,809	16,385,653	17,798,042	18,154,003
Management Fee - Admin & Dietary	631,373	615,572	627,884	640,441	653,250
Total Operating Expenses	61,722,072	59,558,783	60,351,575	61,325,813	63,410,075
Net Operating Income Before County Indirect	1,727,237	405,077	1,126,624	1,381,951	551,843
County Indirect	3,624,733	4,038,923	4,477,943	4,612,281	4,750,650
Net Operating Income	(1,897,496)	(3,633,846)	(3,351,319)	(3,230,330)	(4,198,806)
Capital, Bond Debt and Other	1,876,104	1,039,870	1,837,319	961,926	679,600
Net Income before Transfer from Operations	(3,773,600)	(4,673,717)	(5,188,638)	(4,192,256)	(4,878,406)
Transfer from Operations	(3,438,230)	(6,376,755)	(5,188,638)	(4,192,256)	(4,878,406)
Net Income	($335,370)	$1,703,038	$0	$0	$0
Census Days	239,806	230,612	230,189	229,353	228,630
Average Daily Census	657.00	631.81	630.65	628.36	626.38

Option 3: County builds replacement facility for Cedarbrook Allentown

As noted in this report, one of the biggest challenges facing the Facilities and the ability to be self-funding, is the physical plant of Cedarbrook Allentown and its ability to attract potential residents including the more profitable short-term rehabilitation resident. This option would result in the identification of the most efficient facility size for a new replacement facility for Cedarbrook Allentown, potentially constructing a smaller, more efficient state-of-the-art facility. This option would require working closely with Pennsylvania Department of Public Welfare (PA DPW) and Pennsylvania Department of Health (PA DOH) and would require several years to implement. Further analysis, including the development of a Financial Feasibility plan would be required for this option.

As it does not appear the county contributions can be fully eliminated under Options 1 and Options 2 noted above, we explored alternative ownership options. These options entail Lehigh County relinquishing full or partial operations of the skilled nursing facilities.

Alternative Ownership Options

Option 4: **Lease the facility to New Operator (with potential replacement facility)**
Option 5: **Transfer facility to community based 501(c)(3) non-profit**
Option 6: **Sell facility to New Operator**

Under each of the three options, Lehigh County could decide to involve both locations (Cedarbrook Allentown and Fountain Hill) or retain the operations of Fountain Hill, while working on a strategy of alternative ownership of the Cedarbrook Allentown location. By doing this, the county retains as part of its mission the operation of a county-owned nursing home, while at the same time addressing the underlying issues of an aging and outdated physical plant at the Cedarbrook Allentown location. Lehigh County officials would need to work closely with DPW for the splitting of the license as that practice has not been approved in the past.

While each option has it merits and removes the county's responsibility to fund operating losses of the facilities transferred to an alternative ownership structure, Option 6 will bring the most proceeds to Lehigh County in the short-run, while Option 5 provides the least proceeds to the county. The Facilities could sell licensed beds currently, but would be likely to receive less proceeds in the long run compared to the sale of the building with the beds, as the licensed beds are significantly more valuable when associated with the real estate.

Below is a summary of the benefits of the various Alternative Ownership options, including retaining the Facilities (through Options 1 through 3).

Table 3

Issue	Keep Facility	Lease Facility	Sell Facility
County has administrative oversight over highly regulated facility	Yes	No	No
County has financial obligation to fund operating losses through county contributions	Yes	No	No
County has obligation to fund capital improvements in facility	Yes	No, “triple-net” lease	No
County benefits from “cash run-off”	No	Yes	Yes
County preserves “mission” of Facility	Yes	Yes (through lease terms)	Yes (through sales agreement)
Freeze of pension plan obligations pertaining to transferred employees who would have new retirement benefits under the new structure	No	Yes	Yes
Facility on tax roll for County real estate taxes	No	Maybe	Yes
Facility on tax roll for School District and local municipality real estate taxes	No	Maybe	Yes
End of new claims for workers compensation	No	Yes	Yes
End of new claims for health insurance	No	Yes	Yes

Benefits to the County:

- Purchase price (if sale) provides funds to the County (less transaction costs) or lease payment "locks-in" annual cash flow
- Elimination of nursing home ownership risk
- Preservation of County mission (through sale or transfer agreement)
- Facility on County tax rolls (under a sale or lease)
- No further funding and/or accruing of pension costs
- Divesture of County nursing facility usually means reduction in County's overall Worker's Compensation exposure
- Typically net Cash to County from run-off of A/R and A/P

Depending on alternative ownership structure, impact on existing employees:

- Retention of substantially all of the existing employees
- Retention of seniority for staff
- Pay competitive wage rate
- Competitive private sector benefit package including a 401(k) retirement plan to replace county pension plan
- Improved take home wages with elimination of "mandatory" Employee County Pension Plan contribution
- Potential pension distribution options

These options are available for further study and exploration once the county decides what path will best support the long term goals for the Lehigh County and its residents.

Assessment Overview

ASSESSMENT

The County of Lehigh located in Allentown Pennsylvania contracted Complete HealthCare Resources-Eastern, Inc. to assess the operations of the County nursing facilities, Cedarbrook Allentown and Cedarbrook Fountain Hill. The purpose of the study was to identify opportunities to increase revenue, decrease expenses or improve overall operations. We will also include options for the future operation of the nursing facilities.

METHOD

The study consisted of an internal document review, external document review, on-site facility assessments which included staff interviews, direct observations and a geographic market area review. Materials for the study were collected from the facility, Lehigh County and government data sites including the Pennsylvania Department of Health and the Centers for Medicare and Medicaid Services. Statistics from similar facilities were utilized for benchmarking purposes.

The team of professionals conducting the study included the following Complete HealthCare Resources-Eastern, Inc. consultants; Chief Operating Officer, Vice President of Financial Management and Business Development, Regional Vice President of Operations, Clinical Service Specialist, Business Development Specialist, Environmental Specialist, Nutritional Services Specialist, Clinical Reimbursement Specialist, Social Services-Activities Specialist and Billing Specialist.

SUMMARY

The nursing facilities operate under one license and a budget that encompasses two separate operating locations. The facilities are dually licensed by the Pennsylvania Department of Health and the Centers for Medicare and Medicaid Services representing a combined total of 670 licensed beds. Cedarbrook Allentown is located at 350 South Cedarbrook Road Allentown, Pennsylvania 18104, and Cedarbrook Fountain Hill at 724 Delaware Avenue Bethlehem, Pennsylvania 18015. The assessment team conducted the internal review of Cedarbrook Allentown on February 19, 2014 and Cedarbrook Fountain Hill on February 20, 2014.

The Allentown facility has become undesirable in the market due to the age and condition of the facility. The facility presents with an outdated floor plan of triple and quad rooms with communal toilet and bathing facilities on each unit. This is the primary cause of the occupancy and revenue decline. The market is flooded with newer nursing facilities that offer private and semi-private resident rooms with in-room bathrooms and specialty units for short-term rehabilitation making the Allentown facility a place of last resort. Though the facility provides quality care by quality care providers, it does not outweigh a potential residents' desire for the comforts of home including private or semi-private rooms, in-room bathrooms, phone, television and internet service. The last two decades have caused the nursing home industry to embrace major changes in the lifestyle expectations of the incoming consumers. Those providers who have embraced the changes and modified their buildings to meet those changes continue to achieve stable census and positive payer mix.

In addition to consumer preferences, the current medical model does not support a post-acute stay that does not afford a patient the ability to have easy and safe access to a restroom. Communal bathrooms that are positioned away from the resident rooms present the following risks from the marketing perspective:

- Increased fall risk due to travel distance to the restroom
- Increased incontinence due to distance and waiting time to use the restroom
- Incontinence leads to increased infections, wounds and skin breakdown
- Stress on residents related to distance, waiting and lack of privacy for restroom use
- Increased risk for infection do to communal toileting and increased exposure

Physicians and hospital discharge planners are focused on quality outcomes, reduction in readmissions and a reduction in infections and falls. This makes Cedarbrook Allentown an undesirable choice when making discharge recommendations for their residents. Since 80+ percent of all nursing home admissions come from the acute care setting, this can have a profound impact on occupancy.

Recommendations for revenue opportunities to draw new business to the facility such as converting a section into a short-term rehabilitation unit would not be feasible in the existing Allentown structure, primarily due to the lack of resident bathrooms. This amenity is expected by not only the short-term consumer but also the referring physicians who are concerned about privacy for infection control on post-operative and post-acute patients. The cost of a renovation on this facility would be prohibitive due to its size, aging systems and infrastructure.

Review of Options

We reviewed several options for Lehigh County to consider as part of the long term planning for the Cedarbrook nursing facilities. The aged physical plant at the Allentown facility is the primary issue that must be addressed under all options. Census revenue is the key factor negatively impacting the operations. The Allentown facility, which houses the majority of the licensed beds, is outdated and lacks basic amenities expected by the current and future generations seeking nursing facility care. When the facility was originally constructed, the population expectations were very different than they are today. Cedarbrook Allentown is the only facility in the market with 3 and 4 bed rooms with no bathrooms in the resident rooms. This, along with appearance and layout, make this facility increasingly undesirable when there are many other options available within the market. As such, most options explored include replacing the existing Allentown building.

We have broken the options into two key sections; first the options for Lehigh County to maintain ownership of the operations of the Facilities; and second, the options for Lehigh County to transfer the operations of the Facilities to an Alternative Ownership structure.

Continued County Ownership

Option 1: Continue existing operations under County Ownership

If the county elects to continue existing operations with no changes, the following table shows the 2012 and 2013 operating results and the projected three year projected losses with the continued decline in census. The required transfer from The County Operations funds will increase from approximately $4.7 million required for

break-even operations noted in the 2013 financials provided to approximately $7.1 million in 2016 if no operational changes are implemented. The increasing losses over the period are the result of:

- Declining census due to the physical plant limitation and changes in consumer demand
- Flat or slowly increasing reimbursement, particularly Medicare and Medicaid
- Increasing employee wages and benefits (including health and pension) at levels higher than reimbursement increases

Table 1

Lehigh County Facilities Summary Financial Trend	2012	2013	2014	2015	2016
Revenue	$63,449,309	$59,970,610	$61,170,023	$62,393,423	$63,641,292
Operating Expenses					
Wages and Benefits	43,973,459	43,921,403	45,239,045	46,822,411	48,695,308
Other Operating Expenses	17,591,369	15,250,597	15,555,608	15,866,721	16,184,055
Management Fee - Admin & Dietary	157,243	615,572	627,884	640,441	653,250
Total Operating Expenses	61,722,072	59,787,571	61,422,537	63,329,573	65,532,613
Net Operating Income Before County Indirect	1,727,237	183,039	(252,514)	(936,150)	(1,891,321)
County Indirect	3,624,733	4,038,923	4,477,943	4,612,281	4,750,650
Net Operating Income	(1,897,496)	(3,855,884)	(4,730,457)	(5,548,431)	(6,641,971)
Capital, Bond Debt and Other	1,876,104	1,035,467	1,927,319	926,132	643,812
Net Income before Transfer from Operations	(3,773,600)	(4,891,351)	(6,657,776)	(6,474,563)	(7,285,784)
Transfer from Operations	(3,438,230)	(3,206,207)	(6,657,776)	(6,474,563)	(7,285,784)
Net Income	($335,370)	($1,685,144)	$0	$0	$0
Census Days	239,806	230,612	229,459	228,312	227,170
Average Daily Census	657.00	631.81	628.65	625.51	622.38

Option 2: Implement revenue enhancements and expense reductions

If the county elects to make operational changes to improve efficiencies noted in this Assessment report, and the operational improvements were fully in place by July 1, 2014, the operational losses will be decreased from those noted in Table 1 for the period 2014 to 2016, but the losses would still continue to grow due to the factors noted above. The following table shows the financial impact:

Table 2

Lehigh County Facilities Summary Financial Trend With Implementation of Recommendations	2012	2013	2014	2015	2016
Revenue	$63,449,309	$59,970,610	$61,485,085	$62,714,787	$63,969,083
Operating Expenses					
Wages and Benefits	43,973,459	43,921,403	43,338,039	42,887,330	44,602,823
Other Operating Expenses	17,591,369	15,250,597	16,619,016	18,036,073	18,396,794
Management Fee - Admin & Dietary	157,243	615,572	627,884	640,441	653,250
Total Operating Expenses	61,722,072	59,787,571	60,584,939	61,563,844	63,652,867
Net Operating Income Before County Indirect	1,727,237	183,039	900,146	1,150,943	316,215
County Indirect	3,624,733	4,038,923	4,477,943	4,612,281	4,750,650
Net Operating Income	(1,897,496)	(3,855,884)	(3,577,797)	(3,461,338)	(4,434,434)
Capital, Bond Debt and Other	1,876,104	1,035,467	1,927,319	926,132	643,812
Net Income before Transfer from Operations	(3,773,600)	(4,891,351)	(5,505,116)	(4,387,470)	(5,078,247)
Transfer from Operations	(3,438,230)	(3,206,207)	(5,505,116)	(4,387,470)	(5,078,247)
Net Income	($335,370)	($1,685,144)	$0	$0	$0
Census Days	239,806	230,612	230,189	229,353	228,630
Average Daily Census	657.00	631.81	630.65	628.36	626.38

The recommendations for revenue enhancements and expense reductions include:

- Increase in Medicare short-term stay daily census by three residents and Managed Care daily census by one, resulting in annual increase in revenues of approximately $593,000 and net earnings of approximately $381,000 after related expenses (primarily therapy, pharmacy and other supplies)
- Increase in Dining service revenue of $37,000
- Reduction in wages and benefits of approximately $3.7 million from certain staffing reductions and outsourcing of housekeeping services
- Increase in contracted services expense of approximately $1.3 million from the outsourcing of housekeeping
- Reduction in dietary costs of approximately $57,000
- Increase in marketing and advertising expense of $60,000

For purpose of this analysis we assumed the above recommendations would be implemented by July 1, 2014, impacting the financial results in the second half of 2014 by an estimated $1.4 million, with full impact of these recommendations totaling $2.8 million realized in 2015.

It is expected that the inflationary increases in operating expenses over increases in revenue rates in future periods, along with projected declining census at Cedarbrook, will offset a portion of these earning enhancements over time; however, the operational results are anticipated to be significantly improved over the results if no action is taken, as exhibited in Table 1.

Option 3: County builds replacement facility for Cedarbrook Allentown

One of the biggest challenges that Lehigh County faces regarding the financial performance of the Facilities is the physical plant of the Cedarbrook Allentown

location. The number of four bed units, combined with the lack of bathrooms in the individual resident rooms creates a barrier to census development, particularly with the more highly reimbursed Medicare short-term stay clients. Without addressing these issues, Cedarbrook is likely to experience census declines over a period of years, largely coming from the short-term stay population. This will result in Cedarbrook becoming increasingly dependent on the lower reimbursed Medicaid population, accelerating the operating losses.

A means of addressing that issue is building a replacement facility for Cedarbrook Allentown, perhaps at a reduced size. The construction of a new down-sized facility would have several benefits, including:

- Allows for construction of facility with all private or semi-private rooms with bathrooms, eliminating the less desirable four bed units
- Allows for state-of-the-art design, allowing for specialty units such as short-term stay unit and Memory care units with related amenities, including spa-like shower rooms and private dining and courtyard areas
- Possibility of funding a portion of the project costs by surrendering bed licenses to the Pennsylvania Department of Health, which will reduce the required Medical Assistance budget
- Benefits other county-based non-profit and for-profit nursing home operators, which would absorb the census as a result of the downsizing, increasing their overall occupancy levels and operating margins

Implementation of this option would be a multi-year project, with several key steps:

Step 1: Discussions with DPW on possibility of a grant based upon surrendering a portion of the bed licenses

Step 2: Financial Feasibility analysis to determine optimal size, construction and development costs for the replacement facility, and proforma financial

performance of the replacement facility and ability to fund the required debt service and capital needs

Step 3: Site selection and any associated land development and zoning issues

Step 4: Selection of architectural/engineering firms and design process and DOH and local approvals

Step 5: Bidding and selection of construction firm

Step 6: Construction of replacement facility

Step 7: Occupancy approval with PA DOH and local zoning agencies, and transition planning and relocation of residents to replacement facility

Alternative Ownership Options

Alternative ownership results in the transfer of the operational aspects of the Facilities to an entity other than Lehigh County. The new entity would become the licensed entity with PA Department of Health. The transfer of the physical plants may or may not be included in the operational transfer. The three key options under an Alternative Ownership transition are:

1. Lease the facility to New Operator (with option for replacement facility)
2. Transfer facility to community based 501(c)(3) non-profit (with option to build replacement facility)
3. Sell facility to New Operator

Contributing Factors

- County concern with the impact on taxpayers of financially supporting a nursing facility.
- County concerns about its ability to continue to serve the financially and medically-indigent through alternative ownership.

- Alternative ownership permits the county to step back from (or out of) nursing facility's day-to-day operations.
- Nursing facility impacts county insurance, worker's compensation and other bundled expenditures county wide.
- County officials question their obligation to directly provide nursing facility services to the community.

County Objectives for Alternative Ownership

- Continue mission to serve financially- and medically-indigent of the community
- Shift ownership and operational responsibility to another organization
- Enhance quality of life and care of nursing facility residents
- Eliminate future County financial and contributory responsibilities
- Smooth resident and family transition
- Minimal labor disruption

Other Economic Factors for Consideration

County Indirect Costs- One negative to the Alternative Ownership transition, either from a lease or sale of the building is that current county indirect costs allocated to the Facilities would no longer be possible, but would need to be absorbed by other departments within the county. Approximately $3.0 million of the county indirect costs pertain to Retirement Administration expense. While the county may be able to reduce some of its costs, it would likely not be able to reduce county costs by the $4 million + currently allocated to the Facilities. This may have an adverse impact to the County's General or Operating Fund.

Pension - While the service period and vesting for the pension plan would be frozen at the time of an alternative ownership transition, Lehigh County would continue to have a significant pension obligation to the current retirees and existing employees who are vested in the plan. In 2004, Lehigh County had an analysis performed by an outside

consultant on the pension liability of the nursing home should the operations be sold. At that time, the analysis indicated that the actuarial present value of the projected future pension benefits was approximately $41.4 million. County Administration has estimated that the current actuarial present value of the projected future pension benefits is approximately $52.5 million. This pension obligation would be funded from either proceeds from a sale of the nursing home or from general funds of the county. We recommend that Lehigh County consult with its pension advisor as part of its due diligence in investigating the various alternative ownership structures.

Accrued Paid Time-Off liabilities - The Facilities would need compensate employees for any earned paid time off, such as vacation and sick leave, in accordance with its policies upon an alternative ownership transition. County Administration has estimated this amount to be approximately $2.2 million. This liability can be funded either through an assumption by a Buyer, with an appropriate reduction of the purchase price; from the proceeds of a sale; or from the cash collections of accounts receivable received by the county after the transition of the ownership.

Option 4: Lease

- New Owner/Operator leases the facility from the County while constructing a replacement facility.
- County maintains ownership of building during term of lease.
- New Operator becomes licensed entity to operate facility
- Current County Employees become employees of new Operator
- County receives monthly rent payment
- Under triple net lease, new Operator responsible for all operational aspects of facility including annual capital improvements
- County has no obligation to fund operations of New Operator although risk to take back facility exists

- Depending on situation, New Operator may pay real estate taxes to school district and local municipality
- Payment for value of licensed beds at time of transition

Under this option, Lehigh County could consider leasing both the Cedarbrook facility and the Fountain Hill facility, or after discussions with PA DPW and separation of the licenses for the two facilities, retain the Fountain Hill facility and lease the Cedarbrook Allentown facility to a New Operator. The New Operator could then plan on the development plans for a replacement facility for Cedarbrook Allentown. The impact on the county Medicaid rate would have to be included in the discussion. In 2006, the Facilities, along with other county-owned facilities, went into a separate reimbursement system for county-owned facilities. The initial rate was based upon the rate of the facility as of April 2006 and has been subject to annual inflationary increases. However, the rate in April 2006 was based upon the Peer grouping the facility were assigned; in the case of the Facilities, Peer Group 4 (facilities> 270 licensed beds). This Peer Group had higher rates than facilities in Peer Group 5, facilities with beds less than 270). If Lehigh County were to spilt the licenses and retain the Fountain Hill facility, it is not known if the Medicaid rate would be reset. Determination of the Medicaid rate would need to be ascertained through discussions with DPW prior to any efforts to split the license.

In a lease arrangement, Lehigh County would transfer the existing licenses for the skilled nursing beds to a new operator, who in turn, would enter into a long-term lease of the building and existing furniture, fixture and equipment (FF&E) with Lehigh County. The lease agreement would be on a *triple-net* basis, in that the Tenant would be responsible for:

- Maintenance and all capital improvements
- Property and general liability insurance
- Real estate taxes (if applicable)

The above are in addition to the new operator being responsible for all operating expenses to operate the facility as a skilled nursing facility, as well as the lease payment to Lehigh County. A typical lease term would be ten (10) years, with perhaps two options to renew for additional five (5) year increments, or up to 20 years. At the expiration of the lease term, Lehigh County could either 1) renew the lease with current tenant, setting new terms; 2) lease facility to new operator; 3) take the facility back, along with license for the skilled nursing beds and operate it as a county-owned facility; or 4) sell the facility.

Rent for skilled nursing facilities are generally based upon a price per bed, either on a monthly or annual basis. On an annual basis, rents generally range from $4,000 per bed to $6,000 per bed. Using $4,500 per bed as a base rent, this would translate to an annual rent of $3,015,000, or monthly rent of $251,250.

Facility	Licensed Beds	Rent per Bed	Annual Rent	Monthly Rent
Allentown	473	$4,500	$2,128,500	$177,375
Fountain Hill	197	$4,500	$ 886,500	73,875
Total	670		$3,015,000	$251,250

As the Facilities will require financial improvement to achieve proforma earnings sufficient to service the above rents and provide a reasonable return to the new operator, the County may want to consider a lower rent in the first two years until the earnings stabilized.

This is particularly true as a result of the current transition from a county to non-county facility for Medicaid reimbursement purposes. Under the current reimbursement system, a new non-county facility will be reimbursed at the Peer Group price limits for the various components (Resident Care; Other Resident Care, and

Administrative) plus capital based upon the $26,000 per bed adjusted by the rate factor. The Resident Care component is further adjusted by the CMI, which as of the 2/1/2014 picture date, was reported at 0.83. While the current Medicaid rate for the Facilities is $223.03, because of the low 0.83 CMI (and using the Budget Adjustment Factor or BAF in effect the first three quarters of the state's fiscal year), the initial Medicaid rate for non-county operator would be $201.63, or $21.40 less per day. Based upon 2013 Medicaid in-house census days of 196,133, this would result in a reduction of Medicaid revenues of approximately $4.2 million from revenues realized by the Facilities. A non-county facility, unlike a county facility, has the ability to increase the Medicaid rate through higher CMI. If the new Operator was subsequently able to increase the CMI to the current state average of 1.04, the Medicaid rate would increase to $234.21, or $11.18 per day higher than the current county rate, and approximately $2.2 million in higher Medicaid revenue than those earned under the county reimbursement system.

A variation on the Lease option is to enter into a Lease to Purchase agreement. This is similar to the Lease Option, but the Tenant would have the option to 1) purchase the licensed beds to build a replacement facility, with general price per bed in the $10,000 to $20,000 price range; or 2) purchase the Facilities or one of the facilities from Lehigh County on or after some *trigger point* during the term of the lease. The purchase price could either be established up front upon mutual agreement, or based upon an agreed upon process; such as a multiple of EBITDAR at time of transfer or based on one or more appraisals (both Buyer and Seller obtain independent appraisals as basis for negotiation) at the time of transfer to establish fair market value.

The benefit from the Lease Option (or Lease to Purchase option) is that Lehigh County still retains ownership of the buildings, while absolving itself of the ongoing financial obligations to fund operating losses, and deal with the administrative and regulatory issues faced in operating a nursing home. In addition, as with a sale, Lehigh County

could also benefit from the *cash run-off* proceeds (collection of accounts receivables in excess of any payable at the time of transfer).

Lehigh County officials should confer with bond counsel before pursuing a Lease Option, as certain bonds or related bond documents may have restriction on the lease of the facilities to a either for-profit entity, a non-profit entity; or both.

Option 5: Transfer facility to New 501 (c)(3) Owner/Operator

- Non-profit would lease existing structure while developing a replacement facility
- Non-profit becomes licensed entity to operate facility
- Current County employees transition to employment of the new Operator
- No proceeds from a sale

This option is similar to Option 4 in the base concept, and is what Centre County recently implemented in the alternative ownership of Centre Crest. In this option, instead of leasing of the Facilities to an existing operator (whether for-profit or not-for-profit), Lehigh County officials would work to identify key members of the community to form a local community-based non-profit and transfer the operations to the non-profit. The non-profit could lease the Facilities from the county and work towards building a replacement facility. This option would result in the least amount of proceeds for Lehigh County as it would generally not result in the purchase of either the licensed beds or the physical plant, as Lehigh County would donate any assets to the community non-profit. The county may need to provide some initial financial assistance to the non-profit during the transition period.

The primary benefit to Lehigh County under this option is that the Facilities remain as "community assets" as the non-profit is governed by residents of Lehigh County. By the transfer of the operations, Lehigh County would no longer be responsible for the operational support, other than perhaps the initial financial assistance to help stabilize the non-profit during the transition period.

As with the other options, the lease and transfer of operations could include both locations or just one, with the county retaining ownership of the other location, subject to DPW's approval on splitting of the license.

Option 6: Sale of the Facilities

- County transfers ownership of building at closing
- New Operator becomes licensed entity to operate facility
- New Operator responsible for all operational aspects of facility including annual capital improvements with no county obligation to fund operations
- Sale could be a competitive bid process or negotiate with one party due to real estate transaction. County requirement is to obtain Fair Market Value which can be substantiated through an appraisal
- Depending on situation, New Operator may pay real estate taxes to County, school district and local municipality

Potential buyers of nursing home facilities generally base their valuation using two key metrics, a price per bed and a multiple of earnings.

Price per Bed Approach

In valuing a facility's fair market value on a price per bed basis, many factors go into the determination of the fair market value. This includes:

- Geographic location of the facility – Pennsylvania-based facilities generally have greater value on a per bed basis than facilities in the south west; but lesser value than New York and New Jersey-based facilities
- Urban vs. Rural – Urban facilities generally have higher valuations than rural facilities
- Age and condition of the physical plant
- Recent sales

There have been nine sales of Pennsylvania county-owned nursing facilities since 2009 and five sales of county-owned facilities in the past 18 months. The facilities are:

Name of Facility	Name of County	Licensed Beds	Occupied Beds	Sale Price	Price per Bed	Price Per Occupied Bed
Laurel Crest	Cambria	370	260	$14,250,000	$38,514	$54,808
Lackawanna Healthcare Ctr.	Lackawanna	272	264	$13,400,000	$49,265	$50,758
Mountain View Manor	Northumberland	271	185	$9,984,000	$36,841	$53,968
Weatherwood	Carbon	200	152	$11,050,000	$55,250	$72,697
Valley View	Blair	254	244	$16,500,000	$64,961	$67,623
Falling Springs	Franklin	186	168	$11,000,000	$59,140	$65,476
Parkhouse Pointe	Montgomery	482	460	$41,000,000	$85,062	$89,130
Sunnyview	Butler	220	216	$20,400,000	$92,727	$94,444
Friendship Ridge	Beaver	589	503	$37,500,000	$63,667	$74,553
Total		2,844	2,452	$175,084,000	$61,563	$71,405

Based on the range of price per bed for Falling Springs, Valley View and Weatherwood noted above, the Facilities estimated value, with 670 licensed beds, is estimated in the range of $37,000,000 to $43,525,000. The chart below breaks this value out by the two locations.

Valuation Estimates

Name	Beds	Low Value	High Value
Cedarbrook	473	$ 26,120,000	$ 30,725,000
Fountain Hill	197	$ 10,880,000	$ 12,800,000
Total	670	$ 37,000,000	$ 43,525,000

The above suggested valuations are based upon recent sales prices achieved. There are a variety of factors that impact the valuation or the purchase price a willing buyer will pay in an at-arm's length transaction. This includes the condition of the physical plant and the related costs to address any deferred maintenance; issues with the physical plant structure that may serve as an impediment to census development and a higher quality mix of short-term rehabilitation residents, including four bed units and lack of resident room bathrooms; perceived ability by New Operator to make operational changes to improve the financial performance of the facility, including increases on the Case Mix Index (see Option 4 – Lease for further discussion of CMI impact on the Medicaid rate).

While it is noted that the price per bed achieved by Montgomery County for Parkhouse Pointe was approximately $85,062 per bed, there was also a sizeable tract of developable land that was sold with the facility. The Buyer has indicated the intent to develop senior housing on the campus. A portion of the purchase price paid for Parkhouse Point can be attributed to the land and development rights but cannot be determined, therefore the true value assigned to Parkhouse Pointe, which has similar

physical plant issues with lack of bathrooms and four bed units in the North Tower of the complex, cannot be precisely ascertained.

It is more likely that Fountain Hill, given its physical plant layout, would achieve a price per bed more consistent with recent sales, while the Cedarbrook location may be discounted based upon the physical plant limitations. Only through a competitive bid process will Lehigh County be able to determine the true valuation that a third party will assign to the two locations.

Alternative Ownership Comparisons

Issue	Keep Facility	Lease Facility	Sell Facility
County has administrative oversight over highly regulated facility	Yes	No	No
County has financial obligation to fund operating losses through county contributions	Yes	No	No
County has obligation to fund capital improvements in facility	Yes	No, "triple-net" lease	No
County benefits from "cash run-off"	No	Yes	Yes
County preserves "mission" of Facility	Yes	Yes (through lease terms)	Yes (through sales agreement)
Freeze of pension plan obligations pertaining to transferred employees	No	Yes	Yes
Facility on tax roll for County real estate taxes	No	Maybe	Yes
Facility on tax roll for School District and local municipality real estate taxes	No	Maybe	Yes
End of new claims for workers compensation	No	Yes	Yes
End of new claims for health insurance	No	Yes	Yes

Benefits to the County:

- Purchase price (if sale) provides funds to the County (less transaction costs) or lease payment "locks-in" annual cash flow
- Elimination of nursing home ownership risk
- Preservation of County mission (dependent on purchase price/lease desired by county and who alternate is)
- Facility on County tax rolls (if sale)
- No further funding and/or accruing of pension costs
- Divesture of County nursing facility usually means reduction in County's overall Worker's Compensation exposure
- Typically net Cash to County from run-off of Accounts Receivable and Accounts Payable

Depending on alternative ownership structure, impact on existing employees:

- Retention of substantially all of the existing employees
- Retention of seniority for staff
- Pay competitive wage rate
- Competitive benefit package including a 401(k) retirement plan to replace county pension plan
- Improved take home wages with elimination of "mandatory" Employee County Pension Plan contribution
- Potential pension distribution options

Administration – Operations

ASSESSMENT

An operational assessment of the administrative department was conducted for each facility. The assessment consisted of onsite observations, review of documentation provided by Lehigh County and direct interviews with key administrative staff. As the two facilities share one common license, many of the administrative tasks are performed at the Cedarbrook facility for both facilities.

FINDINGS

There is a licensed administrator and one administrative support person at each of the facilities. The County currently utilizes a management company to provide the Administrator and Chief Financial Officer. Duties are delegated appropriately and each administrator has a working knowledge of the entire operation. The current staffing levels are adequate for the operation.

Appropriate expense controls are in place. Purchases are coordinated with the County purchasing department and utilize State Contract, County Bid and best practices to ensure quality products and services at the best cost. Par levels are maintained and supply levels were appropriate for the size of the facility. We did not identify any overstocking of supplies.

Contracts are reviewed for appropriateness and major services are changed when price or service dictates. The facility most recently changed therapy providers which is showing a positive impact on resident care and will provide some financial benefit as well.

Staffing levels are monitored for efficient staffing patterns and overtime and benefit utilization is tracked to ensure appropriate use. Departments monitor their own staffing levels as well.

OPPORTUNITIES

The Cedar Brook facilities are well run with an emphasis on resident care, expense conservation and revenue enhancement. Administrative staff is knowledgeable and provide appropriate oversight. We did not identify any opportunities in this area.

Activities

ASSESSMENT

Cedarbrook Allentown

Therapeutic Recreation

Current Staffing

1 FTE Director of Therapeutic Recreation
1 FTE Volunteer Services Coordinator
1 FTE Administrative Assistant
6 FTE Therapeutic Assistants (Degreed)
5 FTE Therapeutic Aide II
2 FTE Therapeutic Aide I
4 Per Diem Therapeutic Aide I
1 PT Bus Driver
3 PT Service Attendants

Recommendations

Eliminate 4 Per Diem staff
Eliminate Administrative Assistant

Fountain Hill

Therapeutic Recreation

Current Staffing

1 FTE Asst. Director of Therapeutic Rec
3 FTE Therapeutic Aide II
1 FTE Therapeutic Aide I
1 FTE Therapy Assistant
4 PT Therapy Aide 1
1 PT Attendant
1 PT Bus Driver

Recommendations

Add 1 FTE Therapeutic Aid/I or II

Assessment

The Therapeutic Recreation review consisted of a thorough interview and tour with the Director of Therapeutic Recreation. Interview included staffing and current day to day responsibilities to verify that the activity needs of each individual resident are being met and documented per regulatory guidelines.

Findings

Activities offered in each building are of a good variety and cater to the resident's wants and needs.

Staffing in Cedarbrook Allentown is adequate.

Staffing in Fountain Hill does not match staff/resident ratio in Cedar Brook.

Volunteer and Community Outreach far exceeds what is typically seen in long term care and should be supported so it is sustained.

The physical plant at the Allentown facility is very institutional and does not promote a homelike environment which is preferred by the current generation of nursing home residents.

Opportunities

Eliminate Per Diem positions to create FTE positions that would allow consistency and time off/vacation coverage for department.

Provide adequate staffing to Fountain Hill.

Implement electronic medical record documentation through current Point Click Care system.

Admissions and Marketing

ASSESSMENT

The assessment included a review of the systems and processes related to occupancy, revenue and business development for the facilities. Methods utilized for information collection were government websites including the Pennsylvania Department of Health and Center for Medicare and Medicaid Services, direct observation, employee interviews and county provided reports.

FINDINGS

Cedarbrook Nursing Facilities consists of two separately located County run skilled nursing structures sharing one license. Originating as an Almshouse, the current Cedarbrook Allentown structure was built in 1928, with expansions made in 1959 and 1970. Today the building serves as a 473 bed skilled nursing facility with a secured memory impairment unit and a 42 apartment Independent Living wing. Cedarbrook Allentown is a seven story brick structure located in South Whitehall Township with convenient access to Interstate 78, the Pennsylvania Turnpike (I-476) and Routes 22, 33 and 309. The main entrance is located on the second floor and is accessed by navigating a long walkway and several stairs. A separate, awning covered handicapped entrance with designated signage is located in close proximity to the main entrance and enters onto the first floor. There is a 32 bed unit that has been closed with ten of those beds decertified.

Cedarbrook Fountain Hill, located in the borough of Fountain Hill, is a three story brick structure built in 1970 that was purchased by Lehigh County in 1974. Today, Cedarbrook Fountain Hill serves as a 197 bed skilled nursing facility that includes a 40 bed secured memory impairment unit. Surrounded by the city of Bethlehem,

Cedarbrook Fountain Hill is accessible to Interstate 78, the Pennsylvania Turnpike (I-476) and Routes 22, 33, 309 and 378. Parking lots are located in the front and back of the building, with limited street parking. The main entrance is handicap accessible and enters into the first floor lobby.

Exhibit C

Lehigh County

# of Licensed Units/Beds

Allentown	# of Private Units	# of Semi Private Units	# of Triple Units	# of Quad Units	Total # of Units	# of Private Beds	# of Semi Private Beds	# of Triple Beds	# of Quad Beds	Total # of Beds
Unit B-1	0	7	0	2	9	0	14	0	8	22
Unit B-2	0	0	0	10	10	0	0	0	40	40
Unit B-3	0	2	11	1	14	0	4	33	4	41
Unit C-2	0	2	0	8	10	0	4	0	32	36
Unit C-3	0	3	12	0	15	0	6	36	0	42
Unit D-2	1	19	0	2	22	1	38	0	8	47
Unit D-3	1	20	0	2	23	1	40	0	8	49
Unit D-4	1	20	0	2	23	1	40	0	8	49
Unit D-5	1	20	0	2	23	1	40	0	8	49
Unit D-6	1	20	0	2	23	1	40	0	8	49
Unit D-7	1	20	0	2	23	1	40	0	8	49
Fountain Hill										
Station 1	1	19	0	0	20	1	38	0	0	39
Station 2	1	19	0	0	20	1	38	0	0	39
Station 3	0	20	0	0	20	0	40	0	0	40
Station 4	1	19	0	0	20	1	38	0	0	39
Station 5	0	20	0	0	20	0	40	0	0	40
Total	9	223	23	31	286	9	446	69	124	670

To evaluate the competitive environment within the Lehigh County market share, several organizations were reviewed with key individuals of Cedarbrook Nursing Facilities to gain their perception and insight of reputation services and amenities. There are currently 16 licensed facilities with 2,870 licensed beds in Lehigh County.

Demographic statistics from 2011 in the category of residents age 65 and older indicated 62,278 potential customers. This equates to 52.6 licensed beds per 1,000 individuals within the population age 65 and older.

COMPARISON CHART

Provider Name	Number Of Beds	Private	Semi Private	Triple	Quad	Secured	Rehab Suite	Hospice Suite	CCRC	Star Rating	Occupancy	Comments
Cedarbrook Nursing Homes	680 (10 decertified)	9	230	23	33	196			no	4 combined	96% combined	IL; some amenities
Phoebe Healthcare	395	yes	yes						yes	3	92%	all amenities
Lehigh Center (Genesis)	128		yes						no	5	95%	TCU-all amenities
Manor Care Allentown	166	yes	yes				yes		no	3	95%	all amenities
Manor Care Bethlehem 2021	227	yes	yes				yes		no	4	90%	all amenities
Manor Care Bethlehem 2029	217	yes	yes						no	4	92%	all amenities
Good Shepherd Bethlehem	60								no	5	100%	Specialty Rehab Center
Good Shepherd Baker Center	99								no	5	100%	Specialty Rehab Center
Mosser NH	60	yes	yes						no	3	91%	
Sacred Heart TCF	22								no	4	83%	Hospital Based
Fellowship Manor	121		yes						yes	5	96%	
Westminster Village	111	yes	yes						yes	5	97%	SLC-all amenities
Liberty NH	146		yes						no	4	91%	
Luther Crest NF	60	yes	yes						yes	4	93%	S LC-all amenities
Holy Family Manor	208		yes						yes	4	96%	All amenities
Lehigh Valley TCU	52								no	4	90%	Hospital Based
Total	2752											

Source: Medicare.gov; PADOH Bureau of Health Statistics-2012 Data; facility website pages

Cedarbrook Nursing Facilities have a long history of providing quality long term care. A stable staff and positive work ethic has grown that reputation and provided stable long term resident occupancy through the years. In the ever changing health care arena, the nursing home industry has seen a shift to a short term model of care that

facilities must embrace and adapt to in order to sustain their financial viability. The skilled nursing industry has had a major shift in care models resulting in a reduction in residents requiring long term care and an increased need for short term resident stays. Changes in reimbursements for acute care providers have resulted in shorter hospital stays and services once provided at the hospital have now shifted to the nursing home. The Cedarbrook Nursing Facilities have worked toward that goal but have been limited due to the physical plant at the Allentown facility. The physical plant at Cedarbrook Allentown is antiquated compared to other providers in the market and is the primary barrier to occupancy.

Cedarbrook Nursing Facilities do not have an Admissions and Marketing Department typical for modern nursing home operations. Both of the facilities' admissions processes are conducted out of the Cedarbrook Allentown location by a full time Admissions Coordinator. Not having a department and staff dedicated to occupancy development at each facility, along with the antiquated physical plant, has impacted the ability to stay competitive in the market and generate revenue sufficient to support facility operations.

Staffing

A typical Admissions and Marketing Department would include an internal Admissions Nurse and External Business Development Liaison for a total of two full time employees at each facility. These positions could be filled by transitioning the part time nurse case manager to a full time Admissions Nurse at Cedarbrook Fountain Hill. Recruitment for an external Business Development Liaison at Cedarbrook Allentown and Cedarbrook Fountain Hill would complete key staffing positions responsible for occupancy development to focus on occupancy and mix at both facilities

Cedarbrook Nursing Facilities would clearly benefit from the following; a dedicated internal and external staffing model in both facilities, securing additional managed care organization contracts, including a marketing budget allotment of at least $60,000 annually to execute a Strategic Marketing Action Plan that would position Cedarbrook Nursing Facilities in the community and gain increased market share. By implementing the recommendations mentioned, Cedarbrook Nursing Facilities would have an opportunity to increase census and payor mix to some extent however this will not address the undesirable physical plant and lack of privacy for residents.

Occupancy

During staff interviews with the admissions department, they were not able to define the actual occupancy and mix goals for the facilities however they know "full" is the ultimate goal. The Cedarbrook Allentown facility has experienced decreasing occupancy over the years and in 2013 a 32 bed unit was closed of which ten beds were decertified.

The majority of nursing facilities operate on an annual budget that includes daily occupancy goals. These goals are reviewed daily by the management team and admissions and marketing activity is planned daily to respond to goals. This process supports high occupancy and mix levels. The current team does meet and discuss potential admissions during the morning meeting.

Based on the competitive market area data assessed and as referenced in the market position section of this report, a reasonable and conservative daily occupancy budget for Cedarbrook nursing facilities would be:

Medicare	60
Managed Care	8
Private Pay	35
Medicaid	500
Total Occupancy	603

Opportunity exists to achieve some increase in revenue through referral and admission activity by seeking additional market available managed care contracts. One additional insurance admission would average $350.00/day (based on an average mix of various levels or RUGS categories) or $127,750/year. Cedarbrook Nursing Facilities has 4 managed care contracts at this time but are in the process of assessing additional providers.

Factors identified in the study that impact occupancy and revenue include:

- Physical plant not market competitive
- Limited number of managed care contracts
- Provides basic clinical capabilities (opportunity to increase)
- Lack of marketing budget to promote services
- No current system for customer satisfaction tracking
- No dedicated internal/external occupancy development team
- 24/7 Admission practice not fully implemented

Demographics

The demographics for the Cedarbrook Nursing Facilities consist of an average male age of 82 and female age of 85 years. There is opportunity to capture the short term and managed care market by focusing on a designated short term rehab unit and adapting to a resident centered environment at the Fountain Hill facility.

AGE	MALE	FEMALE
18-44	2	4
45-49	6	7
60-64	3	4
65-69	5	8
70-74	15	22
75-79	20	38
80-84	17	59
85-89	21	63
90-94	16	71
95+	14	54
Total	119	330
Average Age	82	85

2014 Cedarbrook Nursing Home Resident by Age Report

Admissions Process

The admission process for Cedarbrook is somewhat outdated but typical of an older county process designed to accommodate planned admissions coming from home to live in the long term care setting. Inquiries and referrals are only generated through the Allentown location. Admission paperwork, completed by the Social Services Department, is often delayed and not signed prior to or on day of admission. This presents some risk to the facility when providing care prior to consent to treat and agreement of terms between parties.

Last year Cedarbrook Nursing Facilities received 1101 referrals and only admitted 261 residents. The top categories for lost business included; 267 lost to other nursing homes, 112 denied for behavioral problems, 108 denied due to no appropriate bed available and 81 lost due to no insurance contract. 7% of the 261 admitted were short-term rehabilitation clients with the majority being hospital readmissions. There

were 284 discharges for the year which is significantly higher than the number of admissions.

Cedarbrook Nursing Facilities has the Point Click Care software program to accurately assess business; however, it is not being utilized to its full potential. The Inquiry/Referral/Management IRM module in PCC is a valuable tool to track business and manage referrals.

Cedarbrook has a relatively low capture or conversion rate, meaning that they receive a high number of referrals but only admit a small percentage of them. As indicated above, many were lost to competitors which reflect back to the outdated physical plant. Limited clinical capabilities also impact census along with the inability to accept new admissions 24/7 and direct admits from the emergency room though they are working toward that ability. Area providers identified the following unmet placement needs in the market; Total Parenteral Nutrition (TPN), Naso Gastric tubes, new Wound Vacs, Ventilators and Respiratory Therapy.

With industry standard referral source management, admission processes and competitive clinical capabilities, Cedarbrook Nursing Facilities could achieve some improvement in occupancy levels however the physical plant and lack of privacy for residents will limit the type of resident that will choose Cedarbrook Allentown.

Marketing

Cedarbrook Nursing Facilities do not have a budget for marketing. Very limited external marketing and sales functions are employed to promote awareness of facility services. The facilities do not operate on an annual or quarterly strategic marketing action plan though the management group has developed one, they are limited with no

allocated budget. Cedarbrook Nursing Facilities marketing collateral consists of a brochure and a presentation folder. Advertising is a key component to promoting and positioning Cedarbrook Nursing Facilities for business. The facility does not have an informative website, social media page, or a sufficient identity package to promote the services provided. Interviews with primary staff reveal lack of clear identification of market share business availability, competitive activity, or key account management. An appropriate annual budget amount for a skilled facility is approximately $60,000.00.

Market Position

Cedarbrook Nursing Facilities is 1 of 16 skilled nursing providers in Lehigh County. The Allentown facility is the only facility in the market that has 3 and 4 bed resident rooms and does not offer bathrooms in resident rooms. Residents are required to travel to a community bathroom on the hallway that offers a curtain as the only means for privacy. There are very few facilities in the state that do not have bathrooms in resident rooms. There are 2,752 certified beds within those 16 facilities, and Cedarbrook Nursing Facilities represents 25% of the beds in the market. Cedarbrook Nursing Facilities has an overall above average star rating of 4 out of a possible 5.

Cedarbrook Nursing Facilities have a quality reputation for long term care, however, they have not adapted to the market shift to a balance between long and short term care. Market area competitors have made the transition and as a result, capture the majority of short term business available in the market. Cedarbrook Nursing Facilities provides contracted therapy services but has not been able to adequately promote those services to increase the short term population.

There has been a shift in the utilization of skilled nursing facilities in the last 15 years based on changes in reimbursement for acute care providers. These changes are

evidenced by the following statistics: In 1997, at any given time, only about 9% of nursing home residents were admitted for short term care. Today, 38% of nursing home residents will recover or stabilize so they can be discharged to home or other lower levels of care. The short duration of time allows for a resident turnaround where as those leaving will be replaced by new patients needing care. Cedarbrook currently serves a short term mix of approximately 7%. The short-term average for Lehigh County is 27.31%, consistent with the national average.

The table below shows the 2012 market share data retrieved from the Pennsylvania Department of Health. The short term population is reimbursed by Medicare and Managed Care Insurances at a much higher rate than the long term population which is typically reimbursed by Medicaid. Having a well balanced mix in a facility not only meets the needs of the market demand, but also provides financial stability for nursing home providers. Cedarbrook Nursing Facilities are currently reimbursed approximately $219.00 per day for each long term Medicaid resident, which is substantially less than the cost of care. This deficit can be balanced by maintaining a healthy balance of long and short term residents. The average reimbursement Cedarbrook Nursing Facilities achieves for short-term Medicare residents is approximately $434.18.00 per day based upon the 2013 financial data provided by the facility.

	2012 PA Department of Health Utilization Data for Lehigh County				
Facility	Short-Term	Occupancy	Beds	Admits	Discharges
Cedarbrook Nursing Homes	7%	96%	680	330	99
Phoebe Healthcare	25%	92%	395	983	807
Lehigh Center (Genesis)	45%	95%	128	612	546
Manor Care-Allentown	23%	95%	166	575	536
Manor Care-Bethlehem 2021	19%	90%	227	506	447
Manor Care-Bethlehem 2029	18%	92%	217	424	346
Good Shepherd-Bethlehem	3%	100%	60	2	1
Good Shepherd-Raker Center	3%	100%	99	8	0
Mosser NH	18%	91%	60	112	75
Sacred Heart TCF	99%	83%	22	508	507
Fellowship Manor	15%	96%	121	244	182
Westminster Village	22%	97%	111	144	102
Liberty NH	23%	91%	146	318	268
Luther Crest NF	4%	93%	60	77	54
Holy Family Manor	15%	96%	208	397	294
Lehigh Valley TSU	98%	89%	52	1470	1469
County Averages	**27.31%**	**93.50%**	**2752**	**6710**	**5733**

There is more than adequate business within the market area to support a higher occupancy at Cedarbrook Nursing Facilities and with updates to processes, procedures and updates or replacement of the physical plant; they could easily capture a higher or fair percentage of the available market share.

Daily Room Rates

Room rates are approximately $40.00 less per day than area competitors and based on the disparity in physical plant at Allentown, this is appropriate. Fountain Hill could increase rates to closer reflect other area provider rates if they were to designate a specialty services unit such as short term rehabilitation.

Cedarbrook-Allentown

Resident Rooms	Rates
33 four bedroom/quads = 132	$320.00
23 three bedroom/triple = 69	$320.00
133 semi-private = 266	$320.00
6 private = 6	$320.00

Cedarbrook-Fountain Hill

Resident Rooms	Rates
3 private = 3	$320.00
97 semi-private – 194	$320.00

OPPORTUNITIES

The facilities would clearly benefit from a dedicated internal and external staff, a structured and aggressive referral management and admission process, additional managed care organization contracts and marketing budget with formal Strategic Marketing Action Plan to position Cedarbrook Nursing Facilities in the community and to gain an increased market share. By implementing the recommendations mentioned, Cedarbrook Nursing Facilities would increase census, payor mix, CMI, revenue, and strategically position themselves in the community.

1. Create an Admissions and Marketing Department with staff dedicated to occupancy development for the facility. This would require an annual marketing budget of $60,000.
2. Develop a Strategic Marketing Action Plan with budget to address internal process and create an external presence that will increase occupancy, payor mix and community awareness for each facility.
3. Increase short term occupancy by 3 residents per day at Fountain Hill and 1 managed care contract resident per day for an annual revenue increase of approximately $593,150 and with a net earnings of approximately $381,425.

4. Build managed care contract provider list to increase referral base and occupancy.
5. Recruit/adjust staff to include adding an external Business Development Specialist at Cedarbrook Allentown; create an Admissions Director and Business Development Specialist position at Cedarbrook Fountain Hill.
6. Implement industry standard practice of 24/7 admission acceptance.
7. Develop a capital improvement budget with the industry standard $1,000.00 ($670,000 annually) per bed per year to allow for improved appearance.
8. Consider a rehabilitation wing or unit to accommodate short term stay residents.
9. Expand amenities to include resident telephones, wall mounted flat screen televisions, wireless internet access and enhanced resident centered meal service

Business Office – Billing

ASSESSMENT

An operational assessment was completed at Cedarbrook Nursing Home on February 19, 2014. During the course of the assessment, interviews and discussions were held with key members of the business office. Billing processes, procedures and timelines were reviewed.

Staffing

There are currently 10.07 FTE's that work on billing and accounts receivable in the business office, which includes the CFO and Fountain Hill staff. There are 8 Full-Time employees and 2.07 Full-Time Equivalents ("FTE's") filled by several part-time employees, including 1.00 FTE part-time employees at Fountain Hill. Management reported that previously there were 16 FTE's in the Finance/Business Office.

There are also six part-time Switchboard employees representing 2.10 FTE's and one Full-Time and four part-time Switchboard employees representing 2.16 FTE's at Fountain Hill. These positions are unrelated to the billing functions.

Each staff member was interviewed to discuss their specific job duties and the amount of time needed to perform each task. The Business Office Management believes the current staffing levels are not sufficient for the existing workload. Since 2012, the Facilities have been implementing the Point Click Care system, although not all modules have been fully implemented. This includes the Resident Trust system, which has certain limitations in the Point Click Care system. Once Point Click Care is fully implemented, the 10.07 FTE's should be adequate to perform all the necessary normal tasks of the Business Office/ billing function.

Computer Software

The facility utilizes PointClickCare software (PCC) for accounts receivable and claim submission. They also utilize Kea to maintain the resident trust account. Using two different types of software results in duplicate manual entry into both systems. PointClickCare is not utilized to its full potential. Additional education is needed so that PCC can be used to its fullest extent. The additional training would need to be coordinated with the County IT department and Point Click Care.

Billing Cycle

Private-Pay/Resident Liability – claims generated after month end is closed (mid-month)

Medical Assistance – claims submitted the first week of each month

Medicare A – normally submitted mid-month, but December claims were not yet submitted as of my visit. The biller indicated that she was waiting until after the triple-check meeting to submit the claims. Some of the delay is related with staff time devoted to RAC audits, which have been increasing in recent years.

Medicare B – normally submitted mid-month, but December claims were not yet submitted as of the CHRE visit. The biller indicated that she was waiting because of a functional G-code issue and due to the transition of therapy providers.

Insurance/HMO – claims submitted mid-month

Coinsurance – claims submitted as soon as the Medicare remittance advice is received.

Accounts Receivable

Private-pay and resident liability are not pre-billed and are collected after month end.

Collection activity commences after two unpaid months have passed. After two months, a letter is sent to the responsible party requesting payment. The Financial Services Supervisor determines when a collection letter is sent and which accounts will be referred to the legal department. The district magistrate's office is not utilized for collections. The facility does have a formal AR/collections review of MA Pending receivables and plans to expand the review to other payors.

As of January 1, there are 104 Medicaid pending applications (70 pending in Allentown, 34 pending in Fountain Hill) awaiting approval from the Medical Assistance Office. The facility tracks the pending residents on a MA pending log.

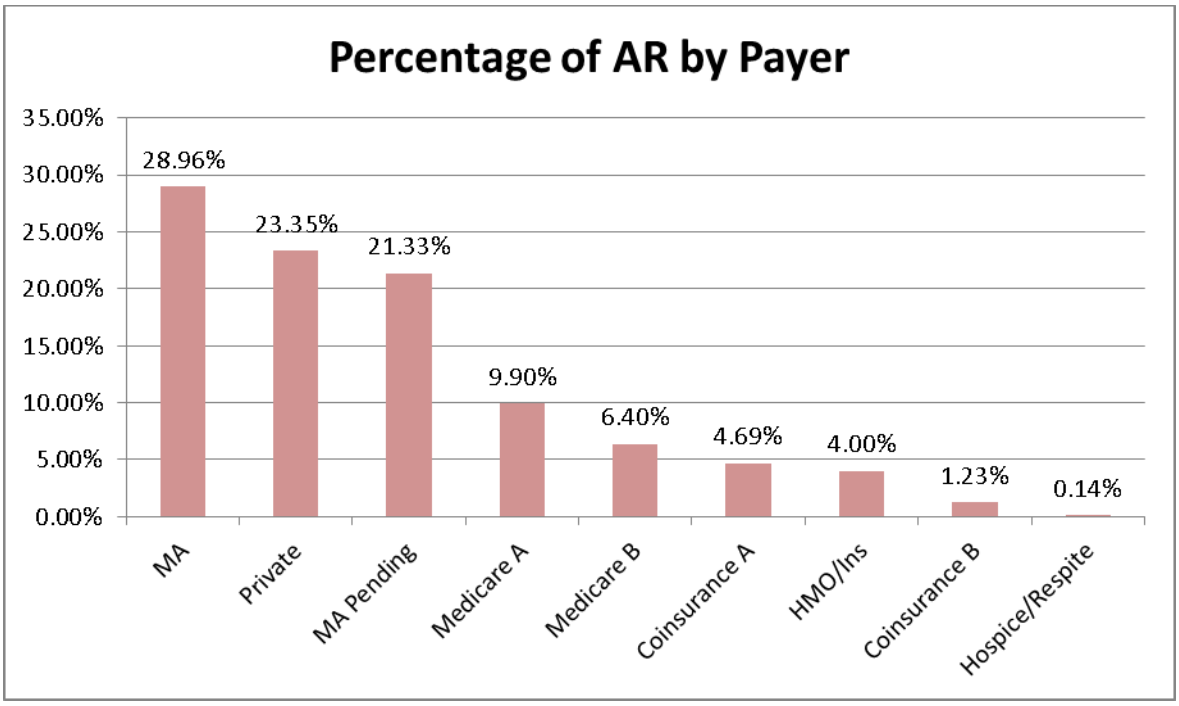
The A/R Aging reports were reviewed dated December 2012 and December 2013. The 12/31/13 aging is carrying approximately $12,221,000 in total receivables, of which approximately $4.5 million or 37% is 120 days or older. This compares to an average of 16.8% of over 120 days receivables for four benchmark facilities as noted in the below table.

Cedarbrook Nursing Homes
Analysis of Accounts Receivable
Aging as of December 31, 2013

	Current	30 Days	60 Days	90 Days	120 Days+	Total
Cedarbrook	4,620,939	1,400,666	1,005,410	661,108	4,532,661	12,220,784
% of Total AR	37.81%	11.46%	8.23%	5.41%	37.09%	100.00%
Facility #1	68.44%	9.77%	4.27%	2.94%	14.58%	100.00%
Facility #2	39.56%	37.90%	3.89%	1.55%	17.10%	100.00%
Facility #3	68.20%	11.22%	5.35%	2.61%	12.62%	100.00%
Facility #4	53.41%	12.28%	7.39%	3.88%	23.04%	100.00%
Avg-CHRE Affiliated	57.40%	17.79%	5.23%	2.75%	16.84%	100.00%

The below chart indicates the payer mix of the 12/31/13 accounts receivable. There is concern that approximately 68% of private pay/resident liability is over 120 days old and unlikely to be collectible. Of additional concern is that approximately $2.6 million represents Medicaid pending applications. Delays in MA

pending applications have been an issue across the state due short staff in county offices, so the experience the Facilities have faced are the same faced by other facilities across the state. Generally the substantial majority of these receivables are approved, so the delays have minimal financial implications, but require short-term funding by the County of these Facilities receivables until the applications are approved and billed to the Medicaid program.



FINDINGS

- Private pay and resident liability are not pre-billed.
- The business office was under the assumption that private pay and resident liability invoices could not be printed until after the month end was closed. The business office is in need of additional software training.
- A more stringent collection policy is needed to minimize bad debt.

OPPORTUNITIES

- The entire collections process should be evaluated, taking a more proactive approach on collections to minimize the accounts that reach the 120+ day category. A revised collection policy is needed, which outlines the steps of the collection process to include:
  - Weekly AR reviews
  - Tracking of collection activity, letters and collection telephone calls.
  - A timeline for performing collection calls and letters, which should occur at least every 10 days.
  - Appropriateness of utilizing small claims court in conjunction with Solicitor's department.
  - Payment requirement on admission day. For MA pending residents, estimate the resident's monthly income and collect it upon admission and every month thereafter, until the MA approval is received.

- Additional PointClickCare training is needed in order to utilize the system to its fullest extent. The software can be set up to track collection activity and print collection letters in accordance to the facility's collection policy. The system can also be set up to pre-bill private pay and resident liability. By waiting until month end to collect the resident liability, there is an increased risk of the income being used elsewhere instead of being paid to the facility.

Clinical Reimbursement

ASSESSMENT

As part of our Operational Assessment for Lehigh County Nursing Home, we have reviewed the two key reimbursements for the facility; the Medicaid reimbursement system and the Medicare system. The following is our analysis of these two components of revenue during onsite facility visit February 19 and 20, 2014.

Included in the review were reviewing facility records and interviews with facility MDS Specialty Coordinator, Minimum Data Set (MDS) MDS Coordinators, and restorative nurse. We also received additional information from the consultant who provides support to the staff at the building.

FINDINGS

MDS Completion/Scheduling Practices

The facility currently budgets for a total of 8 FTE's MDS Coordinator positions between the two facilities –Cedarbrook with 5.5 MDS Coordinators and 2.5 at Fountain Hill. One RNAC splits the week between the two facilities. The LPN that is the Specialty Coordinator oversees the RNACs, completes PPS and OBRA MDS schedules for each facility, coordinates daily Medicare Meeting, manages CMI, reviews each MDS prior to submission to the national data base for the CMI management, creates assessments to use in Point Click Care (PCC), and manages triple check which is a new process. RNACs at each facility complete all the comprehensive MDS assessments including the Care Area Assessments (CAAs) that includes admission MDS, annual MDS and significant change in status, Specialty Coordinator schedules OBRA and all the PPS assessments.

Licensed nurse on the floor completes all the quarterly MDS assessments and then each quarterly MDS is audited by the RNACs and Specialty Coordinator prior to submission. The clerical technician opens all MDS assessment once they are scheduled.

Paper documentation is utilized for Activities of Daily Living (ADLs), cognitive, mood and behavior 7 day tracker. The facility has PCC and ability to utilize Point of Care (POC) however they do not have kiosks for POC that will allow nursing assistant to document the daily care provided. Pain Assessment paper form is also utilized for 5 day assessments. The MDS RAI manual states on page J-7 that this is an interview were the resident is asked to recall the last 5 days of pain occurring and the resident's response is what is coded on the MDS when the resident is able to be interviewed. The consultant indicated that they use a paper back up but do not use interview assessment on capable residents.

The facility has limited use of the PCC. They currently utilize PCC for MDS assessment, limited User Defined Assessments that have been created by Specialty Coordinator and billing. By utilizing all options of the electronic health record system the county has invested in, the staff would have improved work flow and have the ability to track and submit with accuracy.

Medicare Part A

A review of the facility's Medicare Part A residents for 2013 was completed. It is noted that the overall average length of skilled stay was 34.1, compared to an Average Length of Stay ("ALOS"). This is consistent with the industry averages.

It is important that the disciplines, particularly the RNACs are aware of potential therapy discharge dates to review the medical record and ensure a remaining skilled service is not present prior to discharging from Part A. By identifying skilled services outside of therapy for services such as wound care, ostomy care, diabetic teaching and even the dying process, the facility could achieve additional increases in overall length of stay ultimately increasing revenue to the facility. The consultant indicated that the Specialty Coordinator conducts routine short-term resident review weekly; reviewing all residents that are potential discharges for, discussing what the plans and educational needs are. Attending the weekly reviews are the Specialty Coordinator; Social Services, Nursing Supervisor, ADON and Therapy.

It is recommended that prior to discharging a resident from Part A services for therapy that the MDS Coordinator and rehab manager meet to review the current clinical status of the resident, including the admitting diagnosis from the acute care facility and physician's orders. The consultant indicated that the Specialty Coordinator reviews diagnosis codes for those that support needs and review physician orders to ensure that they have met doctor orders for services provided.

This would also include a review of the current therapy progress versus nursing observation on the unit to determine if any inconsistency between the disciplines is apparent, including assistance required for bathing, dressing, toileting or eating. At times what residents are able to do in the therapy room may be different than what is observed on the 3-11 or 11-7 shifts by the nursing staff and could result in an extension of the therapy length of stay and ultimately an increase in revenue to the facility under Medicare. The consultant indicated that this is done in the weekly meeting.

It is also of importance to note that the reimbursement for ADL (activities of daily living) scoring differs from that of Medicaid. PPS scoring is based on a scale ranging from 0-16 where Medicaid is based on 4-18. It is important that the facility MDS Coordinators have a clear understanding of these differences as it can quickly result in lost revenue if not closely monitored. The consultant indicated that the Specialty Coordinator is knowledgeable and is currently responsible for this process; but due to pending retirement in August 2014, Facilities are training RNAC's to take over this function. This includes a review of the nurse aide daily documentation for inconsistent data in support required particularly in the four late loss ADL's; bed mobility, eating, transferring and toileting. While the ADL score may be 16 for Medicare it may be significantly lower under the Medicaid system resulting in decreased revenue under the case mix system. The facility MDS Coordinators indicated that the ADL documentation is paper on the 7 day observation forms and is reviewed by the nursing staff on the floor. The floor staff then educates the nursing assistants when the ADL documentation is not completed or inconsistent.

During our visit to Cedarbrook it was noted the current facility census was 423 with 16 Medicare A /Managed Medicare HMO.

In comparison with facilities of similar size, the number of Medicare Part A residents is below average, reflecting only a 4% Medicare A/Manage Medicare HMO population compared to total census. Lehigh county facilities average 27.31 and the national average is 28%.

Under current Medicare PPS, each resident that is determined to be skilled will categorize into one of 66 categories based on physical functioning, cognition, behaviors, services being provided such as IV, tracheostomy care and oxygen. These group assignments can also be determined by the amount of therapy the resident is

receiving by any combination of physical therapy, occupational therapy or speech therapy. Lehigh has recently hired Advantage Rehab to provide rehabilitation services. They initiated service at Lehigh on November 1, 2013. Upon review of the Medicare Part A RUG distribution, the breakdown is as follows for January 2014 at Lehigh County Nursing Facility is:

- RU – 48%
- RV – 23%
- RH – 14%
- RM – 13%
- RL –0.8%
- Non-Therapy Skilled – 4%

It is identified that the skilled non-therapy RUG distribution for Cedarbrook has some room for improvement though they are making progress. We used 4 CHR-E affiliated facilities for comparison of the distribution for January 2014 reflected as follows;

Facility	#1	#2	#3	#4
RU	57%	38%	47%	27%
RV	24%	23%	29%	43%
RH	1%	15%	9%	5%
RM	1%	5%	9%	17%
Rehab+ext	3%	3%		
Non-Therapy	14%	16%	7%	3%

It is imperative to review the entire clinical picture prior to discharge from Part A to determine if any other "skilled" conditions are relevant prior to therapy discharge such

as; urological care, ostomy care, wounds, new medications, discharge teaching or injections.

If a resident is planned to be discharged to home, it is in the interest of the facility to conduct a therapy home evaluation, if the resident is agreeable, to not only ensure a safe and appropriate discharge but also potentiate the possibility of revising the therapy goals in the facility and extending the length of stay. This could include such areas as; stair climbing, bathing or even cooking a meal, again ultimately increasing facility revenue under PPS. Keeping in line with discharge to home; discharge teaching and plan development is skillable under Medicare guidelines. The contracted therapy staff currently complete home visits prior to discharging a resident to home.

If a resident is remaining in the facility for continued care, but is no longer appropriate for skilled therapy services it would be in the interest of the facility to ensure that appropriate restorative nursing programs are in place prior to therapy discontinuing and that all applicable staff have been educated on the appropriate techniques required for these programs. This could also potentiate an increase in length of stay for PPS ultimately increasing facility revenue.

An interview with the Specialty Coordinator was conducted during an on-site visit on February 19, 2014 indicating that the facility holds a daily Medicare meeting to review those on caseload. The Specialty Coordinator is also present for the Medicare Meeting via phone to schedule MDS assessments due to the distance between the facilities.

CMI (Case Mix Index)

Until June 30, 2006, the reimbursement for county-owned nursing home facilities from Medicaid residents was the same system as non-county owned facilities. Commencing on the state's fiscal 2006/2007 year, county-owned nursing facilities went on their

own reimbursement system for by setting Room & Board rates based upon the April 2006 rate, which was predicated largely on the CMI of the facility in effect at that time. Under the Department of Public Welfare System for County Owned Facilities, the facility's rate is fixed and not affected by the CMI. The facility is however eligible for the Pay for Performance Bonus program which is based on incremental increases in the CMI. If the facility CMI remains the same or goes down, they are not eligible for the quarter. The amount of distribution for eligible facilities can vary widely depending on the number of county facilities that are eligible. The fewer county facilities whose CMI went up, the higher the reimbursement for those eligible county facilities as the Pay for Performance Bonus funds are divided between fewer county facilities.

The graph below reflects the current trend in the facility CMI otherwise known as "case mix" for the MA population of the facility

Picture Date	CMI
2/1/2013	0.91
5/1/2013	0.88
8/1/2013	0.89 P4P
11/1/2013	0.92 P4P
2/1/2014	0.83

Lehigh County Nursing facility has qualified for 2 Pay for Performance (P4P) over the past year 2013. Medicaid Rate is $223.03 per day / per resident in addition the facility also received August 2013 and November 2013 for the P4P. The CMI dropped significantly for the 2/1/2014 picture date, to 0.83. That should allow for greater opportunity to increase the CMI in ensuing quarters achieving the Pay for Performance bonus the next few quarters.

A review of the pending January 2014 Detailed Census Report from PCC report reveals a large amount of reduced physical function category with "2" end splits. Under the revised case mix system the most recent assessment will be utilized to determine the facility CMI. The PCC Detailed Census Report reflects a number of residents in the clinically complex category with a "1" end split. This category is directly related to signs/symptoms of depression and should be researched to ensure that those residents with depressive indicators are identified and reviewed to capture a higher RUG for the CMI. By ensuring the mood is captured during the assessment period, it can increase the facility CMI and ultimately increase the overall facility CMI. Specialty Coordinator utilizes a tool for staff assessment of moods as well as using interview process to ensure mood is correctly documented on MDS and ensure appropriate reimbursement is received for the M splits. Also noted that there is a high number of ADL score that is reflecting a "B" or "A" on the RUG IV 66 grouper. ADL documentation is on paper using 7 day window documentation. The PPS scoring is based on a scale ranging from 0-16 where Medicaid is based on 4-18. It is recommended that the facility MDS Coordinators and floor licensed nurses have a clear understanding of these differences as it can quickly result in lost revenue if not closely monitored. This includes a review of the nurse aide daily documentation for inconsistent data in support required particularly in the four late loss ADL's; bed mobility, eating, transferring and toileting. While the ADL score may be 16 for Medicare it may be significantly lower under the Medicaid system resulting in decreased revenue under the case mix system.

During interview with Specialty Coordinator, she indicated that the staff consistently meets to review new admissions and significant change residents in order to achieve maximum reimbursement. It is recommended that this process include a review of all residents three weeks prior to the scheduled MDS to ensure that assessments are scheduled appropriately to capture maximum reimbursement in accordance with applicable regulation. The consultant indicated that the MDS Nurse performs a first

level audit and the Specialty Coordinator does a second level audit on the MDS to ensure those measures for Medicare and Medicaid are captured on the MDS.

The following is comparison of three CHR-E affiliated facility Quarterly CMI Report for November 1, 2013. A review of the MDS assessments that captured the rehabilitation therapy RUG for the Medical Assistant residents for this Picture Date is as follows:

Facility	# rehab categories captured on CMI	# of total Medicaid residents	Percent of residents in rehab categories	November 1, 2013 Medicaid CMI
Facility #1	13	35	37%	1.13
Facility # 2	45	111	41%	1.05
Facility # 3	30	90	33%	1.01

.

Strategic planning and constant communication between the MDS coordinator and therapy department will ensure capture of the appropriate RUG category that is reflective of the highest burden of care. Long term Industry standard for therapy rehabilitation categories is 25 %-30% capture on the quarterly CMI report. As identified in the comparison table of CMI for November on the higher spectrum is at 41%.

Medicare Part B census average in February 5, 2014 to February 18, 2014 was 66 residents on case load which reflects 16% of the Cedarbrook population. In comparing the previous therapy management company revenue January 2013 to December 2013 with Advantage Rehab service reflecting a negative variance of $23,000. Recommend 3 weeks prior to the assessment reference date a review of the residents status from the last MDS to current status be reviewed with all disciplines including social service, restorative nursing, dietary, activity, MDS Coordinators, licensed floor staff and therapy to discuss and changes in condition and potential therapy interventions. The consultant indicated the Facilities have an internally developed tool called "Internal Communication Device" for this. If therapy interventions are required, then this greatest burden of care is captured on the MDS which can potentially increase the CMI.

Restorative Nursing Program

To qualify for capture into the RUG category for restorative nursing programs 2 programs are required for the past 6 days from the assessment reference date for at least 15 minutes per day. Restorative Nursing Care, based on individual needs, strives to attain, maintain or prevent decline from a resident's highest practicable level of self-care and function unless the resident deteriorates due to a progressive medical condition or the aging process makes a decline unavoidable. Restorative Nursing seeks to maximize existing abilities of residents, fosters an attitude of realistic optimism, enhances self-esteem, emphasizes independence, minimizes the effects of disability and improves the quality of life.

Restorative nursing programs (RNP) may arise during the course of stay, or in conjunction with a formalized rehabilitation program. In many instances, a restorative program is initiated upon discharge from a formalized rehabilitation program such as physical, occupational or speech therapy.

All residents who have a change in functional status (improvement or decline) as noted during routine care, MDS assessments, etc., should be discussed with therapy department and request sent as appropriate. This communication could potentiate an increase in the Medicare Part B census if a skilled therapy need for intervention is identified.

Recommend the current Restorative Nursing Program be reviewed and adapt a different structure where the restorative nursing programs are divided into 2 different levels.

The more complex restorative nursing service are provided by the Restorative Nursing Assistants and the next level that are less complex to be carried out by the nursing assistants on the unit.

Recommend to also follow the MDS 3.0 guidelines of periodic documentation for evaluation of the nursing program. Daily documentation for the minutes provided and how the resident responded should continue with documentation provided by the nursing assistants. The residents on more complex programs to monthly review notes of the restorative nursing programs and for the less complex restorative nursing programs document at least quarterly with the MDS schedule or as changes occur with the resident that impact the restorative nursing program.

OPPORTUNITIES

MEDICARE

By increasing the number of Medicare residents admitted to the facility, an increase in overall reimbursement could be realized.

Recommend Lehigh County Nursing Facility increased overall skilled census by at least 3, primarily at the Fountain Hill location, bringing the total to 34 between both facilities. Based upon the facility average Medicare rate of approximately $425.00, this would result in an annual increase of Medicare revenues of $465,375. If the distribution of the resident days for the additional three residents were in the higher reimbursed therapy categories, the increase in revenues could be substantially higher.

There would be additional expenses pertaining to the additional three residents, primarily for therapy; pharmacy medical supplies and other ancillary costs.

Medicaid

It is recommended to adopt a standardized resident review process at Lehigh County Nursing Facilities to review the resident's current clinical status including but not limited to the following:

ADL status as compared to the previous assessment to identify need of therapy intervention to prevent or improve current clinical status and identify inconsistencies in current documentation. The consultant indicated that the Specialty Coordinator currently tracks each resident and compares the last MDS and CMI before the next MDS is due.

Restorative Nursing Programs to appropriately maintain current clinical status

Weight gain and/or loss reflective of nutritional status as compared to the previous assessment. The consultant indicated the Dietician manages this process and then communicates to the interdisciplinary team when changes occur.

Identification of new onset behaviors or mood symptoms since previous assessment. The consultant indicated that the Specialty Coordinator completes this.

Continence pattern and appropriateness for scheduled bowel and/or urinary program to maintain or improve current status. The consultant indicated that the Restorative Nurse leaders complete this task.

Lehigh County Nursing facilities also identified that the facility does not have a consistent process in place to monitor the case mix week to week. The consultant for the facility indicated they have provided a computer generated tool for the staff to use. It is highly recommended to implement a tracking mechanism which is updated as assessments are completed to assist in determining the current case mix. This monitoring will assist the MDS Coordinators as well as facility Administration in estimating future reimbursement based on a case mix model.

It is highly recommended that the facility focus on programs such as restorative nursing and mood/behavior documentation as these will become imperative to maintaining and/or increasing the case mix.

Clinical Services

ASSESSMENT

An operational assessment was completed at Cedarbrook and Fountain Hill Nursing Facilities located in Allentown/Bethlehem, Pennsylvania in February 2014. One day was spent in each facility. The assessment team consisted of two Registered Nurses with backgrounds in long term care. During the course of the clinical assessment, interviews and discussions were held with key members of the Nursing Management Team. Reviews of staffing practices, processes, supply usage and equipment utilization were completed.

Scheduling

A master schedule is the responsibility of the full time scheduler. She also handles the day to day call offs and replacement staff Monday through Friday. A computerized scheduling program is used. Per interview, Agency is used for Professional services only. Due to recent turnover of staff an increased utilization of Contractual Staff was noted since December.

All staff work an 8 hour day with a paid lunch break. Overtime for licensed staff is capped at 32 hours per pay period. Per Diem and part time staff are capped at 1000 hours per year.

Staffing

A review of the direct care staff including RNs, LPNs, and Nurse Aides was conducted as part of the baseline operational assessment. The current staffing patterns are adequate to meet the needs of the residents. Current staffing is at 3.2 PPD. No recommendations for hands on reduction but do recommend all staff be paid for a 7.5 hour day vs. an 8 hour day by having all staff clock out for a 30 minute meal break.
Job security and fear are currently driving the staffing crisis which is resulting in increased utilization of contractual staff and overtime.

Agency Utilization: A review of agency hours utilized over the last quarter revealed the usage split between RN/LPN. Cedarbrook is utilizing an average of 110 LPN hours and 100 RN hours. Fountain Hill is slightly less at 100 hours for each professional discipline. An increase in utilization was noted in December and has continued to increase with recent turnover in staff.

Facility currently contracted with four agencies with average rates for NA's at $20.75, LPN's at $40.11, and $48.37 for RN's. Facility currently only requires their services for the licensed staff.

Current Staffing hours for Cedarbrook (as provided by DON)

7-3	RESTORATIVE NA	LPN'S	RN'S	NA'S	TRANSPORTATION AIDE
B2		1.5	1	4.5	
B3		1.5	1	4.5	
C2		1	1	4	
C3		1.5	1	4.5	
D2		1	2	5.5	
D3		2	1	6	
D4		2	1	5.5	
D5		0	2.5	5.5	
D6		1.5	1	6.5	
D7		2	1	6	
HOUSE	5				3

3-11	RESTORATIVE NA	LPN'S	RN'S	NA'S	TRANSPORTATION AIDE
B2		2	0	3	
B3		2	0	3	
C2		2	0	3	
C3		2	0	3	
D2		2	1	3.5	
D3		1	1	3.5	
D4		1	1	3.5	
D5		2	0	4.5	
D6		2	0	5.5	
D7		2	0	4.5	
HOUSE	1.5				1

11-7	RESTORATIVE NA	LPN'S	RN'S	NA'S	TRANSPORTATION AIDE
B2		1	0	2	
B3		1	0	2	
C2		1	0	2	
C3		0	1	2	
D2		1	1	2	
D3		1	1	2	
D4		0	1	2	
D5		1	0	3	
D6		1	0	3	
D7		1	0	3	
HOUSE					

Current Staffing for Fountain Hill

7-3	RESTORATIVE NA	LPN'S	RN'S	NA'S	TRANSPORTATION AIDE
Station 1		2	1	4	
Station 2		2	1	4	
Station 3		2	1	5	
Station 4		2	1	5	
Station 5		1	1	5	
HOUSE	2.5				

3-11	RESTORATIVE NA	LPN'S	RN'S	NA'S	TRANSPORTATION AIDE
Station 1		1	0	3	
Station 2		1	1	3	
Station 3		2	0	3	
Station 4		2	0	3	
Station 5		2	0	4	
HOUSE	.5				

11-7	RESTORATIVE NA	LPN'S	RN'S	NA'S	TRANSPORTATION AIDE
Station 1		1	0	2	
Station 2		1	0	2	
Station 3		0	1	2	
Station 4		1	0	2	
Station 5		1	0	2	

Recommendation

Our only recommendation to direct resident care would be to reduce the number of Restorative Aides from 9 to 5. To accomplish this without compromising resident care we recommend the current Restorative Nursing Program be reviewed and adapt a different structure where the restorative nursing programs are divided into 2 different levels.

The more complex restorative nursing service are provided by the Restorative Nursing Assistants and the next level that are less complex to be carried out by the nursing assistants on the unit.

NURSING ADMINISTRATIVE STAFF

The nursing administration team consists of the Director of Nursing, Assistant Director of Nursing, 2 FT and 2PT Staff Educators, an Infection Control/QA RN, a Wound RN, 2 FT Risk Management RN's, a Clinic Coordinator, a Central Supply Director with 2 FT and 2 PT staff, a Scheduler, a Nursing Secretary, 8 FT RNACs, 1 FT Specialty Coordinator (LPNAC), a PT Clerical Tech I, a FT Clerical Tech III, one FT and one PT Employee Health Nurse, 9 Unit Clerks and a Restorative RN.

Recommendations

Based on conversations with the DON and ADON, and based on current industry practice, we would recommend elimination of the Specialty Coordinator, both Clerical Techs, and both Employee Health Nurses. We would also recommend reduction of the unit clerks from 9 to 6. We believe the job responsibilities of these positions could easily be absorbed by other positions within the department.

Central Supply

Per discussions with the Central Supply Director, he currently manages his department with two full time Techs and two PT Techs (between the two facilities) who are responsible for filling all daily orders within the facility as well as maintaining PAR levels on each of the units and putting all stock away on delivery days.

Three bids are required for purchase of items. Bids are usually obtained from:

- McKesson
- Medline
- Gulf South

Overall, the facility is very cost conscious related to equipment and frequently evaluates the usage and appropriateness of higher cost items. PAR levels for supplies

have been established and are posted on each nursing unit. Central delivers supplies and replenishes up to the PAR level.

During assessment a sampling of products and their pricing was reviewed. Facility pricing is within the industry standard. Inventory for both buildings is managed from Cedarbrook and kept to a minimum. Director stocks Fountain Hill through a cart exchange 3x/week.

The facility owns all equipment with the exception of an occasional C-PAP or specialty bed. No rentals currently.

No recommendations for change within this department.

Medical Records

The medical records department consists of a Coordinator and 1 FT FTE and 2 PT FTE's. No recommendations for change in this department.

Clinics

The facility has on-site clinics where physicians come to see their patients that include Podiatry, Eye, and Dental. A Clinical Coordinator is in charge of coordinating clinic appointments and scheduling of outside appointments. The Clinic Coordinator is also responsible for scheduling the transportation aides (3-4) for outside appointments. No recommendations for change in this department.

Environmental Services

ASSESSMENT

Tours of each facility were conducted with facility environmental services staff to review operations and identify potential expense reductions through operational efficiencies. We observed environmental staff conducting or completing duties that are not considered routine environmental services duties in other long-term care facilities that we have visited.

Institutional linen service is provided through an outside contract. Facility laundry staff deliver, receive, and reconcile linen counts. This may by an additional area for outsourcing to further reduce expenditures.

Cedarbrook resident rooms averaged 240 square feet which is smaller than typical resident rooms found in most newer facilities. The four bed or quad resident rooms lack a bathroom. Resident rooms do not present a homelike environment and lack many of the resident requested conveniences that a modern facility provides.

During the tour we noted several damaged terrazzo floors in the corridors. Although these floors are structurally sound the damage could be considered an infection control issue and it is unsightly to first-time visitors.

Unit B resident rooms are currently closed and are being utilized for storage. The structure of these rooms are not rated fire assemblies under the Department of Health Life Safety Code and could result in a potential citation during the facility annual life safety inspection. Corridor hand rails do not return to the walls at their ends as

required by regulation. The Pennsylvania Department of Health has cited facilities in the past for this issue.

Facility supplies and services are purchased through the bidding process. Typically the low bid was accepted and approved for service. This would appear to be the most cost effective method. Housekeeping does not utilize budget spend down sheets to reconcile this supply purchases. Housekeeping staff are responsible for maintaining supply par levels on the resident care floors.

Although department overtime is budgeted annually, the environmental services directors assured me it is not used. Both directors replace call offs with staff on hand.

Housekeeping quality assurance audits are completed on a monthly basis.

Housekeeping staff is responsible for cleaning the AG Center building, the Meals on Wheels building, and the independent living unit in addition to the skilled nursing facilities.

Maintenance staff acts as a courier daily for deliveries to other county buildings.

Maintenance staff acts as backup personnel for the Cedar view building.

Facility maintenance staff performs monthly preventative maintenance services on all equipment. There are a few select countywide maintenance agreements that assist the facility maintenance department in completing their preventative maintenance tasks.

The facility is participating in utility performance contracting.

FINDINGS

Based on interviews with facility staff housekeeping staffing ratios are greater than averages at other facilities in the state, however, they described numerous non-routine duties typically not performed by environmental services staff. Some of those non-routine tasks are listed in this report. For example, housekeeping staff are responsible to:

- Collect and deliver all laundry
- Shovel and salt entrance walkways when maintenance is working short-staffed
- Deliver supplies to Fountain Hill
- Assist facility social service workers in purging resident bedrooms of excessive personal belongings
- Responsible for central supply duties three days a week
- Clean the dietary department after hours
- Assist with resident room changes on a near daily basis
- Coordinate contracted extermination services and vendor tours
- Process UPS deliveries and shipments
- Order and deliver oxygen supplies throughout the facility

In addition, maintenance staff are responsible for the preparation and burial of select deceased residents.

OPPORTUNITIES

Based on interviews and data collection the facility environmental staffing does not appear to be excessive based on the number of non-routine tasks both the housekeeping and maintenance staff are asked to do on daily basis. If for any reason staffing levels are adjusted the question has to be asked "who would complete their tasks" before reducing staffing. The facility staffing ratios are currently so close to, or below, average environmental staffing ratios we do not recommend reducing staff.

The facility may realize some savings by being allowed to shop for their own maintenance agreements. Maintenance agreement contracts for the elevators, fire alarm system, HVAC maintenance, are piggybacked on other County maintenance agreements. If any of these agreements are long-term commitments to a rollover price increase annually facilities can typically can find much more competitive pricing on the open market.

The Facilities Services Director suggested creating a new facility revenue stream by providing residents telephone services in their bedrooms. This could be accomplished by replacing the current facility telephone equipment with a PBX system capable of providing the individual resident telephone service. He was aware of PBX system capabilities and is currently awaiting capital improvements toward this goal.

There may also be some opportunities for savings from contracting housekeeping services out to providers such as HSG, Aramark, or ServiceMaster. These providers typically save facility monies through reduced labor and supply costs. The cost per patient days ("PPD") at four comparable managed facilities ranges from $5.06PPD to $11.64 PPD, with an average PPD of $8.10; compared to $14.04 PPD for the Facilities. Two of the noted managed facilities have outsourced housekeeping at an average cost of $5.20 PPD. Outsourcing of housekeeping service could result in annual savings of

approximately $1.4 million; taking into account additional services provided to the Brookview I/L, and additional Maintenance needed to handle functions currently performed by housekeeping typically completed by maintenance staff. Subcontracting of functions is permitted under Article 3, Section 3 of the collective bargaining agreement with UFCW, as long as the Facilities adhere to the provisions, including the "meet and discuss" provisions.

There is little opportunity to improve upon your current purchasing practice of awarding supplies and service contracts to low bidders. The County may want to consider allowing the facility to shop for comparative pricing on its own in effort to reduce costs to the facility. This could be a two edged sword by taking the long-term care facilities out of the bidding pool of other County buildings. Another thing to consider is refraining from allowing contracts to roll over annually without searching for competitive pricing. Typically only a few years of steady rollover cost increases take the vendor proposals out of the competitive pricing arena.

The same could be said for facility utility costs. The facility is currently involved in a performance contracting program which will eventually realize utility cost savings after the initial equipment installation cost is paid for. There is little or no possibility of improving on utility costs at this time.

Nutritional Services

ASSESSMENT

A full assessment of the dietary services department was conducted for Lehigh County on Wednesday, February 19 at Cedarbrook Allentown and on Thursday, February 20th at Fountain Hill.

Sodexo Operations LLC, provides all management, clinical and line staff for dietary services at for Lehigh County at both the Cedarbrook Allentown and Fountain Hill locations. Sodexo is responsible for managing all aspects of the dietary department including labor, purchasing, menu development, and providing dietitian services.

Information assembled in this report was generated from multiple sources including managerial and personnel interviews, department-specific documents including invoices,

The Sodexo Contract was recently renewed through 2015.

Cedar Brook, Allentown-Yearly contract is $113,752 $0.63per budgeted resident (includes Brookview)

Fountain Hill Yearly contract is $41,045 $0.58 per budgeted resident.

Cedar Brook also serves Brookview Apartments which provides residents with two meals per day served in a disposable container. The only item that returns and is reused is the food cart that is used for transport. As of our visit, there are 30 residents in the apartment complex. The food budget includes those meals (average 60 per day).

Cedar Brook Allentown provides an employee Café ("Market to Go") and is open for 5 hours per day Monday through Friday. This does not operate weekends or holidays. This program breaks even or has minimal profit. The County receives the revenue. The menu is limited, as there is one Sodexo employee who staffs the program. More options would cost more and result in less revenue without increasing the food budget, unless expanded hours would be considered.

Cedar Brook total census for 2013 was 160, 180

Fountain Hill Total Census for 2013 was 70, 433

Food

Cedar Brook Dietary Budgeted PPD for 2014 is $7.35 which does not include supplements.

Fountain Hill Dietary Budgeted PPD for 2014 is $6.70 which does not include supplements.

Labor

Cedar Brook Labor ppd is .74

Fountain Hill Labor ppd is .65

Industry standard is .75-.77

Operational staffing appears adequate with working supervisors and noticeable cross training between staff. The training program is exemplary and the director and her team appear to manage a streamlined, efficient production process.

Clinically they are below industry standard with only 2 FTE of Registered Dietitians. Industry standard is 1 FTE RD for 100 residents.

County and Non County Proposal:

Cedar Brook Allentown Recommend adding 2 FTE of Diet Technician

Additional Cost for this would average $80,000 annually

Fountain Hill

At an average census of 192 there is one full time RD.

County and Non County proposal

Recommend adding 1 FTE of RD.

Additional Cost for this would average $60,000 annually.

Findings:

Adaptive Equipment

Adaptive equipment costs for 2013 total $11,226.15. Adaptive equipment procurement totals for 2013 are as follows:

Dysphagia spoons 960, Nosey cups (24), Feeding cups without handle (1,050), Pedisure spoon (12), One-handle clear mug (72), Two-handled clear mug (156) Gripware scoop dish (24).

During our observation a majority of resident trays received this equipment although many residents needed to be fed or did not use the equipment. This is normally ordered as an occupational therapy aide. With oversight and training; this is considered a beneficial program. However without the training this can be huge cost to the facility if it is not closely monitored.

Cost Breakdown

Nosey Cup-$3.40, Feeding cup-$4.33, Pedisure Spoon, $3.18, Scoop Dish-$5.15

Considering the average meal cost of $7.35, those residents receiving adaptive equipment without any oversight or follow up is costing the facility an average of $9.00 per day over the budgeted food cost. This could be significantly reduced with a better managed rehabilitation program.

Supplements

No medication pass supplement is used-The medication pass supplement is a lower cost alternative for providing residents who need nutritional supplements small servings of calorically dense nutrition while giving medications. Providing a product that supplies 120 calories 4 times a day with meds is more beneficial as they are observed by a licensed professional. This can be given as a medication pass, and at the end of the day the resident has consumed approximately 480 calories plus the meal, whereas, larger amounts of supplements between meals may cause a decrease average meal consumption.

Cost for a medication pass per day averages $.64 per resident (8 0unces). To provide the same amount of nutrition with a supplement between meals such as a "Mighty Shake" 3 times per day costs $1.32 per resident. Labor would play a significant factor as well because an aide has to provide the supplement at 10, 2, and evening whereas the LPN while passing meds is providing additional nutrition while completing the medication pass without additional time involved.

If there is an average of 50 residents receiving supplements a monthly savings would result in $1,000.00 or $12,000.00 per year.

Excess Juice Usage

Nursing pours an additional 4 ounces (approx) of juice to each resident 3 times per day (Regulations require that 6 ounces of Fruit juice is the only juice requirement which is normally served at breakfast) This will result in an additional cost of $40,663 in 2014. (Based on average juice cost of $.25 per 4 ounce serving)

Resident Snacks

There are variety of resident snacks available and both facilities meet the regulatory requirements for snacks. Nursing completes the snack requisition forms, rather than dietary setting par levels for snacks. There is more cost control if dietary sets par levels with nursing input for snack items. This eliminates over ordering.

Employee Meals

Employee meals are available at the Cedarbrook Allentown location. Employee meals are not available at the Fountain Hill location.

Offering employee meals through the dietary department has revenue generating potential for both Cedarbrook Allentown and Fountain Hill facilities.

Example of employee meal generated revenue:

Sell 20 employee meals daily at a selling price of ($3.50) per meal

(20) meals x ($3.50) = ($70.00) daily

($70.00) daily from meals x (365) days per annum= ($25,550)

Sample meal cost breakdown:

Meat ($.80) Vegetable ($.15) Starch ($.20) Dessert ($.30) Milk ($.20)

Total food cost per meal is ($1.65)

(20) meals x ($1.65) = ($33.00) cost to produce (20) employee meals per day.

($33.00) x 365 days per annum= ($12,045.00)

($25,550) (employee meal) – $12,045.00 (cost to produce employee meal) = ($13,505.00)

Employee Meal Profit: ($13,505.00)

Guest Meals

Guest meals are not provided at either the Cedarbrook Allentown or Fountain View locations. However, food items are available for purchase at a minimal cost to guests at the "Market to Go "café.

Cedarbrook Auxiliary provides food once per month. This does have a direct impact on the Market To Go program as the program is closed on Auxiliary sale days.

Example of guest meal generated revenue:

Sell 20 guest meals daily at a selling price of ($5.00) per meal

(20) meals x ($5.00) = ($100.00) daily

($100.00) daily from meals x (365) days per annum= ($36,500.00)

Sample meal cost breakdown:

Meat ($.80) Vegetable ($.15) Starch ($.20) Dessert ($.30) Milk ($.20)

Total food cost per meal is ($1.65)

(20) meals x ($1.65) = $33.00 cost to produce (20) guest meals per day.

($33.00) x (365) days per annum= ($12,045.00)

($36,500.00) (guest meal) – ($12,045.00) (cost to produce guest meal) = ($24,455.00)

Guest Meal Profit is ($24,445.00)

Vending

Vending is currently outsourced. Bringing vending in house can generate additional revenue for both locations.

OPPORTUNITIES

Sodexo is operating the department in a well-organized fashion focusing on good standards and budget compliance. The staffing is lean, but effective. With the recommendations as noted above additional opportunities with financial significance are as follows:

1. Consider a full review of the therapeutic use of adaptive equipment and expenses. At a current average cost of $11,000.00 annually, there is potential to decrease that expense by 50% and save $**5500.00 per year**.
2. Consider less in-between meal and tray supplements and use the Medication Pass supplement that is well known in the long term care industry as an effective supplement for residents. Savings would be **$12,000.00 per year.**
3. Provide the required amount of fruit juice at breakfast per regulatory requirements, have juice available for snacks and use lower cost fluids such as juice drinks, milk, coffee, etc. Savings would be approximately $**40.000.00 per year.**
4. Increase the use of the "Market to Go" program at Cedar Brook and consider adding "Market to Go" at the Fountain Hill Location. (Can be done on lower level or using one side of the main dining room). Additional revenue potential **$13,000.00**
5. Add a Guest Meal option for visitors and family members which would allow direct service to the resident room, rather than the Market Café per the family wish. Additional revenue potential would be **$24,000.00**

Social Services

ASSESSMENT

Cedarbrook Allentown

Social Work

Current Staffing

1 FTE Director

1 FTE Administrative Assistant (SS & Admissions)

4 FTE Social Workers

2 Per Diem

Recommendations

Convert 2 Per Diem to 2 FTE positions

Eliminate Administrative Assistant

Fountain Hill

Social Work

Current Staffing

2 FTE Social Workers

1 Per Diem

Recommendations

Convert 1 Per Diem to 1 FTE

Assessment

There has been a change in the expectations of seniors related to amenities and living space in recent years. When the Allentown facility was constructed, an institutional setting was an acceptable model for nursing facilities. The current generation of seniors needing nursing home placement has different expectations related to the environment where they receive short term care or choose to live for long term care. Privacy and a homelike environment are key factors being considered by consumers seeking nursing home placements. The physical plant at the Allentown facility is institutional compared to current market standards and area competitors. The current

3 and 4 bed rooms with no bathrooms limit the ability to meet the social and emotional needs of the current generation related to dignity and privacy.

The Social Work review consisted of a thorough interview with Director of Social Services which included staffing and current day to day responsibilities to ensure that the psychosocial needs of each resident and their family's needs are being met.

Findings

Director promotes and encourages Patient Centered Care.

Director active in Quality Assurance process.

Director supports end of life care planning.

Staff insufficient to adequately handle current census due to having the extra responsibilities of competing majority of admission paperwork and overall daily tasks associated with Social Work role in long term care.

Hand written assessments and documentation add to inefficiency of meeting the daily documentation needs according to regulation.

Opportunities

Reassign majority of admission paperwork back to Admission staff.

Increase staff to support census along with coverage for time off.

Implement PCC documentation.

Redesign or new construction to provide residents with a homelike environment and privacy for activities of daily living such as bathing, grooming and dressing. Include amenities to improve communication, socialization and resident satisfaction such as phones, televisions and bathrooms.

Addendum

This addendum includes adjusted financial tables and projections based on updated information received from the facility after the report was completed. The variance represents a revision of 2014 projected capital expenditures included in the Capital, Bond Debt and Other line items on the Summary Financial Trend for Option 1 and Option 2. The capital expenditures changed from $974,682 to $629,038, a difference of $345,644.

Operational Losses

Year	Amount
2012	$3,773,000
2013	$4,673,717
Projected	
2014	$5,995,654
2015	$6,279,350
2016	$7,085,943

Option 1: Table 1

Lehigh County Facilities Summary Financial Trend **Option 1 - No Changes**	Actual 2012	Actual 2013	Projected 2014	Projected 2015	Projected 2016
Revenue	$63,449,309	$59,963,860	$61,163,137	$62,386,400	$63,634,128
Operating Expenses					
Wages and Benefits	43,973,459	43,921,403	45,239,045	46,822,411	48,695,308
Other Operating Expenses	17,117,239	15,021,809	15,322,245	15,628,690	15,941,263
Management Fee - Admin & Dietary	631,373	615,572	627,884	640,441	653,250
Total Operating Expenses	61,722,072	59,558,783	61,189,173	63,091,542	65,289,821
Net Operating Income Before County Indirec	1,727,237	405,077	(26,036)	(705,142)	(1,655,693)
County Indirect	3,624,733	4,038,923	4,477,943	4,612,281	4,750,650
Net Operating Income	(1,897,496)	(3,633,846)	(4,503,979)	(5,317,424)	(6,406,343)
Capital, Bond Debt and Other	1,876,104	1,039,870	1,491,675	961,926	679,600
Net Income before Transfer from Operations	(3,773,600)	(4,673,717)	(5,995,654)	(6,279,350)	(7,085,943)
Transfer from Operations	(3,438,230)	(6,376,755)	(5,995,654)	(6,279,350)	(7,085,943)
Net Income	($335,370)	$1,703,038	$0	$0	$0
Census Days	239,806	230,612	229,459	228,312	227,170
Average Daily Census	657.00	631.81	628.65	625.51	622.38

Option 2: Table 2

Lehigh County Facilities Summary Financial Trend **Option 2 - Implementation of Recommendat**	Actual 2012	Actual 2013	Projected 2014	Projected 2015	Projected 2016
Revenue	$63,449,309	$59,963,860	$61,478,200	$62,707,764	$63,961,919
Operating Expenses					
Wages and Benefits	43,973,459	43,921,403	43,338,039	42,887,330	44,602,823
Other Operating Expenses	17,117,239	15,021,809	16,385,653	17,798,042	18,154,003
Management Fee - Admin & Dietary	631,373	615,572	627,884	640,441	653,250
Total Operating Expenses	61,722,072	59,558,783	60,351,575	61,325,813	63,410,075
Net Operating Income Before County Indirect	1,727,237	405,077	1,126,624	1,381,951	551,843
County Indirect	3,624,733	4,038,923	4,477,943	4,612,281	4,750,650
Net Operating Income	(1,897,496)	(3,633,846)	(3,351,319)	(3,230,330)	(4,198,806)
Capital, Bond Debt and Other	1,876,104	1,039,870	1,491,675	961,926	679,600
Net Income before Transfer from Operations	(3,773,600)	(4,673,717)	(4,842,994)	(4,192,256)	(4,878,406)
Transfer from Operations	(3,438,230)	(6,376,755)	(4,842,994)	(4,192,256)	(4,878,406)
Net Income	($335,370)	$1,703,038	$0	$0	$0
Census Days	239,806	230,612	230,189	229,353	228,630
Average Daily Census	657.00	631.81	630.65	628.36	626.38