
COUNTY OF BROOME

WILLOW POINT NURSING HOME

STRATEGIC ASSESSMENT OF COUNTY OWNERSHIP OPTIONS



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FORWARD

This report examines the future strategic options of Broome County (the County) with respect to the operation of Willow Point Nursing Home (Willow Point), its publicly sponsored skilled nursing facility. The County of Broome is facing increased public pressure to address continued operating losses at Willow Point. As a result in 2012 the County embodied the sales/lease task force to address this issue as well as those affecting three other municipally operated enterprises. Since the intent is to look at future strategic options for Willow Point, reliance on historical data is of lesser importance than understanding the operations existing and the future healthcare environment. Awareness of these items will allow the task force and County to assess the operational plausibility of Willow Point, and if confirmed, the development of a rational strategic plan to promote its long term viability. Given the rapid and volatile nature of the US healthcare delivery system, specifically the long-term care segment, emphasis on historical data alone only stymies efforts to realistically address current and future challenges facing the organization. Therefore the report analyzes historical operational data in an attempt to give a perspective or context for potential opportunities for improvement. Greater emphasis is placed on the organizational structure of the operation, stakeholder interests, competitive market forces and projections under specific operating assumptions.

The circumstances surrounding the County's philosophical dilemma of providing long-term care services to the County's residents while maintaining necessary budgetary and cost control are not unique. This dilemma is being faced at an increasingly high rate nationally due to federal and state regulatory pressure on reimbursement and market factors which have resulted in compressed operating margins for all providers of long-term care services and especially those owned by state and local governments. The report comes to identify specific market forces which impact the facility's operations and suggests potential operational strategies to mitigate the negative effects of these forces. The report also addresses specific concerns of Broome County as identified by the lease/sale task force and included in the County's RFP for consulting services.

REPORT OBJECTIVES

The objective of the report is to assist Broome County in determining the future long-term care and service needs of the elderly and medically and financially vulnerable populations. Additionally, the report provides an analysis of the County's ability to operate Willow Point in a financially viable manner and to explore alternatives to the facility's organizational structure/model which may positively impact the services provided to the County's residents, as well as improve the organization's operational and financial performance.

REPORT SCOPE

The scope of the report focuses on the following primary areas as specified in the County's Request for Proposal (RFP) for this project.

1. Assess Willow Point's current and future financial performance as it relates to demands for continuing financial support from County tax subsidies for the periods 2014 - 2017 and for year 5 (2018) and beyond based on projected industry and regulatory trends.
2. Provide a comparison of Willow Point's revenues and expenditures to other nursing facilities in the Broome County service area and provide an analysis of identified differences and recommendations for improvement.
3. Evaluate the current and future long-term care and service level needs of the elderly and medically vulnerable populations, identifying existing service capacity within the market and the ability of other providers to provide the necessary level of services to these populations. Identify potential gaps in long-term services and the potential for Willow Point to be the provider of such services and the related cost/benefit of providing the services.
4. Evaluate the cost and benefit of constructing a new nursing facility and provide a recommendation as to optimal facility size in the context of the regulatory and reimbursement environment.
5. If the feasibility of continued County sponsorship is not a viable alternative, determine:
 - The cost/benefit of the facility's current ownership structure as compared with alternatives that would continue to maintain a relationship between the County and the facility under each alternative ownership structure option.
 - Evaluate the cost/benefit of contracting or leasing the real estate and/or operations to a third party.
 - Evaluate the cost/benefit of privatization options for sale or transfer of the operations and real estate, either as part of a separate or combined transaction including the economic opportunity cost of alternative uses of the existing facility.

REPORT METHODOLOGY

The methodology utilized in the analysis and recommendation within this report included a variety of quantitative and qualitative techniques to identify, gather and analyze the relevant information necessary to properly evaluate the external and internal environments which impact the facility's operations and its ability to provide effective, efficient and quality services to consumers in the Broome County service area. These methods included: meetings with stakeholders; review of industry and regulatory trends; analysis of relevant demographic, financial and quality data; documentation review; competitive market analysis and development of forecasting and valuation models. The data utilized in the report was obtained from numerous internal and external sources as referenced throughout the report to assure validity and objectivity of the data utilized in the analysis, evaluation and development of our projections and recommendations.

In conducting our analysis we approached the project by applying commonly accepted industry practices for performing strategic business and operational analyses as they pertain to the following areas:

- External Environment Analysis
- Internal Financial and Operational Analysis
- Development of Recommendations
- Development of Assumptions Development of Projections

Due to the inherent complexity of the healthcare environment, government structure, differences in stakeholder interests and the complexity of the issues surrounding privatization many of the issues and recommendations are interrelated and subject to individual perceptions, values and historical events. We have made every attempt to provide our analysis in a manner which is objective, factual and free of bias to enable Broome County to make an objective decision with respect to the future delivery of long-term care services to the residents of the county.

EXECUTIVE SUMMARY

Objective 1: Assess Willow Point's current and future financial performance as it relates to demands for continuing financial support from County tax subsidies for the periods 2014 - 2017 and for year 5 (2018) and beyond based on projected industry and regulatory trends.

Summary:

Between 2011 and 2013, the County has indirectly subsidized Willow Point in an amount of \$11,055,871 through a 50% county match of inter-governmental transfer funds (IGT) and another \$53,565 in other transfers. Operationally, Willow Point's revenues, less bad debts and the New York State Cash Receipts Assessment, are substantially insufficient to cover the cost of salaries and benefits, **irrespective of any other costs** of operating the facility as outlined below:

	2011	2012	2013
Net resident service revenue	21,502,690	21,455,851	20,033,597
Other operating revenue	410,947	670,922	312,845
Less:			
Provision for doubtful accounts	(502,570)	(2,946,228)	(2,284,825)
NYS assessment	(1,348,196)	(1,172,791)	(1,058,441)
Available resident service revenue	20,062,871	18,007,754	17,003,177
Salary	12,567,198	12,527,301	11,385,797
Benefits	9,750,900	9,613,523	7,820,261
Total salary and benefits	22,318,098	22,140,824	19,206,058
Excess (shortfall) resident service revenue	(2,255,227)	(4,133,070)	(2,202,881)

There does not appear to be a means of significantly increasing revenues outside of increased case mix. Internally, Willow Point has little room for increased occupancy and struggles with resident selectivity in order to try and obtain a more favorable payor mix for reimbursement. Externally, the regulatory environment does not appear to be in a position of increasing rates to providers for the foreseeable future. The County also bears the risk that any scale back or elimination of IGT funding would dramatically increase its required subsidy of Willow Point. Our expectation is that absent a dramatic change to the salary and benefit structure, Willow Point will continue to require approximately \$5,000,000 per year in County subsidy/IGT match, with a significant risk of higher exposure in the event of any negative changes to IGT funding or a reduction in census.

Objective 2: Provide a comparison of Willow Point's revenues and expenditures to other nursing facilities in the Broome County service area and provide an analysis of identified differences and recommendations for improvement.

Summary:

Willow Point maintains a strong census over other nursing facilities in Broome County; however, the payor mix is less favorable with a larger weight toward Medicaid days which result in lower reimbursement. A summary of the census comparisons are noted below:

2012	Willow Point	County Average
Medicaid	78.10%	63.50%
Medicare	7.50%	11.70%
Private	14.40%	24.90%
 Total Occupancy	 96.50%	 88.00%

Our benchmarking review of Willow Point to other long-term care providers in Broome County (the Group) identified the following items for discussion:

2012	Willow Point	County Average	Variance
	<i>Consistent</i>		
Supplies and materials	18.32	23.02	(4.70)
	<i>Lower Cost</i>		
Salaries and wages	118.22	117.47	0.75
Contracted services	2.93	23.84	(20.91)
Fees	1.01	14.73	(13.72)
Lease - Building	-	6.76	(6.76)
	<i>Higher Cost</i>		
Other direct	39.65	12.37	27.28
Group Health Insurance	57.24	11.59	45.65
Pension	19.20	2.23	16.97

Lower Cost - Outsourced agency services such as therapy, management or nursing are depicted on the fees line and outsourced program functions such as laundry or dietary are depicted on the contracted services line. As a result of Willow Point performing these functions internally, its salaries and wages per day are actually \$33.88 per day lower than those of the Group. However, as shown in the payor mix percentages above, most of the other facilities in the County have higher Medicare occupancy and, therefore, have higher patient acuity which necessitates the need for more staff, especially in the therapies. If Willow Point were to increase Medicare occupancy or take on higher acuity Medicaid patients, this "lower" per day salary would cease to exist because of the increased need in staffing, especially in areas such as therapy, which tend to have high salaries.

In addition, Willow Point's ownership of the building provides savings in leasing costs compared to the Group. It should be noted however, that the savings on the lease expense cost are at least partially offset by an increase in cash outflows for capital purchases in order to maintain the building and improvements.

Higher Cost - While Willow Point presents lower salaries when considering the impact of outsourced functions, there is a substantially larger cost of the related benefits to those employees. The health insurance and pension cost is \$62.62 per resident day greater than the Group. The combined savings on salary to the increase in benefits results in a net \$28.74 per day greater cost to Willow Point than the Group. At 105,969 days in 2012, that is an extra cost of \$3,045,549.

In addition, Willow Point’s other direct expenses were higher than the group, which appears to be directly attributable to its provision for bad debts which totaled \$27.80 per day for 2012.

Recommendations – Willow Point’s costs across various categories are actually very comparable to the Group as seen in the Benchmarking section of this report. The clear outlier is Willow Point’s benefit structure, which is far superior to what is being offered by the Group and leaves Willow Point at a competitive disadvantage. For-profit and not-for-profit facilities in Broome county offer benefits as a percent of salary of 19.1% and 28.5% respectively, compared to Willow Point’s 76.7%. In spite of political hurdles, we recommend the County consider its leverage in negotiating its union contract and attempt to reign in benefits in line with market conditions. Further, if negotiations are ineffective, Willow Point should evaluate the cost/benefit of outsourcing laundry, dietary, therapy and other functions and the impact on such an endeavor with the union relationship and potential to do so under the terms of the contract.

Willow Point’s provision for bad debts was a substantial expense in 2012 and notably higher than the Group. Publicly sponsored facilities often struggle with bad debt expense as admission processes do not have the financial scrutiny that is exhibited by other sponsorships. Public facilities try and maintain the cause of providing care to those that need it in spite of the financial wherewithal or prudence of family members to complete necessary paperwork for insurance approvals. In spite of these factors, Willow Point is still losing substantial cash flow to bad debt. We recommend that Willow Point establish and adhere to strict policies regarding accounts receivable collection, which would include: verifying a resident’s payor source at time of admission, having adequate and knowledgeable collections staff, regularly working claims for collection to prevent disallowance for untimely claims, and utilize a collection agency or attorney (preferably, on a commission basis to limit the high hourly fees charged by an attorney) for claims that are beyond the capability of the collections staff.

***Objective 3:** Evaluate the current and future long-term care and service level needs of the elderly and medically vulnerable populations, identifying existing service capacity within the market and the ability of other providers to provide the necessary level of services to these populations. Identify potential gaps in long-term services and the potential for Willow Point to be the provider of such services and the related cost/benefit of providing the services.*

Summary:

Demographic projections indicate a population growth rate of those ages 65 and over as summarized in the following schedule:

65+ Population Growth Rates

	National	NYS	Broome
2015 - 2020	17.35%	7.88%	5.56%
2020 - 2025	16.23%	8.43%	6.23%
2025 - 2030	11.87%	6.23%	3.35%
2030 - 2035	6.24%	2.45%	-0.66%
2035 - 2040	3.11%	-0.55%	-3.24%

The population growth rates for the long-term care demographic are encouraging. Unfortunately, Broome County's figures aren't as robust as national or state projections, particularly as changes in the NYS healthcare environment are expected to erode long-term care census. The managed care transition is still in its infancy so the ultimate impact to long-term care census is uncertain. What is certain, however, is that insurance companies are financially incentivized to keep the nursing home population in lower levels of care as long as possible in order to reduce the length of the stay at a more costly skilled nursing facility.

Further, as currently estimated by the NYS DOH, bed need for 2016 Broome County has excess bed capacity of 208 beds, or 75,920 resident days. These amounts are about 13.1% of the existing bed capacity. Willow Point's 300 beds appear to provide some excess to the market, but with population growth trends and the uncertainty in managed care implementation, the current bed capacity and need of Broome County appears reasonable.

Also, other providers in the county offer many other levels of care such as independent living, adult care homes, assisted living programs and medical day care program settings may be viable alternatives to nursing home care. Since the availability of these services or alternatives exist, nursing home providers may have less leverage in the future with the implementation of managed care as the managed care companies will try to keep their members in the least expensive method of care.

Objective 4: *Evaluate the cost and benefit of construction a new nursing facility and provide a recommendation as to optimal facility size in the context of the regulatory and reimbursement environment.*

Summary:

Costs of New Facility Construction:

- Extensive additional capital outlay toward an operation that already incurs considerable losses
- Long-term in nature to secure location, site approvals, CON approvals, etc.
- 2 year lag from initial capital outlay to receipt of reimbursed capital in Medicaid rate.

Benefits of New Facility Construction:

- Can custom design facility and use the transition to enact changes in strategic direction which may include different services
- Newer facility can create competitive advantage to increase census, potentially those with a higher payor source
- Historically low interest rates for financing
- Opportunity to upgrade technologies and create additional operational and energy efficiencies
- Increase to facility for capital portion of the Medicaid rate for financing of cost of new facility over the life of the loan (assuming this methodology is changed as part of the managed care transition).

Reduced Bed Analysis – 2015

	<u>240 Beds</u>	<u>218 Beds</u>	<u>196 Beds</u>
Operating Revenue	21,900,000	19,650,000	17,350,000
Expenses:			
Payroll & Benefits	18,500,000	16,750,000	15,100,000
NYS Assessment	1,300,000	1,170,000	1,025,000
Depreciation	2,250,000	2,050,000	1,850,000
Interest	2,700,000	2,400,000	2,150,000
Other	5,100,000	4,750,000	4,300,000
Total Expenses	29,850,000	27,120,000	24,425,000
Operating Loss	(7,950,000)	(7,470,000)	(7,075,000)
IGT Revenue	5,000,000	4,500,000	4,000,000
Net Loss	(2,950,000)	(2,970,000)	(3,075,000)
County Share of IGT	(2,500,000)	(2,250,000)	(2,000,000)
Net Loss to County	(5,450,000)	(5,220,000)	(5,075,000)

The table above is an analysis of projected revenues and expenses if the facility were to under go further bed reductions than those that were recommended by the Berger Commission and implemented by the facility previously. This projection shows that even with drastic bed reductions and staffing cuts, the county would still lose about \$5 million dollars a year.

Objective 5: If the feasibility of continued County sponsorship is not a viable alternative, determine:

- The cost/benefit of the facility's current ownership structure as compared with alternatives that would continue to maintain a relationship between the County and the facility under each alternative ownership structure option.
- Evaluate the cost/benefit of contracting or leasing the real estate and/or operations to a third party.
- Evaluate the cost/benefit of privatization options for sale or transfer of the operations and real estate, either as part of a separate or combined transaction including the economic opportunity cost of alternative uses of the existing facility.

Summary:

The Objective above is contingent upon many different factors. First and foremost, would a new operator want to take ownership of the existing facility? If yes, this would allow the County to include the land and building as part of a sale. Once that happens, the property would be subject to real estate taxes like other for profit entities.

Second, if a new operator did not want to acquire the land and building, instead choosing to lease the real estate, the County would be able to recognize the rental income at the County level. It would maintain ownership of the land and building, allowing for some say as to how the property was being maintained.

Third, a new operator could choose to purchase the bed licenses and the County would maintain ownership of the land and building. Under this scenario the building would no longer be used to house nursing facility residents. Undoubtedly, some of the space could be used by the County for other purposes, but the current layout is best suited for the delivery of long-term care services. This option could open the door to the possible demolition and related cost of some if not all of the facility if other purposes for the space could not be found.

THE ORGANIZATION

Overview

Willow Point Nursing Home was established in 1830 under the New York State County Poorhouse Act of 1824. According to the Yates Report, between 1817 and 1822 the County provided care for 45 “paupers and lunatics” at an average cost of \$1.08 per individual per week. The report estimated the total cost of care raised by taxes for the six-years, 1817 to 1822, was \$4,280 for all persons under care during this time period. The poor and infirmed resided in two units, one for each gender with up to six individuals occupying a room. The facilities were located on a 130 acre farm and residents who were capable of performing tasks on the farm were expected to do so as a means of contributing to their support. The poorhouse residents were provided care by one “keeper” and meals were provided by the keeper’s wife. Also, of note is that at the time of the Yates report there was a total of 37 residents at the poorhouse of which there were 14 males and 23 females, including 5 children under the age of 16 years.

In 1960 the County re-opened Chenango Bridge as the Broome Health Center as the county’s home for the infirmed and the aged. In 1969, the 162 South Building was leased to the County by the Willow Point Land Company and the facility became known as Willow Point. In 1971, the 180 bed North Building was constructed and leased to the County. The County purchased the 342 bed facility in 1973 which continues to remain in operation as the present day Broome County “Willow Point Nursing”. In 1981 due to a shortage of open nursing beds in the Broome County market area, many residents waiting for admission were placed on waiting lists or were placed in nursing homes in other counties. In 1988, Broome County constructed the 41 bed West Wing and transferred 39 residents from the Chenango Bridge facility which was then permanently closed. The 383 beds constructed between 1969 and 1988 make up the current foot print of the Willow Point facility.

New York State Commission on Health Care Facilities in the 21st Century

In 2006, the State of New York passed legislation empanelling a commission to study health care delivery across the state by region to better serve the State’s population, reduce institutional infrastructure costs and eliminate excess capacity and waste from the health delivery system. The Commission, formally known as the Commission on Health Care Facilities in the 21st Century was presided over by Stephen Berger as Chairperson and as a result, the Commission has often been referred to as the Berger Commission. The state right-sizing initiative was funded by federal subsidies under the Federal and State Partnership Agreement and waiver provisions of the State’s Plan which filed with the U.S. Department of Health and Human Services which provides funding for state Medicaid and federal Medicare programs. In essence, theory behind the initiative was that if the healthcare delivery could be properly re-configured, right-sized and excess waste could be eliminated then future savings with respect to healthcare delivery would result in a positive return on investment for both the state and federal governments.

The Commission was composed of an 18 person statewide committee, 6 regional committees having 6 members each and 6 regional advisory committees that would provide additional recommendations for each region. The committees and advisory groups studied information provided by the NYS Department of Health, industry trends and regional demographics and met with individual facilities within the region to determine the capacity needs within region pursuant to the New York State Need Methodology. After establishing existing and future capacity needs by region, the Commission determined based on the research data available, interviews with facilities and public hearings which facilities were least efficient, most likely not to be financially sustainable, as well as those which had excess capacity or performed poorly with respect quality and inspections.

The Regional Advisory Committee's recommendations to the Regional Committee issued on November 3, 2006 and subsequently adopted by the Statewide Commission regarding Willow Point is presented below:

Recommendation 8:

Willow Point should downsize by 83 RHC beds to 300 beds. Construct replacement nursing home. Add 30-slot ADHC

• Background

Willow Point is a 383-bed residential health care facility owned and operated by Broome County, and providing baseline services. While the facility enjoys fairly high occupancy (97-96% in the 2002-04 period), it is plagued by several problems. First, Willow Point is financially precarious and a financial burden on the County; over the 2000-02 period, it lost over \$6.4M.

Additionally, the facility has presented quality concerns, with 14 survey deficiencies (which is significantly above the regional average of 5) and a few "immediate jeopardy" citations (meaning the surveyor believed that it was a life-threatening situation.) Some of Willow Point's Medicare quality indicators fall well below Statewide averages, including percentage of residents in pain and percentage who lose continence. This is perhaps due to the size and age of the Willow Point facility, which Department of Health officials have commented is no longer appropriate for skilled nursing care. Willow Point provides only long, double-loaded corridors which inhibit interactions and do not provide today's therapeutic milieu.

Other facility factors of note are a relatively high number of low-scoring individuals in the facility (about 18% of all residents over the 2001-03 period), and a relatively limited availability of services, although the facility does operate a short-stay program.

• Rationale

Broome County is a "borderline" opportunity for resource shifts. While the bed need methodology shows few surplus beds, the 2004 occupancy across the county was only 92.8%. With Willow Point at a high occupancy, that implies that some of the beds in higher-quality facilities are going unused. In addition, the county still needs over 650 "slots" for non-institutional services, especially for adult day health care, for which only 20 slots exist for the entire county. There are pros and cons to the final size of Willow Point. The current reimbursement methodology gives facilities with over 300 beds a higher "ceiling" on indirect costs, and so 300 makes some financial sense. However, given the size and population of Broome County, the 300 beds may not be necessary to serve the community in the future.

• Required investment

Because of the age, size, and physical layout of the facility, we recommend replacement. A Certificate of Need application would need to be submitted. The new facility should accommodate the ADHC on the first floor, perhaps with additional space to expand if future needs warrant. We would anticipate a new facility to come on line in approximately two-and-a-half to three years.

Key Points of the RAC Recommendation:

Positives:

- Relatively high 96 – 97% occupancy rates (County Occupancy 92.8%)

Negatives

- Three year loss (2002 – 2004) over \$6.4 million
- 14 NYS Inspection violations including immediate jeopardy violations (State Average of 5)
- CMS quality indicators below statewide average for pain and incontinence
- Building age and configuration no longer acceptable by current standards and practices
- High percentage of low scoring case-mix residents
- Facility's high occupancy takes residents away from higher quality institutions

Other

- State projected a "non-institutional" long-term care need for the provision of Home and Community Based Services to an estimated 650 persons
- County need for 20 Adult Day Health Care slots

Recommendation

- Build new facility subject to regional Bed Need Methodology Estimates including an Adult Day Health Care program for 20 individual and having an opportunity for expansion as needed.

ANALYSIS

The NYS DOH Berger commission report which was issued in 2007 identified excess capacity and recommended the downsizing of Willow Point and the construction of a new smaller facility with an Adult Day Health Care program which the Commission believed was achievable within 2 – 3 years. Since the Commission’s report the County has developed architectural plans and submitted a Certificate of Need to the State for the construction of a new facility. Further, the State has not addressed the reimbursement of capital costs to facilities as part of the changes in the new NYS reimbursement methodology for 2014 – 2020. If the new methodology does not provide for capital reimbursement, Willow Point would be required to recover the cost of interest and depreciation only through the components of the rate currently designated for direct patient care, administrative and support expenditures. Losing the potential for capital reimbursement would effectively reduce current operating margins and take away funding currently used to pay for patient care staffing, supplies and other operating costs. Although a final project size and location has not been decided, the cost of the project is currently estimated to be approximately \$ 68.7 million based on a 300 bed facility with an adult day health care program. As a comparison a recent 200 bed construction in Saratoga had an estimated cost of \$45.0 million or \$225,000 per bed. A similar new build for Willow Point at 300 would result in an estimated project cost of \$ 67.5 million which is slightly under the maximum reimbursable cost of \$ 68.7 million, or \$229,000 per bed based on NYS DOH maximum reimbursement caps noted in the table below.



1 SCHENECTADY COUNTY GLENDALE HOME

NYS Nursing Home Capital Reimbursement Caps

	<u>2006</u>	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010</u>
Central Region Cap	\$ 149,000	\$ 152,000	\$ 183,000	\$ 216,000	\$ 229,000
Beds	300	300	300	300	300
Maximum Reimbursable Cost	\$ 44,700,000	\$ 45,600,000	\$ 54,900,000	\$ 64,800,000	\$ 68,700,000

Another part of the Commission Right-Sizing Program included the availability of over \$ 542.0 million in funding provided through the joint State and Federal HEAL/F-SHRP program to affected facilities. As review of the funding shows, considerable payments paid to nursing homes that either: closed, converted or merged as part of the recommendations. As noted in the list there were no awards made to Broome County or Willow Point, however a number publicly owned facilities received considerable awards. As noted in the table below, County facilities received an estimated \$51.0 million in HEAL/F-SHRP in addition to \$ 256.6 million in IGT funding received between 2006 and 2012. By comparison Willow Point received only the approval to submit a certificate of need for the facility's recommended reconfiguration and continued to receive regular IGT payments of \$ 30.4 million. Orange County's Valley View Nursing Home which has been facing similar issues with respect to privatization received \$7.8 million in HEAL/F-SHRP funding toward reconfiguration of the facility and its services.

**NYS Department of Health
Berger Commission HEAL Awards**

Applicant	Sponsor	Facility Type	Award	IGT
A. Holly Patterson Extended Care Facility	County	Nursing Home	\$14,000,000	\$ 80,702,757
Albany County NH and Ann Lee Infirmary	County	Nursing Home	\$3,008,841	\$ 38,394,283
Community General Hospital / Van Duyn	County	Nursing Home	\$12,800,000	\$ 60,388,216
Glendale Home	County	Nursing Home	\$3,000,000	\$ 27,705,503
Mount View Health Facility	County	Nursing Home	\$8,800,000	\$ 3,376,433
The Avenue & Dutch Manor Nursing and Rehabilitation Centers	County	Nursing Home	\$1,900,000	\$ -
Valley View Center for Nursing Care & Rehabilitation	County	Nursing Home	\$7,800,000	\$ 46,083,072
Cold Spring Hills Center for Nursing and Rehabilitation	FP	Nursing Home	\$992,500	\$ -
Lakeside Nursing Home, Inc.	FP	Nursing Home	\$4,900,000	\$ -
Kaleida Health - Gates Closure	NFP	Nursing Home	\$8,800,000	
Nazareth Nursing Home	NFP	Nursing Home	\$7,307,109	\$ -
			\$73,308,450	\$ 256,650,264

FEEDBACK

As part of the overall assessment process, numerous interviews were conducted with key parties with a vested interest in the operation of the facility. This ranged from employees, to County officials, to resident representatives. The overall theme was that Willow Point is viewed in a positive light and a place where members of the community would utilize if they or a loved one needed the services provided. It was also noted that even though the benefit structure is higher than the surrounding facilities, pension dollars and health care services derived from the benefit package often stay in Broome County and can be used to stimulate other areas of the economy.

FINANCIAL OPERATIONS – TRENDS

Inter-Governmental Transfers

As previously discussed, public facilities receive distributions for IGT payments for a specific time period based on a reconciliation of the State Medicaid rate and the Medicare rate paid at the federal level through the Upper Payment Limit calculation. The facility received IGT payments totaling an estimated \$ 47.3 million through 2013. The impact on Willow Point's operating margin depending on whether the revenue is recorded when earned or when actually received is demonstrated below. Since, the organization has historically recorded IGT when received rather than on the accrual basis, operating margins for the years 2008 through 2013 are volatile and give the appearance that the facility is losing more money in certain years. However, when the IGT is adjusted based on the periods to which it actually applies, operating margins are smoother and more representative of the actual income or loss for the respective years.

Cash vs Accrual Basis Impact on IGT Revenue and Operating Margin

	2008	2009	2010	2011	2012	2013
Per DOH	\$ 6,390,795	\$ 5,920,932	\$ 8,675,247	\$ 8,894,800	\$ 8,611,261	\$ 8,894,800
Per Financial Statements	<u>2,845,118</u>	<u>11,968,607</u>	<u>10,000</u>	<u>6,843,520</u>	<u>10,268,223</u>	<u>5,000,000</u>
Reported IGT Over (Under) Actual	<u>\$ (3,545,677)</u>	<u>\$ 6,047,675</u>	<u>\$ (8,665,247)</u>	<u>\$ (2,051,280)</u>	<u>\$ 1,656,962</u>	<u>\$ (3,894,800)</u>
Impact on Operating Margin						
Reported Operating Margin	\$ (1,329,232)	\$ 6,196,292	\$ (5,198,778)	\$ (1,492,352)	\$ 147,857	\$ (3,414,076)
Change in IGT accrual estimate	<u>3,545,677</u>	<u>(6,047,675)</u>	<u>8,665,247</u>	<u>2,051,280</u>	<u>(1,656,962)</u>	<u>3,894,800</u>
Adjusted Operating Margin Profit (Loss)	<u>\$ 2,216,445</u>	<u>\$ 148,617</u>	<u>\$ 3,466,469</u>	<u>\$ 558,928</u>	<u>\$ (1,509,105)</u>	<u>\$ 480,724</u>

Other Operating Revenue

Other operating revenues ranged between approximately \$84,000 to \$690,000 for years 2008 to 2013 from various sources related to the facilities operations. In 2011, flooding in the Southern Tier Region of New York State resulted in damage to the Vestal Park Nursing Center, a 160 bed competitor of Willow Point. In an effort to protect the frail elderly of the damaged Vestal facility and to provide temporary housing to some of the displaced residents, Willow Point entered into an agreement to rent 60 of its beds.

Expenditures

Salary and Benefits

Salary and benefits show a declining trend based on downsizing the facility pursuant to Berger Commission recommendations and changes in staffing patterns to better reflect actual resources required based on resident occupancy and acuity levels. Benefit expenditures have decreased in relation to the aforementioned changes in staffing, changes in benefits agreed upon by the CSEA and the County, as well as County incentives which encourage early retirement of personnel with higher salaries and benefit levels associated with prior collective bargaining agreements between the unions and the County. This has resulted in a decrease in salaries of approximately \$2.0 million or 15.3% and decrease in employee benefits of \$1.3 million or 14.7% as reflected in the financial information below. However, when examined on a per resident basis Salary and Wage costs per resident day increased by \$16.82 per resident day or 16.6% from \$101.27 to \$118.08. Similarly, employee benefit costs increased \$12.04 or 17.4% per resident day from \$69.07 to \$81.11 over the period 2008 through 2013.

Contractual and Other Expenditures

Contractual and other expenditures increased approximately 1.9% or \$105,274 from \$5.6 million in 2008 to \$5.7 million in 2013. However, these expenditures on a per resident day basis increased 40.2% or \$16.88 per day as the result of declining census which increased the fixed component of the expenditure class on a per day basis from \$41.99 to \$58.88 per day. A more thorough analysis of these costs is addressed in the financial benchmarking section of this report.

Provision for Doubtful Accounts

The expense associated with the provision for doubtful accounts increased from \$23,559 in 2008 to \$2.3 million in 2013. The increase is associated with old accounts receivable that had either not been billed, accounts for which follow-up was not performed or no payment sources was validated. This issue, although not impacting revenue in the year services are performed results in future negative revenue offsets and ultimately reduces cash flow to the facility. The cost of this problem on a per resident basis is approximately \$58.88 in 2013 which is an increase of 40.2% or \$16.88 per resident day as compared to 2008 levels.

NYS Assessment

The NYS Cash Receipts Assessment which is effectively a tax paid by providers in New York State which is based on cash receipts associated with healthcare services provided to patients and residents. The assessment expense for Willow Point decreased \$108,885 or 9.3% from approximately \$1.2 million in 2008 to \$1.1 million in 2013. On a per resident day basis the expense actually increased by \$2.18 per day or 24.8%.

Interest and Depreciation

Capital financing and depreciation related expenses decreased (\$1,866) or -1.8% and (\$123,762) or -17.9%, respectively between 2008 and 2013. Costs per patient day increased as these fixed costs were spread over fewer resident days resulting in an increase of \$.27 and \$.68 per resident day over the period. Decreases of this nature in financial statements generally suggest lack of reinvestment or capitalization through debt or equity in the operation. This is most commonly seen with respect to the maturity phase of the organization's life cycle and lack of attention to developing strategic plans to ensure competitive, sustainable future operations. Further, capital costs have historically been reimbursed through Medicaid reimbursement methodology through 2013, although there is uncertainty whether these payments will continue under the future models contemplated by New York State.

Summary

Willow Point incurred losses of (\$1.0) million to (\$5.2) million between 2008 and 2013 and also posted positive bottom lines in 2009 and 2012 of \$6.2 million and \$175,000, respectively during the period resulting in an average annual reduction in net position of (\$750,000) or (\$4.6) million in aggregate for the six years presented. As mentioned previously, the timing of IGT realization, approximately (\$5.1) million in allowances for uncollectible accounts and sunk costs of \$14.8 million related retiree OPEB costs and \$9.2 million related to public employee retirement costs during this period which significantly impacted the incurrence of the (\$4.7) million in losses. Despite the aggregate losses, Willow Point's aggregate cash flow from operations was only slightly negative for the periods at (\$96,736) as the result of the difference between cash and accrual basis reporting. The facility's net profit margin averaged -4.2% for the six years 2008 to 2013, industry margins over the past five years have typically been declining both nationally and statewide and generally profit margins of between -2.0% to +4.0% are not uncommon. Willow Point's profit margin for 2012 (the last year comparative data is available for facilities statewide) was .5%. By comparison, the average net profit margin for all facilities reporting data in 2012 was -.2% and -11.4% for publicly sponsored facilities.

Year	OPEB (GASB-45)	Employee Pension
2008	\$3,137,524	\$1,089,954
2009	\$2,199,288	\$962,179
2010	\$2,402,178	\$1,337,852
2011	\$2,742,824	\$1,717,024
2012	\$2,851,943	\$2,034,876
2013	\$1,418,904	\$2,041,716
Total	\$14,752,661	\$9,183,601

Willow Point Nursing Home
Financial Performance Summary
2008 - 2013

	<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>	<u>2012</u>	<u>2013</u>
Licensed and staffed beds	373	353	333	303	300	300
Resident Days	132,684	125,366	120,394	109,737	105,969	96,421
Admissions	366	292	227	296	330	441
Adjusted occupancy rate	96.3%	94.6%	96.2%	94.6%	96.0%	88.1%

Statement of Activities

Revenue						
Net resident service revenue	\$25,193,962	\$23,991,016	\$24,183,280	\$21,502,690	\$21,455,851	\$20,033,597
Intergovernmental transfers	2,845,118	11,968,607	10,000	6,843,520	10,268,223	5,000,000
Other operating revenue	<u>687,928</u>	<u>84,341</u>	<u>146,590</u>	<u>410,947</u>	<u>670,922</u>	<u>448,264</u>
Total operating revenue	<u>28,727,008</u>	<u>36,043,964</u>	<u>24,339,870</u>	<u>28,757,157</u>	<u>32,394,996</u>	<u>25,481,861</u>
Expense						
Salary	13,436,641	13,818,665	13,054,867	12,567,198	12,527,301	11,385,797
Benefits	9,164,306	8,357,533	8,777,944	9,750,900	9,613,523	7,820,261
Contractual	5,580,855	5,590,352	5,500,051	5,370,467	5,309,336	5,676,977
Provision for doubtful accounts	23,559	356,577	529,790	502,570	2,946,228	2,284,825
NYS assessment	<u>1,167,326</u>	<u>1,110,054</u>	<u>1,070,924</u>	<u>1,348,196</u>	<u>1,172,791</u>	<u>1,058,441</u>
	<u>29,372,687</u>	<u>29,233,181</u>	<u>28,933,576</u>	<u>29,539,331</u>	<u>31,569,179</u>	<u>28,226,301</u>
Earning before interest & depreciation	(645,679)	6,810,783	(4,593,706)	(782,174)	825,817	(2,744,440)
Interest	102,559	96,042	109,060	110,923	106,739	100,693
Depreciation	<u>692,705</u>	<u>629,924</u>	<u>620,888</u>	<u>599,255</u>	<u>571,221</u>	<u>568,943</u>
Net operating income (loss)	<u>(1,440,943)</u>	<u>6,084,817</u>	<u>(5,323,654)</u>	<u>(1,492,352)</u>	<u>147,857</u>	<u>(3,414,076)</u>
Other non-operating revenue (expense)						
Other non-operating revenue (expense)	102,841	100,696	92,117	49,741	27,938	22,025
County transfers to (from) facility	<u>926,340</u>	<u>-</u>	<u>23,008</u>	<u>53,565</u>	<u>-</u>	<u>-</u>
Total non-operating revenue (expense)	<u>1,029,181</u>	<u>100,696</u>	<u>115,125</u>	<u>103,306</u>	<u>27,938</u>	<u>22,025</u>
Change in Net Position - increase (decrease)	<u>\$(411,762)</u>	<u>\$6,185,513</u>	<u>\$(5,208,529)</u>	<u>\$(1,389,046)</u>	<u>\$175,795</u>	<u>\$(3,392,051)</u>

Willow Point Nursing Home
Financial Performance Summary
2008 - 2013

	<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>	<u>2012</u>	<u>2013</u>
Per resident day:						
Revenue						
Net patient revenues	\$189.88	\$286.84	\$200.95	\$195.95	\$202.47	\$207.77
Other operating revenue	\$26.63	\$0.67	\$1.22	\$66.11	\$103.23	\$56.50
Total operating revenue	<u>\$216.51</u>	<u>\$287.51</u>	<u>\$202.17</u>	<u>\$262.06</u>	<u>\$305.70</u>	<u>\$264.28</u>
Expense						
Operating cost	\$221.37	\$233.18	\$240.32	\$269.18	\$297.91	\$292.74
Capital and financing	\$5.99	\$5.79	\$6.06	\$6.47	\$6.40	\$6.94
Total operating cost	<u>\$227.36</u>	<u>\$238.97</u>	<u>\$246.38</u>	<u>\$275.65</u>	<u>\$304.31</u>	<u>\$299.69</u>
Net profit (loss) from operations	(\$10.85)	\$48.54	(\$44.21)	(\$13.60)	\$1.40	(\$35.41)
Non-operating revenue(expense)	\$7.76	\$0.80	\$0.96	\$0.94	\$0.26	\$0.23
Net profit (loss)	<u>(\$3.09)</u>	<u>\$49.34</u>	<u>(\$43.25)</u>	<u>(\$12.66)</u>	<u>\$1.66</u>	<u>(\$35.18)</u>

Cash Flow

	<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>	<u>2012</u>	<u>2013</u>
Operations	\$ 568,599	\$ 4,244,767	\$ (3,478,317)	\$ 2,016,587	\$ (1,551,981)	\$ (1,896,391)
Investing	336,132	34,594	30,627	9,202	6,343	2,862
Financing	<u>55,998</u>	<u>(362,065)</u>	<u>(1,044,672)</u>	<u>(450,850)</u>	<u>(557,168)</u>	<u>1,774,385</u>
Net increase (decrease)	<u>\$ 960,729</u>	<u>\$ 3,917,296</u>	<u>\$ (4,492,362)</u>	<u>\$ 1,574,939</u>	<u>\$ (2,102,806)</u>	<u>\$ (119,144)</u>

Financial Position

Cash

Factoring out years where IGT payments significantly impacted cash balances (2009 and 2011), the facility had \$733,000 at year end over the periods presented which is above average for nursing home in New York State.

Accounts Receivable

Accounts receivable ranged from 5.8 million in 2008 to 4.1 million in 2013, with the highest balance of \$7.0 million 2011. This resulted in the number of days in Accounts Receivable outstanding of between 48.4 days and 119.00 days during the period or an average of 85.2 days. Industry benchmarks suggest AR days outstanding should be between 30 – 45 days based on existing reimbursement models. Historically public facilities see days in AR in the range of 45 – 60 days due to slower month end financial period closings typically seen in public facilities although the trend is moving to those resembling more typical business practices. Accounts receivable accounted for 56.0% of the facility's current assets.

Plant, Property and Equipment

Assets related to plant, property and equipment decreased from \$4.7 million in 2008 to \$3.8 million in 2012 as the result of depreciation of historical asset costs and lack of significant reinvestment in capital assets by the facility. Fixed assets increased to approximately \$5.0 million as the result of the capital investment in a new sprinkler system mandated by new federal fire and safety codes which went into effect nationally in 2012.

Total Assets

Total assets increased from \$13.8 to \$15.9 million over the period for the reasons described in the previous sections. However, as the result of the decrease in facility profitability the asset turnover ratio which is a measure of the productive use of assets in generating income declined 35% from 2.0 to 1.3. Generally speaking, the higher an entity's asset ratio, the more productively the entity is using its investment in fixed assets in the production of income.

Liabilities

Current Portion of Debt

The current portion of debt increased to \$1.8 million as the result of the issuance of bond anticipation notes (BANS) utilized to finance the facility's capital expenditures relating to the federally mandated sprinkler project.

Accounts Payable

Accounts payable averaged approximately \$290,000 over the periods presented which was up slightly to \$440,000 in 2013. This is consistent with the lower facility census and related revenues associated with both the facilities sprinkler project and uncertainties associated with the facility's future. Days in accounts payable or, the number of days vendors wait before payment averaged approximately 19.0 days over the period and was 28.0 days for 2013 which is within normal trade payable terms of less than 30 days.

Accrued payroll and benefits

Current liabilities associated with accrued payroll, compensation absences and related benefits increased 22.3% or \$343,607 between 2008 and 2013. The increase is primarily related to increases in wage rates and the increases in employee benefit costs. Overall, this category of current liabilities increased from 17.0% to 19.5% of total current liabilities over the period.

The current portion of long-term employee benefits decreased -44.7% over the period from \$924,111 to \$511,166 and made up 5.3% of total current liabilities at December 31, 2013 as compared to 10.2% at the end of 2008. Amounts in this category are associated with GASB 45 (OPEB) liabilities for retiree health costs and worker's compensation liabilities. Decreases in the current portion suggest that lower amounts are expected to be due and payable within a one year operating cycle as the result of past initiatives by the facility to reduce post-retirement benefit costs and reduce work related injuries.

Estimated Third Party Liabilities

Estimated third party liabilities are associated with liabilities (often estimated) attributable to known or potential negative rate adjustments which can be related to previous third party overpayments, changes in rate calculations or methodologies which have not yet been implemented by the third party, rate appeals, third party audits and changes in patient acuity levels. Estimated liabilities associated with these factors declined (\$4.9) million or -84.8% over the years 2008 to 2013. As a result this category of liability made up 9.1% of total current liabilities at the end of 2013.

Total Current Liabilities

Total current liabilities increased by \$602,797 or 6.6% between 2008 and 2013 due to the factors previously discussed. Current liabilities as a percentage of total facility debt declined from 50.1% to 40.6% suggesting a reduction in amounts payable within the current operating cycle (one year). The combination of changes in current and liquid assets and changes in current liabilities resulted in the facilities quick ratio to decline from .7 to .5 and the facility's current ratio to increase from .7 to 1.0. The

increase in the current ratio suggests a slight improvement in liquidity and its ability to meet current obligations between 2008 and 2013. However, the reduction in the facilities quick ratio suggests fewer highly liquid assets such as cash, cash equivalents and accounts receivable are available at the end of the six year period.

Long-term debt

Long-term liabilities primarily made up of the long-term portion of debt associated with loans, bonds and other financings with terms over year in duration, other liabilities and post-employment benefit liabilities also payable in excess of one year from the financial statement date. Bond and note liabilities decreased -50.1% from \$2.5 million to \$1.3 million between 2008 and 2013 and other long-term liabilities increased \$626,326 over the same period. Long-term liabilities associated with GASB 45 and worker's compensation increased by 106.6% or \$5.8 million. As noted earlier, the short-term portion of the post-employment liability decreased by -44.7% or (\$412,945) which suggests the facility is incurring these liabilities at lower than historical rates and is also funding at least a portion of the current liabilities for these benefits.

Summary

Overall total liabilities increased \$5.7 million between 2008 and 2013 which resulted in a ratio of debt to total assets of between a low of .91 (2009) and 149.7 (2013) during the period. A ratio of debt to assets which is greater than .99 suggests that all assets are owned by creditors of the entity. In the case of Willow Point successive years of deficit spending and operations has resulted in the erosion of the facility's net position (equity) from (-\$4.2) million in 2008 to (-\$7.9) million in 2014. Typically, negative equity positions in not-for-profit and for-profit organizations are signs of under capitalization, sustained losses and a precursor to business failure, re-organization or potential insolvency. Further, enterprises that have portfolios composed of multiple operations either in the same industry or another sector will typically divest of under performing investments of this nature unless it provides other intangible benefits to the organization as a whole and can be sustained without jeopardizing higher performing segments. Although the county has continued to subsidize facility losses, adjustments must be made at the facility level to improve financial sustainability and reduce the subsidy burden placed on the general fund, otherwise limited resources that could be more productively used to fund other areas benefiting residents will ultimately face budget cuts and county residents will potentially be faced with higher taxes or special assessments.

Statement of Financial Position

	<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>	<u>2012</u>	<u>2013</u>
<u>Assets</u>						
Current Assets:						
Cash	\$ 669,001	\$ 4,687,768	\$ 716,578	\$ 2,713,243	\$ 604,392	\$ 942,899
Accounts receivable	5,784,231	4,772,818	5,761,204	7,010,548	6,221,760	4,115,047
Inventory	87,022	108,011	103,878	92,860	96,220	70,450
Other	<u>220,723</u>	<u>5,966,874</u>	<u>2,967,266</u>	<u>227,931</u>	<u>5,713,641</u>	<u>5,001,480</u>
Total current Assets	<u>6,760,977</u>	<u>15,535,471</u>	<u>9,548,926</u>	<u>10,044,582</u>	<u>12,636,013</u>	<u>10,129,876</u>
Restricted assets	2,372,396	2,270,925	1,749,753	1,297,456	1,305,014	813,671
Plant, Property & Equipment	4,686,593	4,471,299	4,453,133	4,199,446	3,800,829	4,973,797
Other assets	-	-	-	-	-	-
Total assets	<u>\$ 13,819,966</u>	<u>\$ 22,277,695</u>	<u>\$ 15,751,812</u>	<u>\$ 15,541,484</u>	<u>\$ 17,741,856</u>	<u>\$ 15,917,344</u>

Statement of Financial Position

	<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>	<u>2012</u>	<u>2013</u>
<u>Liabilities & Net Assets</u>						
Current Liabilities:						
Current portion of debt	\$ 304,987	\$ 371,325	\$ 223,017	\$ 443,907	\$ 405,330	\$ 1,790,805
Accounts payable	364,004	300,369	\$ 260,944	\$ 202,675	168,984	440,751
Accrued payroll and benefits	1,540,981	1,005,616	1,452,244	1,702,914	2,042,636	1,884,588
Current portion of L/T benefits	924,111	1,130,163	866,833	853,103	545,319	511,166
Other current liabilities	116,207	216,340	147,813	1,124,191	1,147,537	1,310,718
Due to county/other funds	9,997	219,535	-	-	-	2,850,000
Estimated third-party liabilities	<u>5,808,172</u>	<u>6,804,651</u>	<u>4,745,851</u>	<u>2,880,530</u>	<u>3,121,266</u>	<u>883,228</u>
Total current liabilities	<u>9,068,459</u>	<u>10,047,999</u>	<u>7,696,702</u>	<u>7,207,320</u>	<u>7,431,072</u>	<u>9,671,256</u>
Bonds and Notes payable, excluding current	2,674,847	2,600,697	2,444,214	2,178,301	1,949,691	1,334,746
Other long-term liabilities	881,799	898,435	631,088	1,073,999	1,583,303	1,508,169
Other postemployment benefits	<u>5,473,477</u>	<u>6,823,667</u>	<u>8,281,440</u>	<u>9,772,542</u>	<u>11,292,673</u>	<u>11,310,107</u>
Total liabilities	<u>18,098,582</u>	<u>20,370,798</u>	<u>19,053,444</u>	<u>20,232,162</u>	<u>22,256,739</u>	<u>23,824,278</u>
Net Position						
Net Investment in capital assets	3,724,806	3,464,855	3,326,307	2,502,699	2,561,873	2,512,832
Restricted				-	1,305,014	813,671
Unrestricted	<u>(8,003,422)</u>	<u>(1,557,958)</u>	<u>(6,627,939)</u>	<u>(7,193,377)</u>	<u>(8,381,770)</u>	<u>(11,233,437)</u>
Total net position	<u>(4,278,616)</u>	<u>1,906,897</u>	<u>(3,301,632)</u>	<u>(4,690,678)</u>	<u>(4,514,883)</u>	<u>(7,906,934)</u>
Total liabilities and net position	<u>\$ 13,819,966</u>	<u>\$ 22,277,695</u>	<u>\$ 15,751,812</u>	<u>\$ 15,541,484</u>	<u>\$ 17,741,856</u>	<u>\$15,917,344</u>

Financial Performance Ratios

Selected Financial Performance Ratios						
Quick ratio	0.7	0.9	0.8	1.3	0.9	0.5
Current ratio	0.7	1.5	1.2	1.4	1.7	1.0
Accounts receivable turnover	75.5	48.4	86.9	119.0	106.1	75.0
AR % of current assets	85.6%	30.7%	60.3%	69.8%	49.2%	40.6%
AP turnover	23.9	19.5	17.4	13.8	11.6	28.3
Total debt to total assets	131.0%	91.4%	121.0%	130.2%	125.4%	149.7%
Operating margin	-5.0%	16.9%	-21.8%	-5.2%	0.5%	-13.4%
Net profit margin	-3.2%	16.9%	-21.8%	-5.2%	0.5%	-13.4%
Asset turnover	2.0	1.6	1.5	1.4	1.2	1.3
Revenue Growth Rate						
Program revenue growth rate	-	28.2%	-32.7%	-11.1%	-0.2%	-6.6%
Non-program revenue growth rate	-	-87.7%	73.8%	4848.8%	50.8%	-50.2%
Total revenue	-	25.5%	-32.5%	18.1%	12.7%	-21.3%

FACILITY BENCHMARKING

Willow Point Capacity, Occupancy and Utilization

Willow Point's 300 certified and staffed beds which are capable of providing 109,800 resident days of care annually at 100% capacity makes up 18.8% of the comparison market used for benchmarking. Facilities in the benchmarking analysis ranged in size from 32 beds (Good Shepherd-Endwell) to 356 beds (Bridgewater). The median certified capacity of facilities in the analysis was 135 beds and the median number of beds staffed in the comparison was 120. The average certified facility capacity in the market comparison was 141 beds with an average of 129 beds staffed.

Utilization by Payer Source

Medicaid

Medicaid utilization in the market ranged from 30.4% to 84.9%, with an average of 68.1% and a median Medicaid utilization rate of 63.4%. By comparison, Willow Point's Medicaid utilization was 78.1% and made up 22.0% of the comparison market utilization. The largest proportion of Medicaid recipients, 77.3% were also eligible for Medicare Part B and Part D coverage.

- Since Medicaid is generally the lowest reimbursing payer and given the high proportion of Medicaid recipients serviced by the facility it is imperative the facility:
 1. Properly document all medically necessary care provided to residents to ensure the facility receive the highest allowable reimbursement
 2. The facility ensure all relevant eligibility documentation is gathered at or prior to admission to prevent coverage denials.
 3. Work closely with the County Department of Social Services and CASA to ensure residents are approved for Medicaid as rapidly as possible
 4. Attempt to admit other patient's with payer sources that have reimbursement rates for skilled and ancillary services that are greater than rates paid for similar Medicaid residents to make up any Medicaid shortfall related to Medicaid residents.

Medicare

Willow Point had a traditional Medicare Part A utilization rate of 5.3% and a Medicare HMO utilization rate of 2.2%. Comparatively the market had an average traditional Medicare utilization rate of 9.7% and a Medicare HMO utilization rate of 1.4% with one facility recording utilization rates of 21.2% and 4.0% for traditional and managed care coverage, respectively.

- To improve financial viability, the facility should make efforts to increase its admission of Medicare residents which have payment rates that provide the greatest dollar amount of reimbursement in excess of the related daily cost of care for the resident. In any event, the reimbursement received per day should exceed the average Medicaid payment paid to the facility.

Willow Point - Market Benchmarking

Willow Point Broome Market Service Area

	2012	%	Mkt %	Mkt	%	Min	Median	Average	Max
Beds Staffed	300	100.0%	18.8%	1,600	100.0%	54	120	140	356
Certified Capacity	300	100.0%	18.8%	1,600	100.0%	54	150	153	356
Capacity	109,800	100.0%	18.8%	585,600	100.0%	19,764	54,900	55,998	130,296
MCD - Health	82,749	78.1%	22.0%	375,842	70.5%	47.0%	72.3%	67.1%	84.9%
MCD - MCO	-	0.0%	0.0%	738	0.1%	0.0%	0.0%	0.1%	0.8%
MCR Pt B	-	0.0%	0.0%	17,579	3.3%	0.0%	0.3%	3.3%	22.4%
MCR PT D	823	0.8%	27.4%	3,000	0.6%	0.0%	0.0%	0.3%	1.4%
MCR Pt B & D	81,926	77.3%	24.3%	337,078	63.2%	34.0%	63.5%	59.3%	80.1%
MCR Pt B & D - ineligible	-	0.0%	0.0%	18,185	3.4%	0.0%	0.5%	4.2%	19.4%
MCR	5,607	5.3%	11.9%	47,202	8.9%	5.4%	10.8%	10.9%	21.2%
MCR - HMO	2,329	2.2%	26.7%	8,739	1.6%	0.0%	1.4%	1.4%	4.0%
BC	-	0.0%	0.0%	3,850	0.7%	0.0%	0.1%	0.5%	2.0%
Other Private	660	0.6%	21.5%	3,072	0.6%	0.0%	0.4%	0.6%	3.0%
Private	14,624	13.8%	15.9%	92,115	17.3%	6.7%	17.3%	19.0%	40.4%
VA	-	0.0%	0.0%	733	0.1%	0.0%	0.0%	0.1%	1.3%
Other	-	0.0%	0.0%	1,536	0.3%	0.0%	0.0%	0.4%	1.3%
Total Resident Days	105,969	100.0%	19.9%	533,089	100.0%	100.0%	100.0%	100.0%	100.0%
Occupancy Pct	96.5%			91.0%		43.8%	94.5%	86.8%	97.4%
Medicaid	82,749	78.1%	51.7%	376,580	70.5%	47.0%	72.3%	67.2%	85.3%
Medicare	7,936	7.5%	38.5%	55,203	10.5%	6.8%	11.4%	12.2%	25.1%

Willow Point - Market Benchmarking Per Day

Willow Point Broome Market Service Area

	2012	%	Mkt %	Mkt	%	Min	Median	Average	Max
Ancillary Services									
Laboratory Services	0.28	0.1%	6.8%	4.15	0.2%	-	0.35	0.46	1.08
E lectrocardiology	0.00	0.0%	0.0%	-	0.0%	-	-	-	-
Electroencephalography	-	0.0%	0.0%	-	0.0%	-	-	-	-
Radiology	0.21	0.1%	6.5%	3.23	0.1%	-	0.33	0.36	0.96
Inhalation Therapy	-	0.0%	0.0%	4.41	0.2%	-	-	0.49	4.00
Podiatry	-	0.0%	0.0%	0.01	0.0%	-	-	0.00	0.01
Dental	0.60	0.2%	9.7%	6.18	0.3%	0.49	0.65	0.69	1.02
Psychiatric	-	0.0%	0.0%	-	0.0%	-	-	-	-
Physical Therapy	5.75	1.9%	7.0%	81.71	3.3%	3.47	6.99	9.08	31.81
Occupational Therapy	2.49	0.8%	9.9%	25.14	1.0%	0.11	2.06	2.79	5.31
Speech/Hearing Therapy	0.50	0.2%	2.8%	17.83	0.7%	0.00	1.50	1.98	4.33
Pharmacy	3.70	1.2%	7.5%	49.53	2.0%	2.44	4.18	5.50	12.65
Central Service Supply	3.30	1.1%	30.1%	10.96	0.4%	-	-	1.22	5.66
Medical Staff Services	-	0.0%	0.0%	2.76	0.1%	-	-	0.31	1.42
Ancillary Other (specify below),									
Other	0.01	0.0%	0.0%	-	0.0%	-	-	-	-
Other	0.01	0.0%	0.0%	-	0.0%	-	-	-	-
Other	-	0.0%	0.0%	-	0.0%	-	-	-	-
TOTAL	16.84	5.5%	8.2%	205.92	8.4%	11.34	20.32	22.88	49.34

Willow Point - Market Benchmarking Per Day

Willow Point Broome Market Service Area

	2012	%	Mkt %	Mkt	%	Min	Median	Average	Max
Expense by Major Category									
Salaries & Wages	118.22	38.8%	11.2%	1,055.99	43.1%	43.13	117.47	117.33	218.52
Phys Fees	1.29	0.4%	11.9%	10.88	0.4%	-	1.29	1.21	2.64
Employee Benefits	90.72	29.8%	34.9%	259.88	10.6%	8.55	24.49	28.88	65.87
Fees	1.01	0.3%	0.8%	132.58	5.4%	2.62	12.58	14.73	42.77
Supplies & Materials	18.32	6.0%	8.6%	213.84	8.7%	12.85	23.02	23.76	39.51
Purch & Contracted Svcs	22.92	7.5%	6.2%	367.99	15.0%	7.53	24.28	40.89	118.74
Depr, Leases & Rentals	5.95	2.0%	4.0%	147.33	6.0%	8.17	12.09	16.37	27.95
Other Direct	45.97	15.1%	20.1%	228.43	9.3%	8.96	25.23	25.38	46.08
Assessments	-	0.0%	0.0%	33.14	1.4%	-	-	3.68	14.23
Transfers	-	0.0%	0.0%	-	0.0%	-	-	-	-
Total	304.39	100.0%	12.4%	2,450.06	100.0%	207.31	246.92	272.23	520.51

Willow Point - Market Benchmarking

Willow Point	Broome Market Service Area								
	2012	%	Mkt %	Mkt	%	Min	Median	Average	Max
Program Services									
Res. Health Care Fac.	118.53	38.9%	0.0%	757.34	30.9%	59.78	82.62	84.15	115.11
Adult Care Facility	-	0.0%	0.0%	53.48	2.2%	-	-	5.94	53.48
I.C.F. Mental Retardation	-	0.0%	0.0%	-	0.0%	-	-	-	-
Independent Living	-	0.0%	0.0%	0.21	0.0%	-	-	0.02	0.21
Outpatient Clinics	-	0.0%	0.0%	-	0.0%	-	-	-	-
Home Health Care	-	0.0%	0.0%	40.19	1.6%	-	-	4.47	40.19
Homemaker-Services	-	0.0%	0.0%	-	0.0%	-	-	-	-
Meals on Wheels	-	0.0%	0.0%	-	0.0%	-	-	-	-
Research	-	0.0%	0.0%	-	0.0%	-	-	-	-
Physicians' Office & Other Rentals	-	0.0%	0.0%	-	0.0%	-	-	-	-
Gift Shop	-	0.0%	0.0%	2.67	0.1%	-	-	0.30	2.67
Public Restaurant	-	0.0%	0.0%	-	0.0%	-	-	-	-
Fund Raising	-	0.0%	0.0%	-	0.0%	-	-	-	-
Barber & Beauty Shops	-	0.0%	0.0%	4.59	0.2%	-	0.40	0.51	1.60
Sold Services	-	0.0%	0.0%	-	0.0%	-	-	-	-
Other	-	0.0%	0.0%	0.02	0.0%	-	-	0.00	0.02
TOTAL	118.53	38.9%	0.0%	879.02	35.8%	68.55	87.82	97.67	173.08
GRAND TOTAL	304.39	100.0%	0.0%	2,450.06	99.8%	207.31	246.92	272.23	520.51

Willow Point - Market Benchmarking

Willow Point	Broome Market Service Area								
	2012	%	Mkt %	Mkt	%	Min	Median	Average	Max
Administrative, General & Support:									
Depreciation Leases & Rental	3.53	1.2%	0.0%	109.05	4.4%	4.62	9.00	12.12	23.05
Depreciation, Major Movable Equip.	1.86	0.6%	0.0%	19.59	0.8%	0.00	2.54	2.18	4.99
Interest on Capital Debt	1.06	0.3%	0.0%	21.63	0.9%	-	0.69	2.40	8.23
Fiscal Services	9.83	3.2%	0.0%	61.50	2.5%	-	8.81	6.83	14.24
Administrative Services	65.34	21.5%	0.0%	423.57	17.3%	21.63	40.30	47.06	92.50
Plant Operation & Maint.	10.46	3.4%	0.0%	136.14	5.5%	7.45	13.49	15.13	35.04
Grounds	0.08	0.0%	0.0%	1.35	0.1%	-	0.06	0.15	0.64
Security	1.37	0.5%	0.0%	3.54	0.1%	-	0.20	0.39	1.59
Laundry and Linen	7.28	2.4%	0.0%	44.83	1.8%	2.85	5.36	4.98	7.55
Housekeeping	14.21	4.7%	0.0%	68.85	2.8%	4.61	5.95	7.65	16.31
Patient Food Service	31.18	10.2%	0.0%	241.31	9.8%	16.13	24.42	26.81	59.97
Cafeteria	-	0.0%	0.0%	3.58	0.1%	-	-	0.40	3.55
Nursing Administration	8.76	2.9%	0.0%	115.74	4.7%	3.49	13.58	12.86	22.11
Activities Program	6.77	2.2%	0.0%	37.00	1.5%	2.70	3.47	4.11	8.87
Nonphysician Education	-	0.0%	0.0%	-	0.0%	-	-	-	-
Medical Education	-	0.0%	0.0%	-	0.0%	-	-	-	-
Medical Director's Office	0.69	0.2%	0.0%	7.00	0.3%	0.10	0.77	0.78	1.50
Housing	14.21	4.7%	0.0%	68.85	2.8%	4.61	5.95	7.65	16.31
Medical Records	2.03	0.7%	0.0%	15.43	0.6%	-	1.01	1.71	8.75
Utilization Review	-	0.0%	0.0%	8.33	0.3%	-	0.17	0.93	3.83
Social Service	4.47	1.5%	0.0%	44.13	1.8%	3.27	3.84	4.90	9.96
Transportation	0.08	0.0%	0.0%	2.54	0.1%	-	-	0.28	1.70
TOTAL	169.02	55.5%	0.0%	1,365.11	55.6%	125.35	132.27	151.68	298.09

OVERVIEW

The United States currently faces a complex and crucial time with respect to its healthcare delivery system after nearly four decades of spiraling costs and a relatively mediocre performance in terms of quality and access to care as compared to other economically developed countries. Currently, the US ranks 37th in overall healthcare quality, 47th in infant survival rate and 1st in terms of having the highest healthcare cost per capita in the world according to the World Health Organization rankings.

Based on 2012 data from the Centers for Medicare and Medicaid, national health care delivery cost increased 3.7% to \$ 2.8 trillion dollars or 17.2% of gross domestic product. Nursing home expenditures were \$151.1 billion for the same period and despite only growing at a rate of 1.6% compared to a historical 4.6% rate of growth which was primarily due to a onetime adjustment to nursing home Medicare payment rates. Home care which is in some instances a non-institutional alternative to nursing home care increased to \$77.8 billion or 5.1% during 2012 primarily due to increases in Medicare spending. CMS estimates that without intervention to slow this trend the projected cost in 2040 will be in excess of \$4.5 trillion.

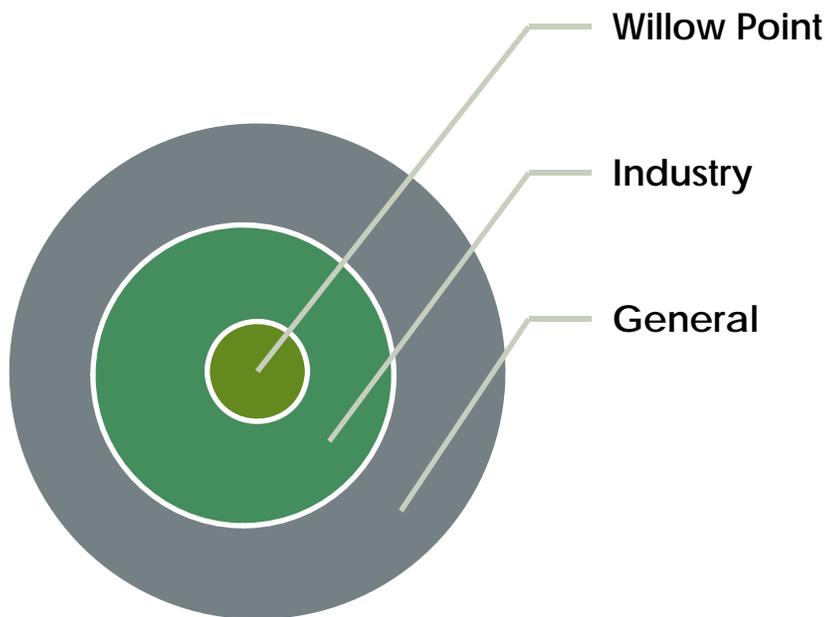
These issues in addition to State and local factors manifest in a complex, uncertain operating environment for all providers in the healthcare delivery system, including long-term care providers such as nursing homes as the government and the industry attempt to address the problem of an expensive, fragmented and largely ineffective health delivery system.

In order for the nation to correct the healthcare delivery system and reduce cost of delivery, it must address the following:

- Improve quality of care provided to patients
- Improve patient clinical outcomes
- Increase patient access to quality, affordable care
- Increase patient engagement in wellness, detection and treatment of chronic illness
- Improve the collection, management and delivery of information across providers and patients to support informed decision making and care management
- Provide a mechanism to ensure patients have access to affordable health insurance that adequately reimburses providers based on the medical service provided and the quality and effectiveness of the treatment

As a result of these factors, all aspects of healthcare delivery along the continuum of care are being challenged with modifications to delivery options, coordination of care between providers, required quality improvements and changes to the reimbursement system. These changes are dynamic and continually evolving as the nation attempts to correct the current problems with the delivery system. Providers face current and future challenges in meeting the new requirements which implies that providers must be **operationally agile and adaptive** to the rapidly changing environment.

GENERAL ENVIRONMENT



STAKEHOLDER DIVERSITY

Business operates in a complex environment that is shaped by many factors including;

- the diversity of and interests of stakeholders (which are often at conflict with the interests of other stakeholders having an interest in the purchase of services provided by the organization)
- maximizing value of the organization as owners/shareholders or as suppliers of labor and materials to the organization's delivery of services.

Even among stakeholders within the same category, personal interests may shade the interests of different stakeholders. For example, suppliers of products have their own motives for promoting their products over those of other available suppliers. Similarly in the context of enterprises owned by governments, differences in fundamental political philosophies and personal beliefs may influence the direction of the organization's governance.

DEMOGRAPHICS

Population demographics impact the organization's operational environment by defining the target consumer market for the organization's services. Increases in specific factors such as growth in the aging population, population income levels, gender, living arrangements and education level influence a consumer's choice in selecting services such as nursing home care. Despite what is often referred to as the "Graying of America" or "Aging of the Baby-Boomer population", the anticipated high rate of growth in these areas on a national basis does not always hold true on a regional or local market basis where the entity competes. Similarly, national indicators of growth in median household income or rates of unemployment are not necessarily the same on a regional or local basis.

Entities are confronted with many decisions regarding whether to enter or continue to compete in a market based on demographics of consumers who purchase their services, the existing capacity of the market and market growth opportunities, as well as industry profitability.

NATIONAL

Nationally the population growth is projected to begin an upsurge beginning in 2015 and continuing through 2040 as seen in Table 2 below. The projected percentage change in total population is expected to range between 4.0% and 4.9% over this period of time. The major age cohort experiencing the largest growth is the elderly 65 years of age and over population which is expected to grow at a rate of 16.4% to 17.0% between 2010 and 2020 before tapering off to more modest levels of 12.8% to 4.8% between the years 2020 to 2050. Between the years 2015 to 2025 the 45 - 64 years of age cohort remains relatively constant in the range of 5.0% to 3.3% over the years 2030 to 2045. The information in the table below is in millions.

Table 2 - Projections of the Population by Selected Age Groups and Sex for the United States: 2015 to 2040

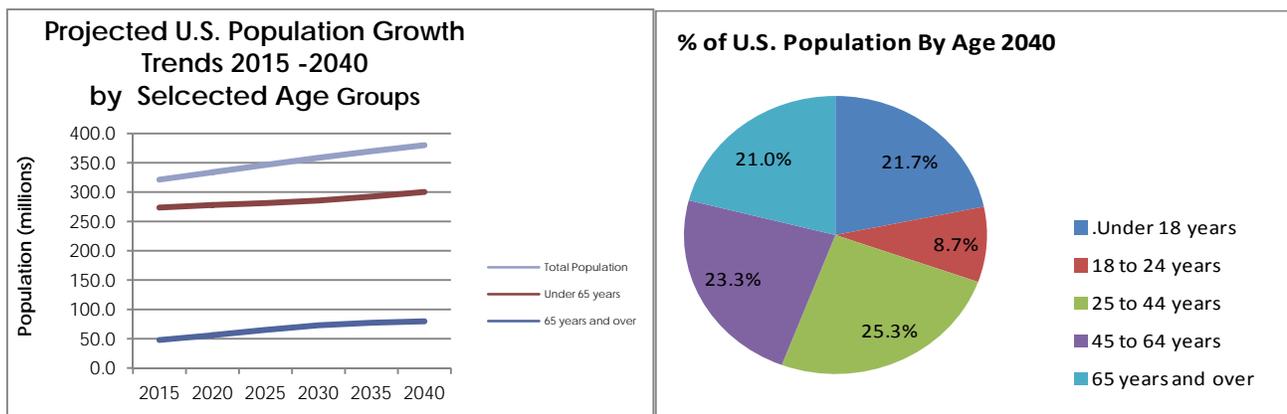
Category	2015	2020	2025	2030	2035	2040
.Under 18 years	74,518	76,159	78,190	80,348	81,509	82,621
.18 to 24 years	30,983	30,028	30,180	30,605	32,125	33,199
.25 to 44 years	84,327	88,501	91,833	93,878	95,013	96,078
.45 to 64 years	83,839	83,238	81,152	80,865	83,700	88,398
.65 to 84 years	41,389	49,276	57,663	63,828	65,736	65,604
.85 years and over	6,306	6,693	7,389	8,946	11,579	14,115
Total Population	321,363	333,896	346,407	358,471	369,662	380,016
Male	158,362	164,812	171,196	177,323	183,013	188,335
Female	163,001	169,084	175,211	181,148	186,649	191,681

Source: U.S. Census Bureau, Population Division. Table 2 - Projections of the Population by Selected Age Groups and Sex for the United States: 2015 to 2060 (NP2012-T2). Released Dec-12.

These national patterns in population growth suggest an increasing market demographic for long-term care services for the 65 and older age group through 2030 and a stable market for the 45-64 year old age group which utilizes short-term care services provided by long-term care and other providers. These factors suggest nursing home providers on a national level would continue to invest in upgrades to facilities and programs that provide long and short-term services providing profit margins, regulation and the entrance of alternative services remain manageable.

State

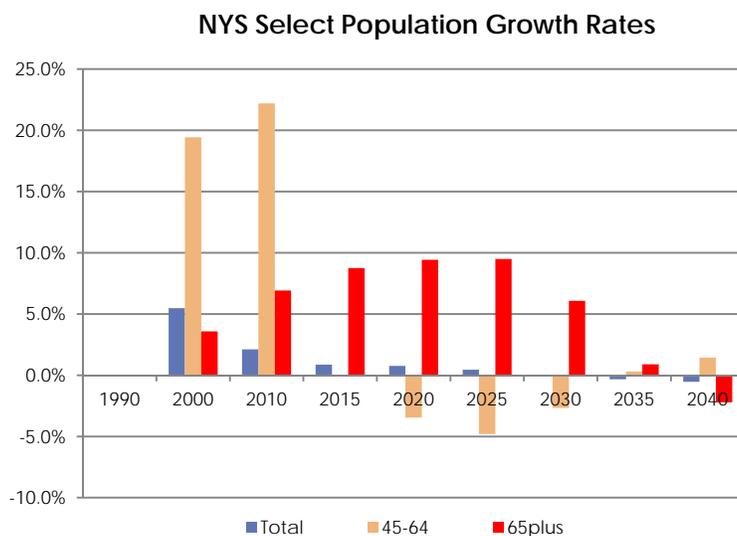
At the State level we see a different age demographic picture emerge. Between the years 2015 and 2040, total population is expected to remain relatively constant with total population growth rates of less than 1% over the period. The age 65 and over cohort is expected to rise between 8.8% and 9.5% between 2015 and 2025 before declining to a 6.9% growth rate in 2030 and declining thereafter. The 45 - 64 years of age cohort after experiencing rapid growth between the years 2000 to 2010 declines modestly and remains flat after 2035.



The New York State age demographic is not as robust as the growth at the national level for those persons age 65 and over and the 45 to 64 years of age cohort actually declines compared to the modest increases seen at the national level. On the state level this age demographic pattern suggests that while there will be an increase in consumers in the 65 year of age and older category, competition between providers will be more intense and similarly competition for short-term patients will also become more intensified as providers compete for market share in a market that has less demand. Providers in the New York market or those considering entering the market will need to differentiate their services on the basis of quality, convenience and amenities, as well as develop strong affiliations with referral sources to gain competitive advantage.

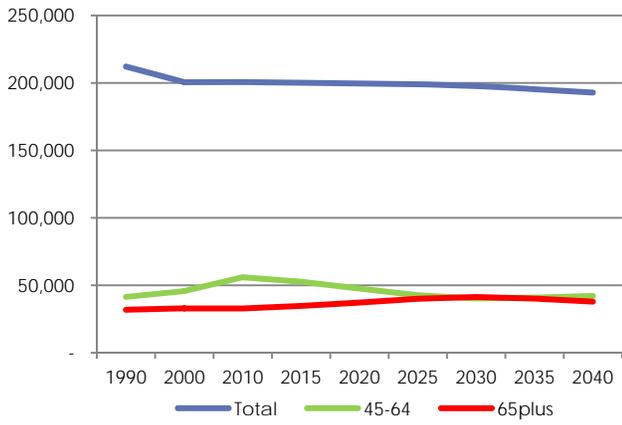
LOCAL BROOME COUNTY MARKET

The Broome County market has similar makeup to the New York State age demographic. We see a relatively flat and declining total population growth trend through 2030 followed by a sharper decline in total population after 2030. The age 65 and older cohort reaches a 9.5% growth rate in 2030; however this increase only generates an approximate 5,400 additional consumers in this age group between years 2015 and 2025. The 45 - 64 year age group declines 2.7% to 4.8% every five years between 2015 and 2030 before remaining constant after 2030. As a result of the these factors and the generally small market area served, demand for long-term services can be expected to be modest resulting in a need for providers to increase competition based on service diversity, quality and amenities in order increase market share or retain market share at existing levels.

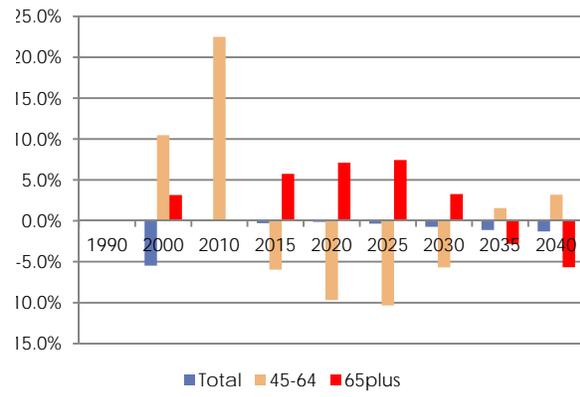


The market for short-term services which also exhibits a flat future growth trend will require facilities to increase affiliations with referral sources and differentiate themselves based on quality of services and effectiveness of clinical outcomes with respect to short-term services. Providers will need to demonstrate data driven quality and service value to managed care organizations, as well as a more knowledgeable and well informed younger consumer. This younger age generally has higher expectations and exhibits preferences for service, convenience and amenities.

Broome County Select Population Trends



Broome County Select Population Growth Rates



POPULATION ATTRIBUTES – MIGRATION

Population shifts can be a factor in business decisions regarding long-term care services since migration of persons from different states and abroad can result in difficulties establishing Medicaid coverage and therefore payment for long-term care services.

Population migration in New York was below that of the United States based on 2012 U.S. Census estimates. Broome County's demographics showed population shifts closer to national trends with the exception of international migration which was below that of both the national and state estimates. Although the .3% of international migration is not significant, approximately 7.5% of the inbound international migrations are not U.S. citizens which suggest potential increases in safety net populations requiring services for which no payment source would be available. In addition approximately 5.1% of the migration into the County is below 150% of the Federal Poverty Level. This suggests that those individuals entering the county will require public assistance benefits and Medicaid to pay for needed services. However, these estimates are relatively small and impact approximately 400 individuals or .2% of the county population. Nonetheless, providers of long-term care services will need to ensure applicants screened for facility admission have adequate documentation and file timely for assistance benefits as a requirement of admission or face the possibility of providing free care to these individuals during their long-term care period of stay at the facilities.

Total Migration

	United States	New York	Broome
Moved; within same county	9.20%	6.70%	8.20%
Moved; from different county, same state	3.20%	2.40%	3.20%
Moved; from different state	2.30%	1.40%	1.50%
Moved; from abroad	0.60%	0.80%	0.30%

Migration - Poverty Below 150% of the Federal Poverty Level

	United States	New York	Broome
Moved; within same county	12.70%	8.80%	12.60%
Moved; from different county, same state	3.10%	2.10%	3.10%
Moved; from different state	2.20%	1.20%	1.70%
Moved; from abroad	0.60%	0.90%	0.30%

Income

Household income is an indicator of the market's ability to afford and contribute to care provided to long-term care nursing home residents. In general, as income levels rise and disposable income increases, individuals and family members are more inclined to contribute to the cost of medical services.

INCOME AND BENEFITS (IN 2012 INFLATION-ADJUSTED DOLLARS)

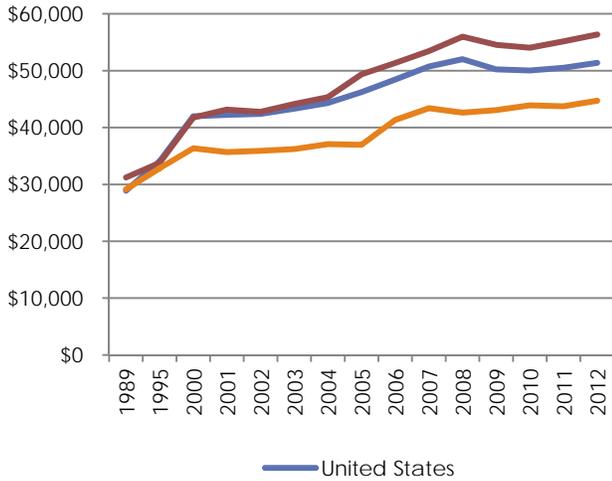
	United States			New York			Broome		
	Est Pop	Pct	Income	Est Pop	Pct	Income	Est Pop	Pct	Income
Total households	115,226,802			7,230,896			80,223		
Median household income (dollars)			\$ 53,046			\$ 57,683			\$ 45,856
Mean household income (dollars)			\$ 73,034			\$ 83,578			\$ 60,319
With earnings	90,674,480	78.7%	\$ 74,373	5,641,832	78.0%	\$ 87,428	58,858	73.4%	\$ 62,236
With Social Security	32,660,129	28.3%	\$ 16,727	2,056,813	28.4%	\$ 17,084	27,045	33.7%	\$ 17,080
With retirement income	20,291,143	17.6%	\$ 23,126	1,266,037	17.5%	\$ 24,625	19,616	24.5%	\$ 19,969
With Supplemental Security Income	5,271,043	4.6%	\$ 8,912	396,288	5.5%	\$ 8,973	4,375	5.5%	\$ 8,876
With cash public assistance income	3,132,921	2.7%	\$ 3,807	235,645	3.3%	\$ 4,065	3,004	3.7%	\$ 3,919
With Food Stamp/SNAP benefits in the past 12 months	13,180,710	11.4%		976,011	13.5%		10,586	13.2%	

Broome's median and mean household income estimates are below that of the nation and the state. The county's mean household income is higher than its median income indicating that a small percent of the population has household income greater than 50% of the county's population.

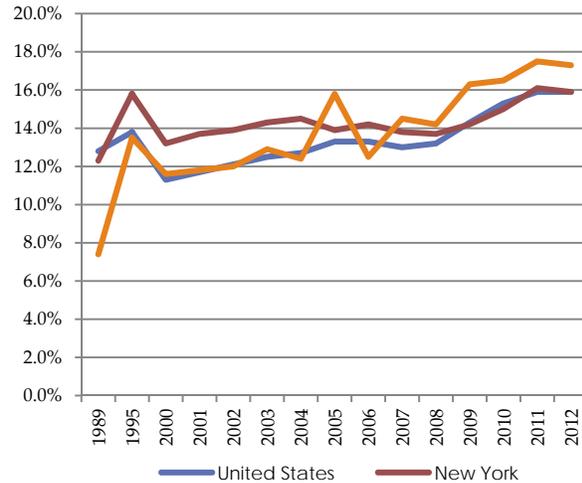
As indicated in the chart below, the median household income in the county has been below the state average from 2000 to 2011. However, we must also consider the impact of higher salaries and wages in the metropolitan NYC area which skews the state average upward. We would assume that these trends will continue into the future.

Other relevant income factors for assessing long-term care service viability include mean social security income and retirement income which is an indicator of the over 65 year old populations' ability to contribute to their cost of care. Social Security income of \$17,080 is estimated to be slightly higher in Broome County than the national average of \$16,727 and on par with the statewide average of \$17,084. Retirement income for county residents is below both state (19.0%) and national (14.0%) averages. Supplemental Security Income (SSI) is also a consideration due to the prevalence of individuals with disabilities who are institutionalized or in the community and will eventually require long-term care services. Average Supplement Security Income is not significantly different from the national and state averages.

Median Household Income



Percent in Poverty



Health Insurance

Health insurance coverage is important in assessing market financial viability for long-term care services as it represents an indicator of how the cost of services provided will be paid.

Estimates for health insurance coverage of Broome County's residents is above both state and national averages as indicated in the table below. Although this indicator is positive it also has some negative connotations with respect to the current trends in health insurance. Current trends in health insurance indicate a large movement by governmental (Medicare and Medicaid) and other third party payers to managed care products which traditionally pay less than traditional fee-for-service type plans. Therefore, the providers in the County will be more vulnerable to reductions in reimbursement as the result of this trend. Providers will need to examine closely each process in their service delivery value chain and improve efficiencies to insure that operating costs for services are below payments received for services to maintain profit margins in this climate.

Health Insurance Coverage

	United States	New York	Broome
With Health Insurance Coverage	85.10%	88.70%	90.80%
With Private Health Insurance	66.90%	67.00%	71.30%
With Public Insurance (Medicare, Medicaid)	29.40%	32.80%	34.30%
No Health Insurance Coverage	14.90%	11.30%	9.20%

Generational Social Culture

Greatest Generation which is among the “oldest of the old” and steadily declining size makes up approximately 1.8%, 2.0% and 2.8% of the national, state and local Broome population, respectively. It is interesting to note that national and state demographic for this cohort is predominantly female with the exception of the Broome populous where males outnumber females. This generation which entered the 65 and above age demographic beginning in 1966 is characterized by values of personal responsibility, duty, honor and faith and was instrumental in the development of the U.S. economy and social welfare programs such as Medicare. Additionally, this generation exhibits conservative approaches to investment and spending.

Silent or Traditionalist Generation is considered to be the oldest of the existing working population and makes up 7.4%, 7.6% and 9.4% of the national, state and local population. This cohort grew up during the depression era and values conformity, authority and rules and has a defined sense of right and wrong. Generally this group is disciplined, dislikes conflict and is detailed oriented. This group is susceptible to common chronic diseases such as chronic obstructive pulmonary disease, diabetes, osteoporosis, high blood pressure, high cholesterol and cardiovascular disease. This group typically may not follow treatment plans due to affordability issues. Signs of dementia or Alzheimer’s disease and illness related to smoking or alcoholism may begin to appear or are progressing in this cohort as well as mental health issues such as depression. Typically this demographic has established estates, wills and trusts to protect personal wealth. Similar to the Greatest Generation it is generally conservative in spending and consumption patterns.

The Baby Boomer cohort began reaching the age 65 and older demographic in 2008 makes up 16.0%, 15.9% and 17.1% of the national, state and local market with the split in gender relatively equal. This generation unlike previous generations experienced shifts in political, economic and social opportunities including reform in civil rights and gender equality. The Boomer cohort values individual choice, community involvement, prosperity, ownership and self-actualization, as well as health and wellness. Generally, they are characterized as adaptive, goal-oriented, focus on individual choice and freedom, are adaptive to diverse workplaces and possess generally positive attitudes. This group which also makes up the retiring segment of workforce places emphasis on team-building; seeks collaboration and group decision making, and generally attempts to avoid workplace conflict.

Baby Boomers, despite educational and economic opportunity are concerned with sufficiency of retirement income, as well as managing savings and personal debt. Retirement, estate and trust planning continues to become increasingly important to this age group. This cohort also provides care for aging relatives and due to the increase in geographic mobility many times manages care for persons in other geographic locations. Diabetes, high cholesterol, high blood pressure, heart and lung disease, obesity and incidence of cancer have begun to affect this generation as the result of previously made lifestyle decisions. This group also exhibits increased prevalence of mental disease related to depression, anxiety and self-esteem issues and are susceptible to substance abuse which has increased the prevalence of liver disease among this demographic.

Generation X individuals make up the current 34 to 53 year old age group comprising 27.8%, 28.3% and 26.3% of national, state and local populations. This cohort along with the Baby Boomers and Millennials make up a predominant part of the existing workforce and will attain age 65 in 2026. This group is important not only for their impact on the market supply of labor, but also from the perspective of mid to long-term operational and financing consideration by providers as this group will enter the senior market within the next 10 to 15 years. This generation values diversity among people, self-contribution, feedback, recognition and autonomy. Characteristically, they are adaptable, independent and have expectations of high quality results and productivity, perceive themselves as both technologically competent and as a marketable commodity and have a preference for flexibility in the work environment. This generational cohort seeks a balance between work and personal life with a philosophy toward working to live rather living to work.

Financially, this cohort has improved savings patterns and accumulation of retirement savings compared to other generations. The high incidence of divorce, however has led to many one income households despite emphasis on developing careers, delaying marriage and starting families.

Medically, this generation is beginning to experience the adverse health effects associated with smoking, substance abuse and eating disorders. Females within this age group are also experiencing increases in maternity. The group also exhibits patterns of mental health issues with respect to depression and anxiety.

Given this groups philosophy towards independence, work/life balance, technological competence and autonomy they will most likely tend to pursue less confining home and community based services when needed and be less likely candidates for traditional institutional based long-term care services. As employees, the group needs a flexible work environment which accommodates their preferences for work/life balance and empowerment. As a result, long-term care providers will need to improve in areas of transformational leadership in order to recruit, retain and harness the synergy of this group's talent in an operationally productive work environment. In terms of eventually marketing long-term care services to this group, providers will need to improve amenities, keep pace with available technologies and offer options which enhance independence, diversity and autonomy.

The Millennial Generation also known as Generation Y or Echo-Boomers which comprise the age cohort born between 1980 and 1994 are generally characterized as technologically savvy and having a live for today attitude. This generation which has enjoyed the security and benefits of provided them by Baby Boomer and Generation X parents have generally been praised and rewarded for minimal efforts and have grown to expect recognition and reward within the community and workplace with minimal personal effort. As products of their childhood experiences watching their parents lose jobs due to downsizing or economic trends, the have formed a perception that the workplace is temporary and unreliable with little employer commitment to long-term employment. As a result this group is opportunistic and has a tendency to move from job to job to meet immediate personal needs. This group is highly accepting of social, cultural and ethnic diversity among people and they generally prefer to work in teams.

This group values self-expression over self-control, personal marketing and branding, believe respect must be earned and are tolerant of violence as a form of communication. Financially they believe financial gain is important to lifestyle enjoyment rather than as a means to accumulating wealth. The cohort embraces change and challenge, is readily adaptable, identifies with global perspectives, accepts people with diverse backgrounds and is committed and loyal when dedicated to a cause, ideal or product. In addition they expect employers to have a commitment to corporate social responsibility.

In the workplace this group requires an understanding of how they contribute to organization and how they effect change. Work is considered an expression and not a definition of themselves as individuals and prefer active versus passive involvement. They seek flexibility in work hours, dress codes and a relaxed environment. This group prefers to work in teams and is less likely to accept managerial or leadership positions if it interferes with their personal lifestyle.

Financially this group has problems with debt management, savings, loans and credit. The cohort expects financial independency prior to marriage or long-term committed relationships. However the group struggles with balancing financial responsibilities for basic necessities and lifestyle entertainment and recreational choices.

Medical issues facing this group include access to routine and preventative medical care, accidents and maternity in addition to psychosis, disorders related to tobacco use, alcohol and drug-related medical conditions. This cohort also has a prevalence of depression, anxiety and bipolar disorders.

Millennials do not constitute a short to mid-term market for long-term care services except in rare circumstances due to accident or catastrophic congenital or acute conditions. However, over the long-term strategic planning horizon this group will become an increasing large part of the workforce. As a result, providers will need to develop flexible, culturally appropriate environments in which to cultivate the talent and skill sets of this age group. Providers will also need to demonstrate increased awareness and commitment to corporate social responsibility and enhance the social value of their services to properly engage this demographic.

Generation Z is the age demographic born after 1994 which will be entering the job market within the next five years. This group is the first generation to be born into a completely technological world. As a result the group is extensively technologically, savvy and gravitates toward technological entertainment and convenience in practically all facets of life. The group's preoccupation with technology from computing to text messaging and recreation has resulted in the development of a generation prone to a sedentary lifestyle and issues of obesity and long-term propensities for diabetes and cardiovascular disease. The age group is highly technology proficient which enables them to multi-task. Additionally, reliance on virtual social networking has led to the inability to form traditional work and social relationships. Providers will be faced with the difficulty of providing a workplace which is technologically progressive enough to stimulate the interest of this group, as well as providing an internal culture that nurtures social and team oriented development.

GENERATIONAL BREAKDOWN OF THE MARKET

Market Entrance	Generation	United States			New York			Broome		
		Total	Male	Female	Total	Male	Female	Total	Male	Female
2065	Generation Z	19.8%	20.6%	19.0%	18.2%	19.2%	17.3%	16.3%	17.3%	15.5%
2045	Millennial	27.4%	28.3%	26.7%	28.0%	29.0%	27.1%	28.2%	29.6%	27.0%
2026	Generation X	27.8%	28.0%	27.6%	28.3%	28.5%	28.1%	26.3%	26.6%	26.0%
2008	Baby Boomers	16.0%	15.5%	16.3%	15.9%	15.4%	16.5%	17.1%	17.0%	17.1%
1990	Silent	7.4%	6.4%	8.2%	7.6%	6.5%	8.5%	9.4%	8.0%	10.7%
1966	Great	1.8%	1.2%	2.4%	2.0%	1.3%	2.7%	2.8%	1.6%	3.9%

Although a considerable amount of attention has been placed on generational socio-cultural difference it is imperative to fully understand these differences in order to properly market and position long-term healthcare providers for future changes in both consumer and workforce demographics. Traditional models of institutional nursing home services do not adequately address the changes in consumer preferences among future demographics and therefore without adequate changes in the delivery model, the facility poses the risk of losing competitive advantage and reducing the probability of sustaining financial viability in the mid to long-term. Additionally, cultural shifts in the workforce demographic will require a progressive leadership style to build a consistent organizational culture which promotes teamwork across a diverse workforce in order to improve both the quality of resident care and effectiveness of clinical outcomes.

Mobility

Citizens of Broome County spend less time on average commuting to and from work than residents of the state and nationally. This factor suggests that residents will seek long-term care services within an equally convenient travel time and distance from their home all other factors such as quality, scope of services, cost and amenities of the provider being equal. Additionally, from a labor supply standpoint we would anticipate prospective employees to seek positions within a similar travel time absent other inducements such as increased wages and benefits.

COMMUTING TO WORK

Commuting Time

	United States	New York	Broome
Mean Travel Time to Work (minutes)	25.4	31.5	18.5

Unemployment

The unemployment factor impacts long-term care services from the point of view of both consumers of long-term service and those individuals employed in the field of health care services. The impact of unemployment on consumers' results in generally less disposable income available to the household from which to contribute to the cost of care provided to family members residing in nursing homes. It is estimated that Broome County's unemployment rate will continue to be below both state and national estimates. However, changes in the economic environment, particularly a slow recovery from the 2008 financial crisis in the U.S. and the impact of state policy changes regarding the closure of two large facilities for the care of the mentally disabled in the Binghamton area will continue to hamper improvements in the regions employment picture. The labor market having an excess supply of non-professional healthcare workers will enable providers to maintain current wage rates for individuals providing administrative, general and support services to the providers. Similarly, the impact of the excess supply should allow suppliers to maintain labor rates at or near existing levels resulting in the cost of manufactured supplies to the industry to remain relatively flat.

Employment OCCUPATION

WORKER CLASSIFICATION - Percent Employed

Classification	United States	New York	Broome
Civilian employed population 16 years and over	141,996,548	9,073,362	91,147
Private wage and salary workers	78.7%	77.3%	73.6%
Government workers	14.9%	16.5%	20.2%
Self-employed in own not incorporated business workers	6.3%	6.0%	6.1%
Unpaid family workers	0.1%	0.1%	0.1%

Increased job growth in 2014 is indicative of slow improvement in the economy as the result of increased business spending, consumer confidence, housing resurgence and U.S. international trade which supports continued job growth and hiring. Hospital and healthcare employment decreased by approximately 10,000 jobs as the result of uncertainties mainly due to the implementation of the Affordable Care Act. Although there has been some increase in local and state government hiring nationally, federal government hiring has continued to decline as the result of sequestration which is expected to continue through 2015 resulting in downward pressure on employment figures. Short-term temporary rises in unemployment rates are related to increases in persons actively seeking employment which is a sign of increased confidence in the overall state of the economy.

Declining unemployment rates are expected to slow resulting in an expected national unemployment rate of approximately 5.8% at the end of 2014 and into 2015. Overall, the long-term trend is toward a smaller labor force as baby boomers enter retirement age. However, it is expected that demand for clinical healthcare specialties and healthcare technology will continue to rise as a result of retirement and technology changes.

Average hourly rates for the national workforce increased approximately 2.5% with inflation remaining relatively flat over the past year resulting in gain in purchasing power of approximately .9%

Given Broome's recent unemployment history in comparison with national and state averages, we would expect to see Broome's unemployment rate decline from 6.0% in October 2014. Given the rural nature of Broome's population we would expect to see higher demand for healthcare clinical and technology specialties due to the lower population density of the county.

HISTORICAL UNEMPLOYMENT RATES

Region	2004	2005	2006	2007	2008	2009	2010	2011	2012
United States	5.5%	5.1%	4.6%	4.6%	5.8%	9.3%	9.6%	8.9%	8.1%
New York State	5.8%	5.0%	4.6%	4.6%	5.4%	8.4%	8.6%	8.2%	8.5%
Broome County	5.4%	4.9%	4.7%	4.5%	5.6%	8.3%	9.0%	8.6%	8.8%

Sources: [Bureau of Labor Statistics](#), Local Area Unemployment Statistics (LAUS) data. [Bureau of the Census, Small Area Income & Poverty Estimates Program](#)

LATEST UNEMPLOYMENT RATES - October, 2014

	United States	New York	Broome County
Civilian Unemployed – October , 2014	5.8%	6.0%	6.0%

SOURCE: BLS, LAUS. December 8, 2014.

Inflation

Based on the Bureau of Economic Analysis projections inflation is projected to remain approximately 2% through 2014 specifically with respect to normal goods and supplies due to competition in global markets and excess domestic production capacity which is expected to trend through 2015. Food prices are expected to trend to approximately 3% by year end as the result of global weather conditions in general market pressures. Energy prices are anticipated to increase at approximately 1 1/2 to 2% with the caveat that foreign political unrest will not result in adverse OPEC oil increases through 2015 which is at best unpredictable. Increases in the cost of foreign oil supply could also adversely impact the cost of goods and supplies resulting from increased costs of production and transportation for those goods reliant on oil byproducts. The cost of purchase services is expected to remain slightly above increases in purchase goods which historically have been the precedent. Core inflation which removes the impact of food and energy prices from the inflation index is expected to remain between 1.6 and 1.8% through 2014 in alignment with current Federal Reserve economic growth policy. According to the American Journal of Health System Pharmacy (AJHP) pharmaceutical prices are expected to increase 3 to 5% during 2014, however trends in pharmaceutical usage suggest a 4.5% reduction in pharmaceutical usage in the long-term care industry.

Consumer prices are expected to remain moderate at approximately 2% through 2014 with a slight acceleration upward toward year-end from the 1.8% level realized in December 2013. The moderate increase in consumer prices should remain at or below wage increases resulting in a .2% to .9% increase in real income to workers based on current economic projections.

Based on current trends we would expect to see a general inflation increase in long-term care costs of approximately 2% with a 3% increase in food related supplies and a 3 to 5% increase in pharmaceuticals through 2014. We would expect labor costs to trend slightly above 2% with the exception of high demand clinical specialties which would be expected to trend at the going market rate for those skill levels. Additionally the slight rise in consumer real income would only be expected to have a marginal positive impact on the demand for long-term care services by consumers.

GDP

According to estimates by the Bureau of Economic Analysis the gross domestic product of United States is expected to grow at an annual rate 2.7% through 2015. This growth rate is the product of slower than anticipated economic recovery in the US which is being constrained by continued US attempts at reducing the national deficit. It is anticipated that economic growth will accelerate through the end of 2014. Improvements in business and consumer outlook are anticipated to continue through year with the potential for increasing economic growth by 3% into 2015 as job growth returns to more normal levels.

Anticipated increases in GDP indicate improvement in the business environment which has historically suggested improvements in job growth and increased consumer spending. As a result improved consumer confidence could provide a slight increase in consumer spending and long-term care services.

Interest

The Federal Reserve continues to maintain that it will continue to keep short-term interest rates at or near current levels at least through the end of 2014 given no significant changes in the economy. Current Fed policy is geared toward continuing to stimulate economic recovery and improve job growth. Analyst projections predict 10 year treasury rates to increase from 2.7% to 3.3% which will trend mortgage rates from the current 4.25% to approximately 5.5% by the end of 2015 which is still low in comparison to historical standards.

It is anticipated short-term interest rates will remain constant through 2014 and trend slightly upward toward 2015. However the Federal Reserve is cautious depending upon the rate of economic growth and job market recovery. As a result it is anticipated the Federal Reserve will require functional improvements in the job market which would include creation of full-time positions to replace existing part-time positions.

We would anticipate that as a result of existing Federal Reserve policy that the cost of short-term working capital financing will increase through the end of 2014 and into 2015 by approximately .5% to 1.0%. However, other factors inherent to the healthcare industry and long-term care segment, as well as operational characteristics of individual facilities impact the risk premium for long-term care providers. Issues with respect to regulatory compliance, quality and profitability can result in variances in financing rates of .25% and upwards based on the providers relative risk. According to Van Der Walde & Co., declining nursing home profit margins; increases in public equity capital; lower nursing home cap rates in comparison to senior housing investment alternatives and higher risk associated with government payments (Medicare and Medicaid) have limited nursing home access to capital and increased interest rates to nursing home operators. As a result it is anticipated that financing for nursing homes will continue to be difficult due to reduced access to capital markets and higher interest rates until overall federal policy with respect healthcare spending and program funding becomes stabilized. This will deter potential new entrants into the long-term care market who may have otherwise established new facilities or purchased existing established operations or result in attempts at below market acquisitions of existing facilities to offset the additional cost of capital related to nursing home financing.

Technological Changes

Technological changes and innovation impact delivery of healthcare services through biomedical innovation leading to discoveries of new technologies and procedures. These advances directly increase the effectiveness and efficiency of diagnosis and treatment of chronic disease while increasing longevity and enhancing quality of life for patients. As a result continued advances in medical technology will inevitably increase the overall population by extending life expectancy resulting in growth of a healthier the elderly population. In addition, disruptive technologies such as remote monitoring which includes Telemedicine, mattress sensors, robotics, cardiac monitoring patches and fall sensors will continue to increase the scope and availability of home and community based alternatives to long-term care. It is estimated that approximately \$36 billion will be saved globally over

the next five years through the adoption of these technologies by remotely monitoring patients with cardiac and chronic disease alone.

Cost-effectiveness of mobile and cloud computing, as well as “software as a service” (SAAS) will need to be weighed against increasing threats of privacy breach and data security as more emphasis is put on mobile information exchange in a rapidly changing environment.

Currently technology incentives for providers have been heavily biased toward acute and primary care settings under both the HITECH and Patient Protection and Affordable Care Acts with little or no incentive provided for the integration of long-term care services. In order for long-term care providers to develop a competitive advantage additional capital investment in these areas will become imperative in order to improve quality, demonstrate effectiveness of clinical outcomes and exchange information with other healthcare providers. The importance of these technologies will increase as market competition increases as the result of consolidations, movements to Medicare and Medicaid managed care and bundling of reimbursements based on episodes of care rather than on the location and type of provider of care.

Global Issues

Results of global economic and political policy can at any time positively or negatively impact domestic economics resulting in consequences to the healthcare industry. Recent examples have included the 2008 financial crisis and foreign wars which have impacted the nation’s spending, debt level and consequently has resulted in reductions in government funding of healthcare programs. Due to continued uncertainty and the complex interrelationship of these many factors, organizational and operational infrastructures of providers must be operationally agile to adapt to a rapidly changing and at times volatile environment. Additionally, it will necessary for providers to operate at levels that improve operational efficiency and effectiveness in response to changes in the regulatory and reimbursement environments. The combination of additional regulatory requirements with respect to access, quality, healthcare information exchange and compliance coupled with continued downward pressure on reimbursement will continue to compress operating margins for most healthcare providers in the foreseeable future.

Regulatory/Legal

Regulatory and legal factors impacting the industry can generally be categorized into those which are generally business specific types of regulation and impact all businesses such as minimum wage laws and those specific to the healthcare industry. The latter are generally enacted as legislation at the Federal or State level and over seen by the Centers for Medicare and Medicaid Services (CMS) and The New York State Department of Health who provide surveillance and enforce activities to ensure providers are in compliance with the requisite laws and regulations pertaining to the specific type of healthcare service. Generally, Federal and State regulations address issues across broad categories related to provider licensing and organizational matters; the physical environment of care (quality and patient safety) and reimbursement or payment for services. Within each category providers are responsible for operating according to specific standards and may face fines or sanctions for failure to comply with these requirements.

In order to control the cost of healthcare, improve quality and clinical outcomes associated with healthcare services and reduce disparities in access to care, significant changes began to be implemented over the last decade as the result of public and political pressure to improve the delivery of healthcare services and reduce cost. Providers who have traditionally relied on cost cutting measures and adding new policies to comply with the regulations are now finding these methods are no longer successful. Instead, providers must evaluate their operations at every step in the service delivery value chain and implement or refined processes to ensure they are effective, efficient and economical in order to remain financially viable in both the short and long-term. Below we provide a current list of Federal and State changes which must be considered in determining the short and long-range options for Willow Point.

NEW YORK STATE

NYS Fiscal Year 2014-15 Budget State

(SOURCE: LEADINGAGE NY)

The NYS budget is effective for the period April 1, 2014 through March 31, 2015 and provides for an estimated \$138 billion in expenditures and increases overall spending by 1.3 % from the prior year. The following excerpts of the State's budget are expected to impact the nursing homes and long-term care alternatives.

Nursing Home Specific

- Requires homes and other providers to establish safe patient handling committees by Jan. 1, 2016 and implement programs by Jan. 1, 2017. The requirements center largely on developing policies and procedures and adopting best practices based on DOH-provided materials.
- Increases options for nursing homes to access capital funding.
- Maintains elimination of the Medicaid trend factor for SFY 2014-15

Standard Wage

- Eliminates proposal requiring Managed Care and Managed Long-Term Care plans requiring contracted nursing homes to pay standard employee rates of compensation.

Case-Mix Index Constraint

- Eliminates proposal to cap nursing home CMI at 2% if statewide growth exceeds the 2% limit
- Retains current cap on facility-specific CMI change at 5 % pending audit.

Nursing Home Quality Initiative (Formerly Known as the Quality Pool)

- The Nursing Home Quality Incentive is an incentive program for nursing homes based on mainly clinical data. It is an annual quality and performance evaluation project. The primary goal is to improve the quality of care for residents in nursing facilities across New York State. A facility will be ranked within 5 quintiles. Quintile 1 will see the highest positive adjustment of about 1.1% of your 2013 operating rate, quintile 2 about 0.6%, and quintile 3 about 0.1%. Quintiles 4 and 5 will expect to see a negative adjustment to their 2013 Medicaid rate. The 2013 Nursing Home Quality Initiative has received CMS approval and rate adjustments are expected to be processed in early 2015.
- Willow Point received a level J,K, or L deficiency during the period January 1, 2012 through June 30, 2013. As a result, it is automatically ineligible for Nursing Home Quality Incentive benefits for the 2013 period. The impact is estimated to result in a funding reduction of approximately \$111,000.

Managed Care Rate Requirement

- Requires Medicaid Managed Care and MLTC plans to reimburse a nursing home with which they do not have a negotiated rate agreement based on the home's Medicaid fee-for-service rate for a three year benchmark period, inclusive of cash receipts assessment reimbursement, in effect at the time the service was provided.
- Does not apply to short-term rehab stays.

Inter-governmental Transfer

- Extends Inter-governmental Transfer (IGT) funding for public homes for an additional three years through March 31, 2017 and increases the annual statewide IGT payment cap from \$300 to \$500 million subject to Federal Upper Payment Limitations.

Universal Settlement

- The Universal Settlement is a proposal from the Department of Health (DOH) that will settle all outstanding appeals/litigation and is supposed to mitigate losses and accelerate gains resulting from the Department's statewide pricing methodology. If this proposal is granted, facilities will accept the DOH's settlement amount and relinquish all appeals for Medicaid rates prior to 2012 along with any

litigation. There are a few exceptions to this rule. The Department's goal is to have full participation from all nursing homes in order to move forward with this proposal.

Capital Funding

- Expands the Health Care Facility Restructuring Program to allow loans to be made to not-for-profit nursing homes.

Transitional Adult Homes and Related Issues

- Provides for investment in the development of supported housing to facilitate transitioning people with serious mental illness out of ACFs and nursing homes.
- Appropriates \$30 million to support the transition of people with serious mental illness out of adult homes and into the community. The funds will be used for activities such as education, assessments, training, in-reach, care coordination and supported housing.

Adult Day Health Care

- Restores the 2 % across-the-board cut to Medicaid rates effective April 1, 2014, including Adult Day Health Care (ADHC) rates.
- Retains 0.8 % unreimbursed cash receipts assessment tax.

General Provisions Impacting Health Care Providers

Medicaid Global Spending

- Extended through March 31, 2016 authorizes the State spending cap and gives the Commissioner of Health to take action to reduce spending should actual expenditures exceed budget projections. The Cap limits growth in Medicaid spending to a 10 moving average of the medical component of the Consumer Price Index which is 3.8 % and 3.6 % for State Fiscal Years 2014-15 and 2015-16 or approximately \$17.1 billion and \$17.9 billion, respectively.
- Under the global cap, DOH and the Division of the Budget (DOB) continue to monitor monthly State Medicaid spending. If spending is projected to exceed the global cap, DOH is authorized to take unilateral action to reduce spending to remain within the cap. This authority is now extended through SFY 2015-16.
- Provides for the State to share 50 % of the savings with providers and managed care plans based on claims submitted by providers and managed care plans during the past three years. The remaining savings to assist financially distressed and critically needed providers up to the remaining 50 %.
- Caps annual growth in the local share of Medicaid at 1 % in SFY 2014-15 and zero in SFY 2015-16. Savings to counties are estimated to be \$187 million in SFY 2014-15.

Medicaid Trend Factor and Two Percent Across-the-Board Cut

- The trend factor adjustments to Medicaid reimbursements have been eliminated through March 31, 2015.
- Eliminates 2 % across-the-board cut to all Medicaid providers. Provides for potential rate add-ons for provider segments electing alternate funding reductions in prior years.

Vital Access Provider (VAP) Program

- Provides VAP program all eligible providers in the amount of \$313.4 million for SFY 2014-15.

Delivery System Reform Incentive Payment (DSRIP) Program

- Provides for the reinvestment of \$8 billion in Federal funding to the delivery system from savings generated through the State's Medicaid 1115 waiver which is under review by CMS.
- Appropriates \$4 billion for payments under the waiver for public oversight, transparency and promotion of efficiency for DSRIP programs and related MRT initiatives.

Capital Restructuring Financing Program

- Provides \$1.2 billion health care capital program support improvements in the financial stability, quality and efficiency of health care providers.

- Eligible for grants include, but are not limited to: closures, mergers, restructuring, improvements to infrastructure, increases in primary care service capacity, development of telehealth infrastructure.
- Providers must apply to DOH for funding.
- Other Capital Programs
 - Health Care Facility Restructuring Program expanded to permit loans to not-for-profit nursing homes, not-for-profit diagnostic and treatment centers and any other not-for-profit facility licensed under Article 28 of the Public Health Law.
 - Elimination of DASNY bond fees on borrowings for new and refinanced health care projects.
 - Health Information Technology Infrastructure
 - Provides for funding of health Information Technology (IT) proposals in the amount of \$75 million to be used for:
 - Supporting the State Health Information Network of New York (SHIN-NY)
 - Implementation of an All Payer Claims Database (APD) as a repository for health care utilization and spending data to determine performance of the health care delivery system
 - \$10 million for discretionary DOH IT needs.
 - Establishes a work group charged with evaluating and issuing a report on the State's health information technology infrastructure, including the APD, SPARCS, RHIOs SHIN-NY and Medicaid eligibility systems.

Pay for Success Program

- Increases funding for the Pay for Success initiative (also known as "Social Impact Bonds") from \$30 million in the SFY 2013-14 budget to \$53 million in the SFY 2014-15 budget. Service providers partner with an intermediary to raise operating funds to support an evidence-based, cost-effective program. State will repay third-party investors that provide program funding if specific outcomes are achieved.

Certificate of Need and Health Planning

- Does not eliminate the public need review for certain hospital and primary care construction projects, continues to require character and competence review look-back period for health care facility operators that have repeated deficiencies.
- Provides \$2.5 million for the Finger Lakes Health Systems Agency to engage in regional planning and statewide coordination and demonstration of best practices for regional health planning.

Medicaid Eligibility

- MAGI spend-down: Applicants with excess income are authorized to spend-down to the Modified Adjusted Gross Income (MAGI) equivalent of the applicable income standard.
- Presumptive eligibility: Presumptive eligibility for Medicaid is expanded through determinations of eligibility for MAGI populations by qualified hospitals consistent with the Affordable Care Act.
- Integrated eligibility system: The State is permitted to enter into a non-competitive contract for the purpose of implementing an integrated eligibility system covering Medicaid and human services programs, subject to the availability of enhanced Federal financial participation.
- Eligibility integrity: DOH is authorized to enter into a non-competitive contract to review the accuracy of determinations of eligibility and eliminate duplicative benefits.
- Limits recoveries from the estates of MAGI-eligible beneficiaries, age 55 or older at the time they receive Medicaid, to amounts expended for nursing home services, home and community-based services, hospital services and prescription drugs.
- Modifies the authority to impose liens on the property of certain individuals permanently placed in nursing homes and intermediate care facilities.

Prescription Drugs

- Modifies Medicaid co-payment amounts to permit Medicaid managed care plans to charge a lower (\$1) co-payment for preferred brand name drugs on the plans' formularies.
- Requires prior authorization of refills sought when more than a 10-day supply should be remaining of the amount previously dispensed.
- Expands Elderly Pharmaceutical Insurance Program (EPIC) eligibility for catastrophic coverage to seniors with income up to \$75,000 and \$100,000 for individuals and married couples, respectively.

- Provides for registration, inspection and regulation of drug compounding outsourcing facilities, consistent with federal law.

Other Budget Provisions Affecting Long-Term Care and Related Programs

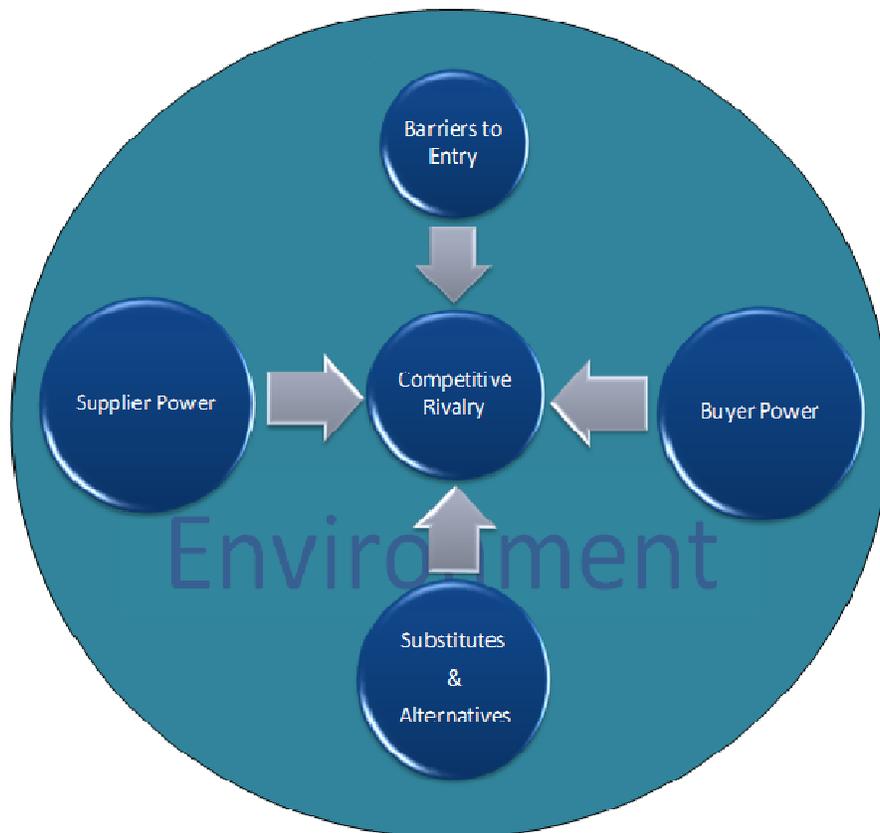
The budget includes numerous provisions which provide funding to improve access to home and community based services and alternatives to nursing care. The legislation is consistent with Federal initiatives related to the Patient Protection and Affordable Care Act which attempts to slow health care spending while improving access to affordable health insurance coverage and access to care. Many of these reforms involve incentives that promote efficient and effective care, as well as improving quality and patient engagement in self-directed care. Programs impacted by these provisions include: various levels of home health care, managed Medicaid and Medicare plans, Assisted Living Programs, Adult Care Facilities, Senior Housing and Adult Day Care Services among others. As the growth and importance of these alternatives increase their competition for the same market segment of the population currently utilizing higher cost nursing homes will intensify. Therefore, it is imperative for nursing homes to become more cost effective and differentiate themselves in terms of price, quality, services offered and amenities in order to remain financially viable in the future.

FEDERAL

- *PATIENT PROTECTION AND AFFORDABLE CARE ACT (OBAMACARE)*
This is the most overarching regulation impacting all facets of healthcare delivery including long-term care. The reform framework drives many of the current and future changes expected in the industry and will more than likely be refined over the next decade as the results of its impact on controlling healthcare cost, improving access, quality and effectiveness of clinical outcomes become available and are analyzed. A detailed analysis of its provisions with respect to long-term care services is provided later in the section.
- *BIPARTISAN BUDGET ACT OF 2013 (EFFECT FFY 2014 AND 2015)*
 - Extended 2% sequestration reduction for an additional two years to 2023
 - Nursing homes will continue to receive Medicare payments reduced by 2% for the years 2014 through 2023
 - No further reductions to Medicare reimbursement rates through October 31, 2014 (FFY 2013-14)
 - Stayed implementation of Therapy Cap limits effective March 31, 2015
- *Protecting Access to Medicare Act of 2014 (Sustainable Growth Rate Patch)*
 - Stays the proposed 24% cut in physician reimbursement that would have been implemented under the Sustainable Growth Rate provisions of the Medicare payment program until March 31, 2015.
 - Delays the major overhaul of the International Classification of Disease coding system used by providers for diagnosis coding in medical records and billing from version ICD-9 to version ICD-10 until October 1, 2015.
 - Enacts a value based purchasing program for skilled nursing homes based on hospital readmission rates beginning October 1, 2018. The legislation provides for a 2% withhold on payments to nursing home providers. 70% of the withheld money would be repaid to providers with readmission rates which have readmission rates better than the rates established by CMS. Facility readmission scores will be posted to the CMS Nursing Home Compare website beginning in 2017.
 - Delays the implementation on Therapy Caps for providers until March 31, 2015.
 - Delays enforcement of the Two-Midnight Rule for inpatient hospital stays until March 31, 2015. Under legislation enacted in October of 2013 inpatient hospital stays not meeting the criteria of the patient being hospitalized for two midnights were to be treated as outpatient stays (Medicare Observation Days) and did qualify for Medicare Part A coverage. As a result these days would not be counted toward the three day minimum required hospital stay for persons admitted to nursing homes to be covered by Medicare Part A.

- Nurse practitioners with more than 3,600 hours of experience are permitted to practice without a collaborative agreement with a physician. However it requires the NP to have a "collaborative relationship" with a physician who is board certified in the same specialty.
- Rural dentistry program: A mobile dentistry pilot program is created in Cattaraugus, Chautauqua and Allegany Counties.
- Extends HCRA provisions for three years to December 31, 2017 including workforce recruitment and retention funding and assessment taxes.

INDUSTRY ENVIRONMENT



The competitive environment of Willow Point was evaluated by looking at five areas which make up the environment in which it operates. These five areas are commonly referred to as the five forces that shape competitive strategy and it provides an accepted framework for the assessment and evaluation of an organization within an industry or market. The forces can be categorized as follows:

1. Threats or barriers to market entry by new competitors
2. Leverage of suppliers
3. Buying power of consumers
4. Competition or rivalry between existing market competitors; and
5. Availability of substitutes or alternatives

Threats or barriers to market entry: Determines the ease with which new competitors may enter the market thereby increasing competition or the difficulty encountered by organizations that choose to divest and leave the market.

In the healthcare industry factors influencing market entry and exit include: Perceived return on investment for operators; Government approval (Certificate of Need processes and closure plan approvals); Significant capital investment (or lost investment in the case of divestiture); Number of existing providers in the market service area; Industry experience of the providers; consumer loyalty and the consumer knowledge of the services. Unlike other industries, need based methodologies which are strictly adhered to by the state licensing agency, high capital investment and low profit margins result in difficulty for new providers to enter the market, as well as for existing providers to divest of their operations. This has a positive effect on competition for Willow Point Nursing Home, though impossible to determine the likely entrance or divestiture of other facilities, there is less of a probability this should occur assuming all current needs are met and there is excess capacity with available suppliers.

Leverage of suppliers: Reflects the extent to which labor and suppliers of services and products control the price of these resources which are ultimately utilized by the healthcare organization in delivering its services. The amount of specific leverage of suppliers is dependent on the number of healthcare organizations utilizing the resource in the market and the level to which products are homogeneous in nature and the availability of alternatives or substitutes. For instance, positions having relatively low required skill levels have less influence over the establishment of labor rates than positions having highly specialized skill levels that are also low in availability in the labor market. Similarly, the cost of highly specialized purchased services and medications are able to command higher prices than other services or supplies that have lower cost alternatives that can be readily substituted or products for which there exists numerous other suppliers capable of delivering the same for similar product of equal quality at the same or lower cost. Healthcare providers are able to reduce supplier leverage when they are large or the only provider in the market. In these cases, providers due to their size, either individually or as part of an affiliate group or system, can reduce supplier leverage based on the volume of resources utilized or as the largest or only employer in the market.

Power of consumers or buyers of services impacts the competitive environment in a manner similar to that of suppliers: In the case of consumer leverage, the more homogeneous a healthcare service is, the more leverage consumers have over utilizing the services of a specific provider or the price that they are willing to pay for the service.

For example, long-term nursing home care as the result of established federal and state standards is relatively homogeneous between providers in comparison to the provision of specialized trauma care, cardiac surgery or long-term pediatric ventilator care. Therefore, consumers should expect to receive similar services and care irrespective of the nursing home where the care is provided. In comparison to the other types of healthcare services mentioned which may not be readily available in the consumer's service area or may not be provided by all providers due to specialized skills or technology required to provide the care.

The converse is also true for providers. Providers of reasonable homogeneous services have less leverage with consumers and buyers of healthcare services such as long-term care since the service is readily available from competitors and acceptable substitutes such as care provided in the home by family members or home care agencies. Similarly, various other levels of care provided for in independent living, adult care homes, assisted living programs and medical day care program settings may be viable alternatives to nursing home care. Since the availability of these services or alternatives exist, nursing home providers have less ability (leverage) to influence the price charged for the services and must accept the market rate set by insurers and the consumer market for such services in the provider's service area.

Existing competition and rivalry: Competition among existing providers is another factor that impacts the organization's competitive positioning. Generally, the existence of many healthcare providers providing the same, homogeneous service results in greater price competition for consumers and buyers of these services. This competition includes competition for insurance contracts with third party

payer networks, affiliations with other providers of healthcare services and competition for patients that have the highest reimbursement, lower clinical complexity and lower cost of care.

In order for healthcare providers to differentiate themselves under these conditions, providers must provide better quality of care, have higher clinical outcomes and provide additional services or amenities which add value. Competition between rival providers also influences profit margins as highly competitive environments tend to have a downward pressure on reimbursement and compress operating margins. These factors can greatly influence a provider's decision with respect to staying in the business, expanding, contracting or divesting its operations. In the case of divestiture, lower profit margins will generally result in lower valuation of the operation and therefore reduce the selling price and operation's marketability.

Availability of substitutes and alternatives. As touched upon in the preceding sections, availability of substitute and alternative services also impact the competitive environment. The more substitutes and alternatives that are available the more choice consumers and buyers of the services have in choosing which service to purchase. These choices are often influenced by cost, quality, convenience, consumer preference and perceived consumer value. As more alternatives become available to consumers and buyers, the greater the competitive pressure is on traditional suppliers of the services to differentiate their services and align their prices with less costly alternatives.

Basis for Assessment

The aforementioned factors provide the general framework for assessing Willow Point's competitive positioning in the Broome County service area. The report looks at Willow Point's current position in the market and the potential for improving its competitive position, as well as the implications of these factors both on the organization's future viability and the impact of these factors on potential alternatives to the current model of long-term care service delivery in the market. Our evaluation looks at Willow Point's current operating strategy as it pertains to the major stakeholders in each market force category including the organization's performance against competitors in the market.

Market Threats and Barriers to Entry

Licensing Authority

The authority to grant licenses to healthcare service providers is relegated by the individual states in which a provider intends to operate. In New York State the licensing agency for nursing homes is the New State Department of Health Bureau of Long-Term Care. The process for application requires prospective operators to file a Certificate of Need (CON) application to the Bureau which details location, capacity, services and programs to be provided and detailed forecasts of the proposed facility's financial operation for the first three years of operation.

Additionally, information about the prospective operators financial condition, availability and access to capital for the acquisition/construction, program development and financing of operations, as well as the details of the operator's experience in operating long-term care facilities and any previous sanctions or enforcement actions by regulatory agencies are required to be provided. The information is utilized by the Department in assessing the proposed impact that the proposed entity would have on existing capacity in the region in which it is to be located, assess the proposed programs and services being offered and evaluate the proposed operator's character and competence with respect to operating a long-term care facility.

The Bureau assesses the application based on requirements of the NYS Public Health Law and the NYS Commissioner's Rules and Regulations, as well as the existing and future capacity estimated for the region. Applications which pass the Bureau's evaluation process are forward to NYS Public Health Council with a recommendation for approval or rejection by the Bureau. Additionally, if the project involves new construction or significant renovation to existing structures, the projects architectural and engineering specifications must also be approved by the Department of Health Bureau of Architecture and Engineering.

The Public Health Council (PHC) holds monthly meetings at which it discusses submitted applications which have also been posted for public comment. The PHC approves or disapproves the CON applications based on the Bureau's recommendations, public commentary on the proposed applications and its own internal discussions with respect to the projects necessity and viability.

This process can take anywhere from as little as three months to more than several years depending upon issues identified with the application, application revisions, appeals and other matters. Once approved, the operator is given an initial period of up to one year to begin substantial progress toward the implementation of the approved project with extensions available for good faith efforts and reasonable causes in the delay of the implementation. In cases of new construction or renovation, construction progress is monitored by the State through quarterly progress reports and field inspections by the Department personnel.

Upon completion of construction or transfer of ownership, the operation is subject to pre-opening survey by the NYS Department of Health Regional Office's survey team to insure the new operation adheres to all requirements of operation pursuant to Federal and State regulations for nursing homes operations. If the operation is approved for opening the operator can submit applications to the Centers for Medicare and Medicaid Services (CMS) for approval to participate in the Medicare program and may submit an application to New York State for approval as a Medicaid provider.

Capital Financing Requirements

New entrants to the market must have adequate access to significant amounts of capital financing to acquire and renovate an existing nursing home or construct an approved new construction. In the case of acquiring and existing facility, new operators may expect to expend between \$20,000 and \$100,000 per licensed bed or approximately \$2.0 million to \$10.0 million per 100 licensed beds acquired. In contrast, new construction can be \$289,000 to \$578,000 per bed or over \$57 million per 100 beds depending on regional location, design and construction.

If the facility is new and not a transfer of ownership of an existing facility to a new owner, the facility may only admit up to five (5) residents per day with certain exceptions to requirement available. However, this restriction on the admission process when coupled with the application processing for Medicaid and Medicare approval can result in significant cash flow burden placed on the new operations. As a result, new entrants must have access to adequate working capital in addition to the capital financing requirements to ensure the financial viability of the operation. The issue of adequate working capital is also relevant to operators acquiring existing facilities depending on the terms of the sale, existing liabilities assumed and current labor and supply costs.

Regulatory Requirements

In addition to compliance with federal, state and local laws regulating general business in the areas of zoning, taxes, anti-trust and trade regulations, employment and others that govern typical business operations, the healthcare sector and especially long-term care industry are heavily regulated at the federal and state levels with respect to patient safety, quality of care, patient rights, billing and payment for services, and protection of patient health information to name a few.

As part of the federal and state requirements, nursing homes are subject to an annual inspection or survey process which is performed by the New York State Department of Health for facilities operating in New York State. During the survey process facilities are inspected for compliance with federal and state laws and regulation related to patient safety, patient rights, clinical and quality of care standards. Facilities found to be noncompliant can face penalties which require at a minimum a written and implemented plan of correction approved by the surveying agency, public reporting of the violation on state and federal websites and monetary penalties. In cases of gross negligence on the part of the operator, payments from Medicaid and Medicare may be stopped or the facility may be disbarred from participating in the Medicaid and Medicare programs and the admission of new patients may be stopped until the issue(s) are corrected. In extreme cases, the operator may

face fines, civil penalties, imprisonment or the facility may be closed or an independent operator may be appointed to operate the facility by the regulatory agency.

Increased Emphasis on Transparency and Quality

In addition to the previously mentioned regulatory items, the industry has been under increasing pressure since the major reforms of the Omnibus Budget Reconciliation Act of 1996 (OBRA-96) which significantly increased regulatory requirements and reforms in the long-term care industry. Since then various changes in the federal and state regulations have been made to further improve quality of care and protect residents of long-term care facilities. Most recently, due to the rising costs of healthcare in the United States and the low performance in the areas of quality of care and effectiveness of clinical outcomes in the U.S. compared with other Organization for Economic Co-operation and Development (OECD) countries the industry has seen increased pressure for quality improvement and public reporting transparency. As a result, the Centers for Medicare and Medicaid Services (CMS) and state regulatory agencies must now report individual facility quality measures and inspection results publicly on their websites to assist consumers in making well informed decisions with respect to choosing a long-term care facility. Additionally, independent consumer and public interest organizations also report comparative ratings and rankings.

Return on Investment

Costs of Divestiture

Similar to the issues facing new operators entering the long-term care market, existing operators face regulatory requirements for divestiture of nursing home operations. Operators seeking to leave the market must decide on whether to sell, contract or entirely close the respective facility's operations and plant. Each alternative for divestiture carries with its regulatory restrictions which are not commonly faced by other industries due to the nature of services provided, funding sources and the vulnerable populations the industry's services. As a result, sales, contractual agreements and closures face close scrutiny by regulators at the federal and state levels.

In the simplest cases regarding the sale of an existing facility, contracting for management of an existing operation or other forms of ownership, a full or limited Certificate of Need application must be submitted by the proposed new operator to the New York State Department of Health for approval and subjected to process as outlined above with respect to application of new operators.

However, in the case of complete divestiture and closure a Closure Plan must be submitted to the Department at least 90 days prior to the intended date of facility closure. The plan must include a detailed description of the process for the placement of existing facility residents, identification and agreements with existing facilities agreeing to accept the residents of the closing facility, transportation arrangements for transporting the facility's residents to the accepting facility and a plan for maintaining staff and operations at the facility during the closure process.

The cost of maintaining continuing facility operations and the cost of care and transport of all residents in the facility to other locations during the wind down of operations, as well as the unemployment costs associated with terminating employment of existing staff are borne by the operator of the facility. In addition to wind down and closure costs, the divesting operator must provide for the repayment of all debt and liabilities that have been incurred by the facility during its operation. The owner/sponsor also incurs the loss of all investment and equity in the facility that is not covered by the proceeds of the facility's sale, including its loss of use for any alternative purpose and any future income could potentially be derived from the property if it is leased or used for an alternative business purposes. These costs must be weighed in the context of past and future operating losses, economic opportunity costs of invested capital and alternative use of the existing properties and the cost of selling or maintaining the closed facility. Therefore, the costs and regulatory requirements associated with closure create a barrier to market exit which should be a consideration for anyone contemplating entering the market, as well as those existing operators considering divesting of existing operations.

Facility Sponsorship

In general, facilities are classified according to size in terms of the number of licensed beds; whether they are Medicare/Medicaid certified and sponsorship; Proprietary, Not-for-Profit and Public/Governmental. The largest ownership percentages of nursing homes are Proprietary, followed next by Public/Governmental. Over the course of the last 20 years the total nursing homes nationally has changed insignificantly. However, pressures due to reductions in reimbursement and increases in operating costs, Not-for-Profit and Governmental operators have divested, sold or transferred ownership to proprietary owners who have developed greater economies of scale and improved efficiencies to better counter the adverse aspects of the changing reimbursement and operating environment. This shifting in ownership is demonstrated in the table below.

Change in Nursing Homes Ownership: 2002 - 2012

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	% Chg
<i>Number of Facilities:</i>												
Government	1,014	1,029	984	955	964	940	927	915	897	891	912	-10.1%
NonProfit	4,720	4,634	4,548	4,495	4,381	4,279	4,209	4,143	4,011	3,970	3,920	-16.9%
For-Profit	10,826	10,717	10,631	10,582	10,578	10,638	10,627	10,644	10,741	10,822	10,848	0.2%
Total	16,560	16,380	16,163	16,032	15,923	15,857	15,763	15,702	15,649	15,683	15,672	-5.4%
<i>Percent of Total</i>												
Government	6.1%	6.3%	6.1%	6.0%	6.1%	5.9%	5.9%	5.8%	5.7%	5.7%	5.8%	-0.3%
NonProfit	28.5%	28.3%	28.1%	28.0%	27.5%	27.0%	26.7%	26.4%	25.6%	25.3%	25.0%	-3.5%
For-Profit	65.4%	65.4%	65.8%	66.0%	66.4%	67.1%	67.4%	67.8%	68.6%	69.0%	69.2%	3.8%
Total	100.0%	0.0%										

Source: CMS Provider Profiles

Unique Circumstance of Government Sponsored Facilities

Government facilities have a long history of providing care to the elderly, infirmed and poor. Many county nursing facilities began as "poor-houses", labor farms or alms houses through the late eighteenth and nineteenth century prior to the development of what is considered today as a modern nursing home.

Over time as government structures have changed and expanded, governments have found themselves competing with for-profit and not-for-profit enterprises to attract and retain qualified and skilled employees. Historically government depended on robust benefit packages to offset generally lower than market wages paid to government employees. The introduction of unions resulted in collective bargaining on behalf of government or civil service employees resulting in greater negotiating power and increases in both wages and benefits. Overtime this has led to labor and benefits at, or beyond labor and benefit costs of the private sector.

Since nursing home care is predominantly labor intensive, the increasing labor/benefit cost curve has resulted in increased upward pressure on government provided cost of care as depicted in the following Table. Willow Point's Benefits as a percentage of Total Salaries for 2012 were 76.7% compared to 71.1% for other government sponsored facilities statewide. This disparity was even greater when compared to benefits for For-Profit (32.0%) and Not-For-Profit (37.3%) entities statewide. By comparison, For-Profits and Not-For-Profits, in Broome County had benefits levels of 19.1% and 28.1% respectively.

Comparison of Salary & Benefits 2012 by Sponsor NYS & Broome County			
Sponsor	Salary	Benefits	Benefits as % of Salary
Statewide			
For-Profit	\$ 2,236,422,231	\$ 714,755,692	32.0%
Not-For-Profit	\$ 2,366,676,469	\$ 881,863,972	37.3%
Government	\$ 388,771,065	\$ 276,548,709	71.1%
Total	\$ 4,991,869,765	\$ 1,873,168,373	37.5%

Sponsor	Salary		Benefits		Benefits as % of Salary
	Broome County				
For-Profit	\$	20,312,741	\$	3,876,634	19.1%
Not-For-Profit	\$	23,008,629	\$	6,561,748	28.5%
Government	\$	12,527,301	\$	9,613,523	76.7%
Total	\$	55,848,671	\$	20,051,905	35.9%
Willow Point	\$	12,527,301	\$	9,613,523	76.7%

Much of the difference in benefits are related to near 100% funding of health care insurance for active and retired employees and payments to the New York State and Local Employees' Retirement System under collective bargaining agreements with Civil Service Employee Association (CSEA), which is the union that represents county employees. We can see from the table below that although total health insurance costs remained relatively cost neutral for the period 2010 to 2012, the amount for the retiree portion of health insurance rose by 14.2% in 2011 and 4.0% for a combined increase of approximately \$450,000 or 18.7% over the 2010 cost of \$2,402,178 for these benefits. Similarly, employee pension contributions rose 28.3% in 2011 and 18.5% in 2012 increasing by almost \$ 700,000 or 52.1% over the 2010 amount funded by the County.

Willow Point Employee Retirement & Pension Cost								
Year	Health Insurance				Total	OPEB % Incr	Employee Pension	% Incr
	Active	% Incr	Retired	% Incr				
2010	\$ 3,669,961	-	\$ 2,402,178	-	\$ 6,072,139	-	\$ 1,337,852	-
2011	\$ 3,376,860	-8.0%	\$ 2,742,824	14.2%	\$ 6,119,684	0.8%	\$ 1,717,024	28.3%
2012	\$ 3,213,668	-4.8%	\$ 2,851,943	4.0%	\$ 6,065,611	-0.9%	\$ 2,034,876	18.5%

As previously discussed, the current health care environment places pressure on providers to control cost. In order for Willow Point to reach a level of financial sustainability, the organization will need to curb the cost escalations associated with these two factors which would result in savings of approximately \$300,000 average based on recent trends. These savings could be greater or lesser depending on the reinvestment rates of the funding requirements, mortality and escalation in the cost of health insurance.

Funding of Public Healthcare Services

As with most healthcare providers an increasingly large proportion of payments for services made to publically sponsored providers are paid by federally funded programs such as Medicare and Medicaid. Under the provisions of Title XVIII and Title XIX of the Social Security Act payments under both programs must be equitable for the same type of service provided to program beneficiaries. Since rates of payment for Medicaid are often different between providers, as well as between states, a reconciliation of the Federal portion of payments paid to States under Medicaid must be performed. This reconciliation compares what the amount paid for services would have been had the same services been provided under the provisions of the Medicare program as compared to the actual payments for services under the State's Medicaid provisions. The estimated ceiling calculated under the Medicare program's provisions is known as the Upper Payment Limit (UPL). The difference in excess of the amount actually paid to providers under the Medicaid reimbursement methodology and UPL ceiling is paid to the State for use in funding the specific type of healthcare service which the calculation was based upon (nursing home, hospital, clinic, etc.). States have discretion in how the UPL payment is used as long as it remains within the specific provider category.

In New York State the distribution of the UPL funding is determined by legislation passed as part of the annual budgetary process and is included in the provisions of the New York State Public Health Law. The portion of the UPL associated with publicly sponsored facilities is referred to as Inter-Governmental Transfer Payments (IGT) and is distributed to public facilities based on their relative utilization to all other public facilities in the service category. UPL amounts for non-public facilities are pooled and distributed to financially distressed non-public facilities based on the relative magnitude of operating losses incurred by the non-public providers. These distribution methodologies are subject to legislative revisions at the Federal and State levels and therefore their ongoing certainty as a funding source is often questionable. Public nursing homes in New York have been allocated up to \$300 million for state fiscal year 2013-2014 and up to \$500 million for state fiscal years 2014-2017 under current legislation.

The historical and projected State IGT amounts and payments to Willow Point are shown in the following Figures and Tables:



Willow Point Nursing Home

Actual and Estimated NYS IGT Payments 2008 - 2015

SFY	State IGT	CMS UPL	MCD Patient	Estimated	Willow Point	Prior SFY	Current SFY	Calendar Year	
IGT	Pool	Limit	Day Base	Payment	Payment	01/01 - 03/31	04/01 - 12/31	Year	01/01 -12/31
2008-2009	\$ 300,000,000	\$ 150,000,000	2006	12/2009	\$ 5,109,255	\$ -	\$ 3,831,941	2008	\$ 3,831,941
2009-2010	\$ 300,000,000	\$ 167,000,000	2007	9/2011	\$ 5,790,094	\$ 1,277,314	\$ 4,342,571	2009	\$ 5,619,884
2010-2011	\$ 300,000,000	\$ 189,000,000	2008	12/2011	\$ 6,591,029	\$ 1,447,524	\$ 4,943,272	2010	\$ 6,390,795
2011-2012	\$ 300,000,000	\$ 172,500,000	2009	03/2013	\$ 5,697,566	\$ 1,647,757	\$ 4,273,175	2011	\$ 5,920,932
2012-2013	\$ 300,000,000	\$ 293,000,000	2010	06/2014	\$ 9,667,807	\$ 1,424,392	\$ 7,250,855	2012	\$ 8,675,247
2013-2014	\$ 300,000,000	\$ 294,000,000	2011	12/2015	\$ 8,637,131	* \$ 2,416,952	\$ 6,477,848	2013	\$ 8,894,800
2014-2015	\$ 500,000,000	\$ 296,000,000	2012	12/2016	\$ 8,602,637	* \$ 2,159,283	\$ 6,451,978	2014	\$ 8,611,261

* Estimated

It must be noted that amounts distributed to facilities are subject to the UPL calculation ceilings established by CMS and the number of Medicaid days provided to Medicaid beneficiaries. Therefore reductions in facility Medicaid utilization can adversely reduce the amount awarded to the facility, *ceteris paribus*. In general, the local government sponsor of the facility fund an amount equal to the local government federal participation rate in order for the facility to receive its share of the IGT distribution for the period which has been 50% in most years with the exception of the years in which States received Federal Economic Stimulus incentives under ARRA. Counties generally utilize the IGT funding received to reduce deficits incurred by the facility or as a means to reduce current year subsidies to their facilities. As an example, Broome County would need to advance approximately \$4,319,000 and \$ 4,301,000 in 2015 and 2016 in order for the facility to receive \$ 8,637,000 and \$ 8,603,000 for services rendered to Medicaid participants between April 1, 2013 and March 31, 2015.

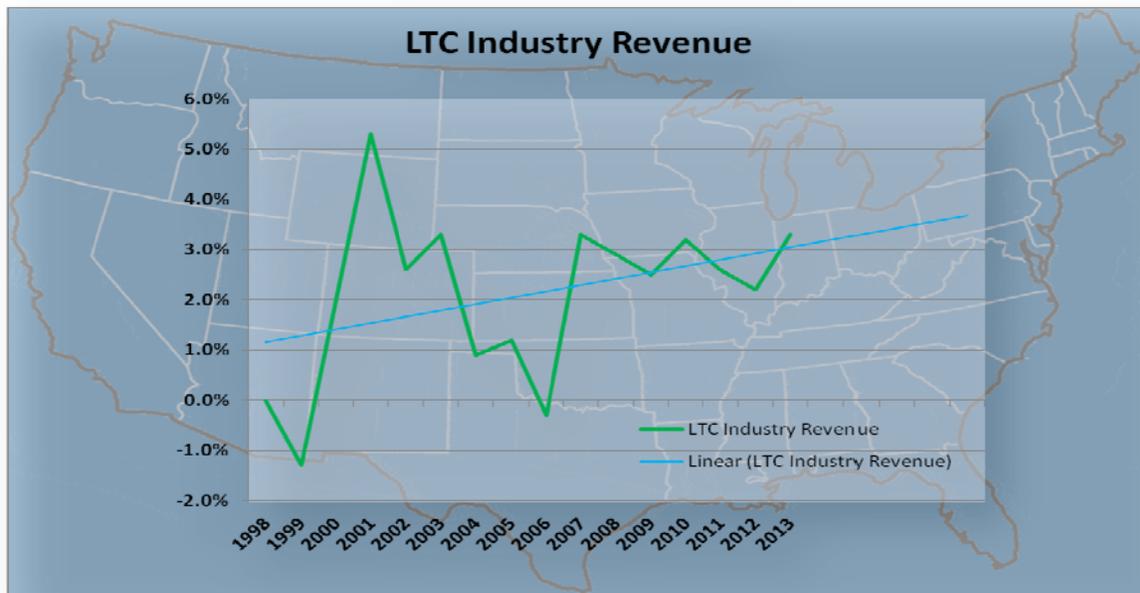
As mentioned previously, the uncertainty associated with this funding source makes it difficult to rely upon in long-term projections. This is especially true since current Federal initiatives are aimed at reducing or at a minimum controlling the growth rate of health care expenditures under Federal programs. On the other hand, Federal policy is also aimed at providing improved access to medically necessary health care service to individuals with low or no income, as well as protecting the health and safety of the frail and vulnerable safety-net populations. This paradox is likely to lead to continued funding of the IGT, however reductions in Federal Medicare payments under Medicare managed care plan initiatives of the ACA will lower the UPL closer to the rates paid on behalf of Medicaid patients. Additionally, efforts to place patients in Home and Community Based alternatives is expected to reduce Medicare and Medicaid utilization in nursing homes as a result of these factors IGT distributions would be expected to decrease over the mid to long-term planning horizon.

Privatization

Industry Perspective

LONG-TERM CARE INDUSTRY – NATIONAL

The industry generates approximately \$120.6 billion in revenue annually with an estimated national profit margin of 6.8% or \$8.3 billion industry wide. Revenue Growth for 2008 – 2013 was approximately 2.8% with a 3.3% revenue growth rate projected for 2013-2018 according to industry analysts. The nursing home industry spends in excess of \$ 50.6 billion in salaries and wages for employees annually.



Medicare and Medicaid make up approximately 75.5% of the service revenue for nursing homes nationally. Continued pressure on reimbursement reduction at the Federal and State levels along with movement to Medicaid and Medicare managed care programs reduce revenue growth for providers. The impact of these changes in reimbursement will most likely offset improvements in revenue from an increasing population over 65 years old and improvements in private payer payments associated with slow to moderate economic recovery expected nationally through 2018.

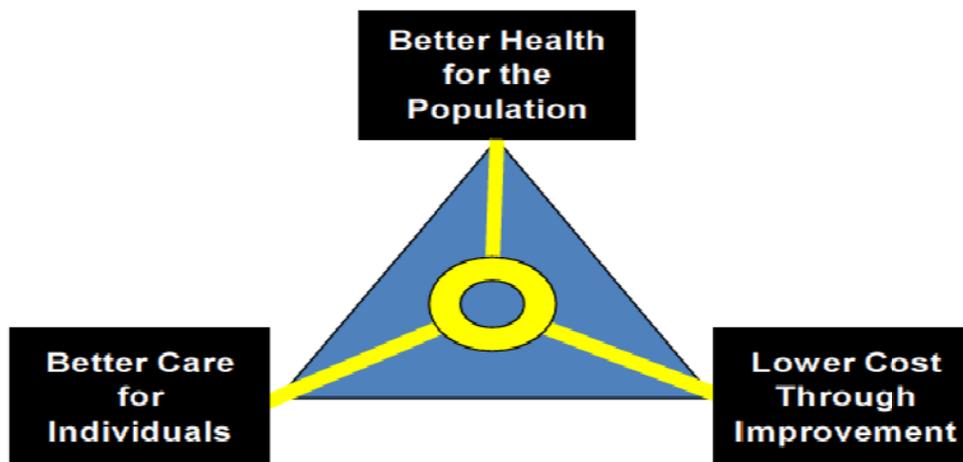
Growing Senior Population

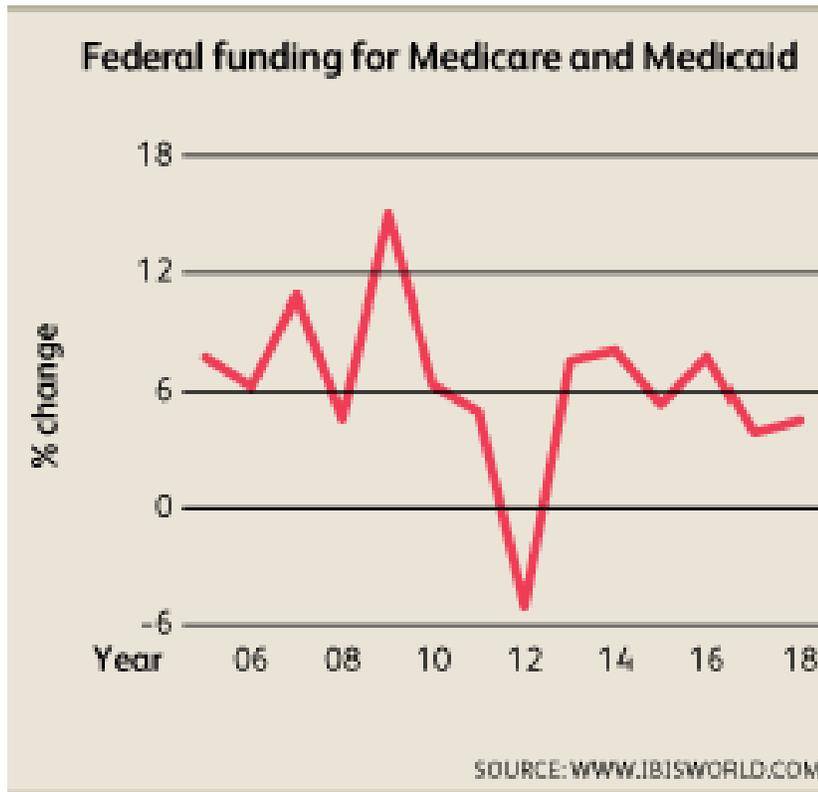
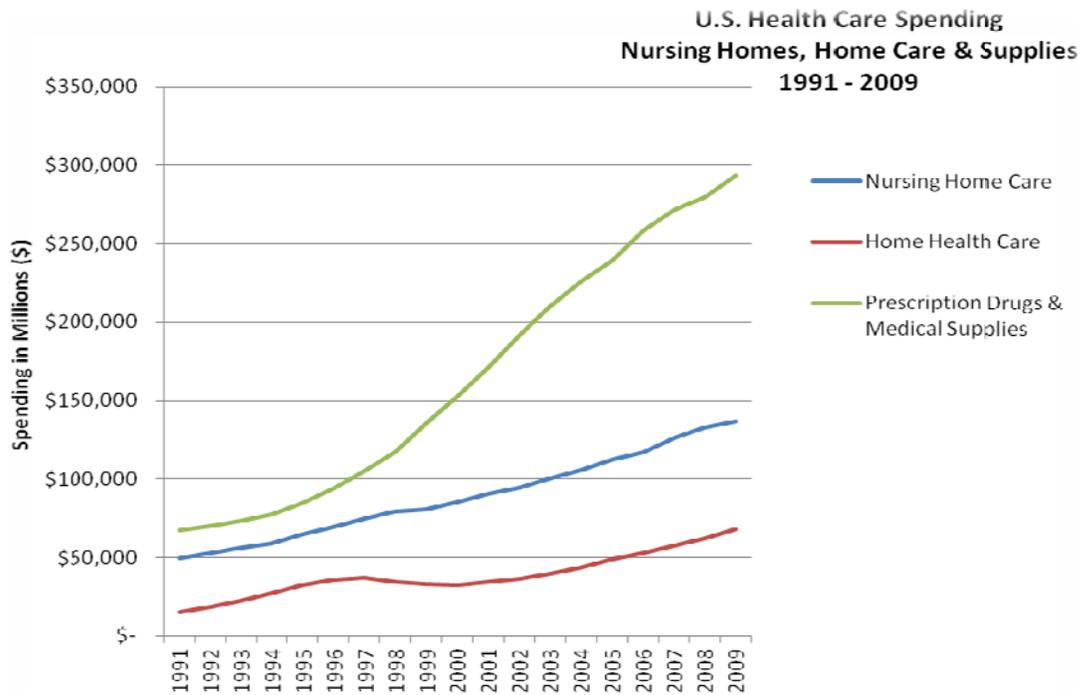
On a national basis the U.S. population of persons over the age of 65 is expected to continue to rise from 2014 through 2018, based on U.S. Census bureau projections the continued “Graying of America” will continue steady through 2040. The increased aging population will result in the potential for increasing industry demand for services over the period offset by the dampening effect of increases in medical innovation, coordination of preventative care and improved health conscious behaviors by aging baby boomers. Additionally, the availability of substitutes and alternatives such as lower cost home and community based cares will also increase the competitive environment and absorb some of the demand for services that were traditionally provided in nursing homes.

According to national sources, 88% of residents in nursing homes are over 65 and 45% are over 85 years of age. Upward trends in these age groups suggests a potential increased demand for nursing home service from 2014 through 2040.

Reductions in Medicare and Medicaid

Continued global and domestic pressure on the U.S. to reduce National Healthcare Expenditures will most likely result in continued reductions in federal expenditures under the Medicare and Medicaid programs. As funding under these programs is reduced, state and local governments will also feel the pressure to identify ways to reduce spending under the Medicaid program. Current initiatives under the Patient Protection and Affordable Care Act (PPACA), also known as the Affordable Care Act (ACA) or Obama-Care provides incentives for states, health maintenance organizations and providers to reduce cost and improve quality or face reductions in reimbursement. These programs include: value based purchasing programs; payment for performance; bundled provider payments; incentives for increased use of healthcare information technology and the establishment of Accountable Care Organizations (ACO) and Primary Care Medical Homes (PCMH). The latter initiatives, ACO's and PCMH's, are a means to improve the coordination of care among providers, increase patient engagement, improve quality of life, as well as reduce healthcare costs. The association between improvements in population and community health, improvements in quality, patient engagement and clinical outcomes and reductions in healthcare costs as described by CMS are depicted in the following diagram.





Increased Disability Expenditures

Federal spending on persons with physical, mental and emotional disabilities is expected to continue to rise as disabled persons begin aging in greater numbers according to industry projections. As a result, the demand for long-term care services to this population will also increase. Although current trends are away from institutional resident care programs and toward home and community based services, this population will have increased needs as they age and require residential healthcare services.

Increased Access to Healthcare Insurance

Slow improvement in the national economy will increase employment numbers through 2018. The mandates under the PPACA which improve access to affordable healthcare coverage, as well as though requiring employers to offer healthcare benefits to full-time employees will increase the number of individuals having private health insurance coverage. This will result in a slight improvement in the demand for long-term care services by those having private forms of healthcare coverage although the volume will still remain considerably below those individuals covered by Medicare and Medicaid.

Per Capita/Median Household Income

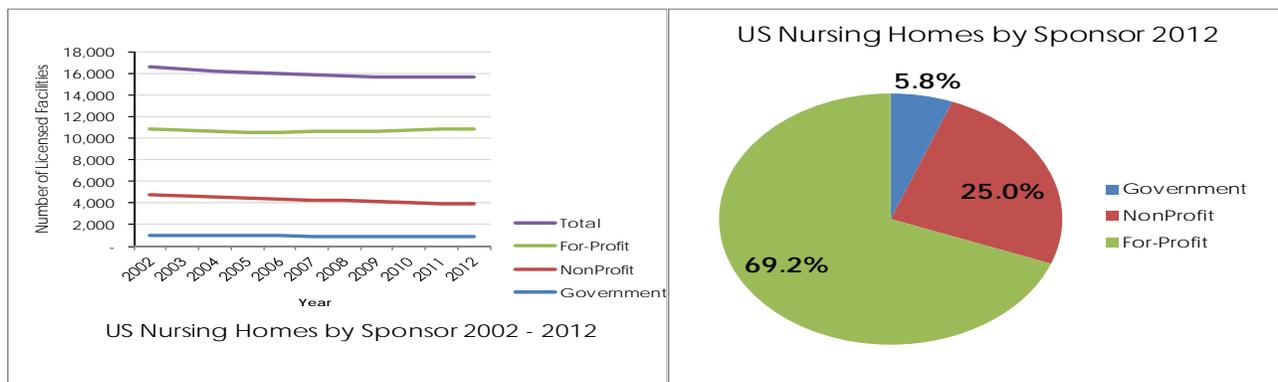
Improvement in the general economy is expected to also increase the amount of median and per capita household income as wages adjust to labor market supply and demand forces and corporate profitability. Generally, as consumer income increases, consumer spending is also likely to increase as persons are able to afford to purchase additional goods and services. These factors imply that more families will be able to afford to contribute toward in-home or residential services for aging family members.

As indicated in the overview of this report, the healthcare industry at the national level has been under increased pressure to reduce national healthcare spending, improve clinical outcomes and quality of care. In order to accomplish these objectives, the overall delivery system of which the long-term care industry has been an increasingly important component, must improve both its effectiveness and efficiency of operation. To further complicate matters, changes in attitudes among the population nationally have resulted in baby-boomer and post-baby boomer generations being more highly educated, informed and demanding of more patient centric environments in which to receive care at all levels including the post-acute and long-term settings.



As noted by provider associations and independent researchers, increased pressure to improve care and reduce cost, evidence based medical practices and improvements in medical innovation have led to a bifurcation of the traditional nursing home services into a long-term and short-term component servicing distinct populations with each having different needs and requiring different services. To ensure the highest quality, most cost effective patient centered care, the transition from an acute setting through post-acute care and ideally, discharge to the community should be coordinated, seamless and appropriate for the patient, as well as the providers involved in the individual's care. Likewise, the coordination of admissions into long-term care services from the community should be equally well coordinated and appropriate to the individual's needs. However, due to the fragmentation of the existing healthcare delivery system in the U.S., seamless and appropriate transitioning has not been fully accomplished on a consistent basis. Current and future initiatives implemented at the regulatory, industry and provider levels are aimed at improving quality and clinical outcomes and reduce cost in a coordinated and seamless environment that promotes patient engagement, satisfaction and quality of life.

Industry analysts believe there will continue to be downward pressure on reimbursements to providers in all settings with incentives provided for improvements in quality, clinical effectiveness and coordination of care. Provisions of the Patient Protection and Affordable Care (PPACA), commonly referred to as “Obama-Care” have specific incentives for cost reduction and quality improvement as part of its value-based purchasing and pay-for-performance provisions with reward providers for improving quality and care coordination while reducing the cost of care. Provisions for the establishment of managed Medicare and Medicaid programs, eligibility coordination of services and coverage for individuals dually eligible for Medicare and Medicaid coverage and the establishment of Accountable Care Organizations and Primary Care Medical Homes are a few of the major PPACA provisions that will require providers to assess their current operational strategies to insure viability under the evolving changes in the environment.



As reimbursement methodologies changed from pure cost based models during the industry’s infancy of the 1960’s and early 1970’s to the prospective payment and bundled payment methodologies of the mature industry from the mid-1990’s forward, providers have been forced to become more operationally effective in order to ward off profit margin compression resulting from flat or declining reimbursement streams and the escalating costs of the traditional nursing home care model as trends in reimbursement became tied to severity of illness and acuity of care.

In addition to the reductions in reimbursement, the 2002 U.S. Supreme Court decision *Olmstead v. LC* mandated governments and providers to take appropriate steps to place individuals in the least restrictive and most integrated care setting appropriate to the patient’s needs in compliance with the Americans with Disabilities Act (ADA). This decision has led to the increase in funding for home and community based service programs which include home care, adult care facilities, and independent and assisted living programs, adult day care, supportive housing, as well as other congregate living settings. As a result, new alternatives have entered the market and compete for patients that would have previously been admitted to nursing homes for custodial care.

Nursing home providers have taken a number of steps to counter-act the complexities being faced in the evolving long-term care market. To gain increasing economies of scale along the value chain, for-profit and larger non-profit organizations have continued to acquire smaller independent, stand-alone facilities and have developed affiliations or mergers with other healthcare providers. Providers have also taken steps to reduce cost and improve operational efficiency in order offset downward forces on reimbursement and increased competition from home and community based service providers. Providers have also recognized the need to differentiate themselves through amenities and services that are needed or desired by consumers and them more attractive to the consuming public. Providers have for example, improved accommodations, facility appearance, consumer oriented social activities and conveniences such as internet connectivity and café style meal services. Although a number of these changes have been an attempt to attract the younger short-stay population, others have been centered around Alzheimer’s and dementia care programs and programs for the rehabilitation and care of persons with multiple chronic conditions.

Reductions in reimbursement and movement to managed care payment systems by third party payers such as Medicare and Medicaid have resulted in steps to reduce cost and gain operational efficiency, however increases in the acuity level of patients has resulted in upward pressure on cost due to the necessity for more expensive medications, supplies and a skilled workforce. The implementation of value based purchasing by Medicare and other payers, has necessitated that providers continually assess and improve quality or face additional “penalty” reductions in reimbursement for services. Similarly, low or poor quality may also result in the poor quality provider being unable to contract with third-party payers as part of the payer’s network of providers. Equally as bad, they may find that hospitals and other referral sources no longer refer patients due to the long-term care provider’s low quality scores and lower value associated with such services by consumers.

To ensure compliance with federal and state regulations and to protect residents of nursing facilities, nursing homes undergo annual inspections by the state and CMS appointed surveillance agency. Generally, the state which licenses the facility delegates this responsibility to one of its own health or inspection agencies within the state government or allows the provider to contract with a third party that is approved by CMS to perform inspections on behalf of CMS. In an attempt to assist consumers making long-term care decisions and to provide transparency with respect to results of annual inspections, most states and CMS provide websites that report comparative results of federal and state inspections.

As indicated by the tables above, the number of nursing homes nationally has decreased from 16,560 in 2002 to approximately 15,672 in 2012 or a decrease of approximately 5.4% for the period. Government sponsored nursing homes declined by an estimated 102 facilities over the period or 10.1% and Non-Profit facilities declined by 800 facilities or 16.9%. For-profit facilities increased by 22 facilities or less than .2% during the same period.

Long-Term Care Industry – New York State

BROOME COUNTY MARKET

Broome County

Broome County is located in the central southern-tier region of New York State bordering the New York State counties of Chenango to the north, Delaware County to the east and Tioga and Cortland Counties to the west and northwest, respectively. To the south, Broome County borders the Pennsylvania counties of Wayne to the southeast and Susquehanna County to the south. Broome County covers an area of approximately 715 square miles with a population density of approximately 280.6 residents per square mile base on U.S. Census estimates. The County has approximately 18 municipalities composed of the City of Binghamton; 16 towns and 7 villages.

Municipalities	
Cities	
Binghamton	
Towns	Villages
Barker	Deposit
Binghamton	Endicott
Chenango	Johnson City
Colesville	Lisle
Conklin	Port Dickinson
Dickinson	Whitney Point
Fenton	Windsor
Kirkwood	
Lisle	
Maine	
Nanticoke	
Sanford	
Triangle	
Union	
Vestal	
Windsor	

Municipality Populations Over 65 Years of Age

		Total		65 years and over		75 years and over		AGE 85 years and over	
		Population	Margin of Error	%	Margin of Error	%	Margin of Error	%	Margin of Error
United States		306,603,772	*****	5.20%	+/-0.1	4.30%	+/-0.1	1.70%	+/-0.1
New York		19,302,448	*****	4.90%	+/-0.1	4.50%	+/-0.1	2.00%	+/-0.1
Broome County		200,448	*****	5.10%	+/-0.1	5.80%	+/-0.1	2.70%	+/-0.2
Barker	Town	2,739	+/-46	5.70%	+/-1.5	3.50%	+/-1.4	0.80%	+/-0.6
Binghamton	City	47,313	+/-32	3.30%	+/-0.9	6.40%	+/-0.8	3.20%	+/-0.5
Binghamton	Town	4,934	+/-18	6.50%	+/-1.7	4.10%	+/-2.0	2.60%	+/-1.1
Chenango	Town	11,261	+/-38	7.60%	+/-1.5	5.60%	+/-1.1	1.60%	+/-0.8
Colesville	Town	5,244	+/-18	6.50%	+/-3.9	5.30%	+/-3.6	1.10%	+/-1.0
Conklin	Town	5,479	+/-18	8.30%	+/-3.2	4.40%	+/-2.1	0.50%	+/-0.6
Dickinson	Town	5,302	+/-26	1.50%	+/-3.3	6.20%	+/-2.7	4.90%	+/-1.5
Fenton	Town	6,676	+/-35	9.30%	+/-2.7	5.90%	+/-1.8	1.10%	+/-0.8
Kirkwood	Town	5,837	+/-32	8.50%	+/-1.7	4.00%	+/-2.0	2.20%	+/-1.2
Lisle	Town	2,734	+/-26	4.30%	+/-3.5	3.70%	+/-2.2	1.10%	+/-0.7
Maine	Town	5,365	+/-25	5.20%	+/-2.4	4.90%	+/-2.0	1.30%	+/-0.9
Nanticoke	Town	1,539	+/-138	7.70%	+/-2.4	3.00%	+/-1.6	1.00%	+/-0.7
Sanford	Town	2,545	+/-141	8.90%	+/-2.8	5.80%	+/-1.7	1.10%	+/-0.9
Triangle	Town	2,952	+/-19	7.10%	+/-2.6	3.70%	+/-1.8	2.40%	+/-1.1
Union	Town	56,233	+/-50	4.70%	+/-0.7	6.00%	+/-0.6	3.50%	+/-0.4
Vestal	Town	28,011	+/-26	4.40%	+/-1.2	6.80%	+/-1.0	2.70%	+/-0.7
Windsor	Town	6,284	+/-31	6.90%	+/-3.1	4.00%	+/-1.7	2.00%	+/-1.0

Projected Nursing Home Populations

ESTIMATED PREVALENCE OF PERSONS RESIDING IN NURSING HOMES
United States,

	Current Number of Persons in Nursing Homes and Total Population Estimates						Rate per 1,000 Population by Age		
	United States		New York		Broome		United States	New York	Broome
	In NH	Tot Pop	In NH	Tot Pop	In NH	Tot Pop	In NH	In NH	In NH
Total:	1,502,264	308,745,538	116,558	19,378,102	1,753	200,600	4.87	6.01	8.74
Male:	500,185	151,781,326	40,463	9,377,147	452	98,373	3.30	4.32	4.59
Under 20 years	-	42,592,593	-	4	-	3	-	-	-
20 to 24 years	6,847	11,014,176	637	712,002	2	9,415	0.62	0.89	0.21
25 to 29 years	5,591	10,635,591	681	680,203	-	6,402	0.53	1.00	-
30 to 34 years	5,168	9,996,500	568	629,759	10	5,329	0.52	0.90	1.88
35 to 39 years	6,009	10,042,022	471	613,775	3	5,061	0.60	0.77	0.59
40 to 44 years	9,074	10,393,977	720	663,333	2	5,982	0.87	1.09	0.33
45 to 49 years	15,750	11,209,085	1,223	709,523	5	7,365	1.41	1.72	0.68
50 to 54 years	23,711	10,933,274	1,753	687,779	11	7,828	2.17	2.55	1.41
55 to 59 years	30,965	9,523,648	2,545	591,847	14	6,730	3.25	4.30	2.08
60 to 64 years	36,308	8,077,500	2,989	500,359	25	5,622	4.49	5.97	4.45
65 to 69 years	41,819	5,852,547	3,528	352,255	33	3,961	7.15	10.02	8.33
70 to 74 years	46,995	4,243,972	4,001	258,616	47	3,172	11.07	15.47	14.82
75 to 79 years	60,138	3,182,388	4,813	200,049	50	2,619	18.90	24.06	19.09
80 to 84 years	77,712	2,294,374	6,184	150,993	85	2,119	33.87	40.96	40.11
85 years +	134,098	1,789,679	10,350	122,622	165	1,680	74.93	84.41	98.21
Female:	1,002,079	156,964,212	76,095	10,000,955	1,301	102,227	6.38	7.61	12.73
Under 20 years	-	-	-	31	-	34	-	-	-
20 to 24 years	4,845	10,571,823	586	698,933	-	8,535	0.46	0.84	-
25 to 29 years	3,383	10,466,258	549	699,974	-	6,051	0.32	0.78	-
30 to 34 years	3,565	9,965,599	366	649,401	6	5,202	0.36	0.56	1.15
35 to 39 years	4,189	10,137,620	316	640,349	6	5,116	0.41	0.49	1.17
40 to 44 years	6,568	10,496,987	443	692,560	4	6,052	0.63	0.64	0.66
45 to 49 years	11,566	11,499,506	798	749,240	7	7,600	1.01	1.07	0.92
50 to 54 years	17,735	11,364,851	1,234	732,149	10	7,943	1.56	1.69	1.26
55 to 59 years	24,793	10,141,157	1,761	645,561	15	6,830	2.44	2.73	2.20
60 to 64 years	33,562	8,740,424	2,425	565,901	23	6,019	3.84	4.29	3.82
65 to 69 years	45,411	6,582,716	3,330	420,956	51	4,596	6.90	7.91	11.10
70 to 74 years	63,085	5,034,194	4,623	328,775	60	3,939	12.53	14.06	15.23
75 to 79 years	105,321	4,135,407	7,630	274,758	144	3,527	25.47	27.77	40.83
80 to 84 years	177,619	3,448,953	13,129	240,667	214	3,274	51.50	54.55	65.36
85 years +	500,437	3,703,754	38,905	268,252	761	3,957	135.12	145.03	192.32
Total	1,502,264	308,745,538	116,558	19,378,102	1,753	200,600	4.87	6.01	8.74
Under 20 years	-	42,592,593	-	34	-	36	-	-	-
20 to 24 years	11,692	21,585,999	1,223	1,410,935	2	17,950	0.54	0.87	0.11
25 to 29 years	8,974	21,101,849	1,230	1,380,177	-	12,453	0.43	0.89	-
30 to 34 years	8,733	19,962,099	934	1,279,160	16	10,531	0.44	0.73	1.52
35 to 39 years	10,198	20,179,642	787	1,254,124	9	10,177	0.51	0.63	0.88
40 to 44 years	15,642	20,890,964	1,163	1,355,893	6	12,034	0.75	0.86	0.50
45 to 49 years	27,316	22,708,591	2,021	1,458,763	12	14,965	1.20	1.39	0.80
50 to 54 years	41,446	22,298,125	2,987	1,419,928	21	15,771	1.86	2.10	1.33
55 to 59 years	55,758	19,664,805	4,306	1,237,408	29	13,560	2.84	3.48	2.14
60 to 64 years	69,870	16,817,924	5,414	1,066,260	48	11,641	4.15	5.08	4.12
65 to 69 years	87,230	12,435,263	6,858	773,211	84	8,557	7.01	8.87	9.82
70 to 74 years	110,080	9,278,166	8,624	587,391	107	7,111	11.86	14.68	15.05
75 to 79 years	165,459	7,317,795	12,443	474,807	194	6,146	22.61	26.21	31.57
80 to 84 years	255,331	5,743,327	19,313	391,660	299	5,393	44.46	49.31	55.44
85 years +	634,535	5,493,433	49,255	390,874	926	5,637	115.51	126.01	164.27

Source: U.S. Census Bureau, 2010 Census.

Market Capacity - Nursing Homes and Alternatives

Currently Broome County has eleven nursing homes within the county borders, all of which are within 11.58 miles from the current Willow Point Nursing Home Location. Additionally, one additional facility, Riverview Manor Health Care Center located in the Town of Owego in Tioga County is also within the 25 mile radius of Willow Point and provides services to Tioga, Broome and surrounding counties. Total nursing home beds in the market area total 1,634 which includes 12 special purpose Ventilator patient beds at the Bridgewater Center for Rehabilitation and Nursing in Binghamton. Willow Point's 300 certified beds make up 18.5% of the 1,622 traditional nursing home beds in the market area as indicated in the following Table.

Nursing Homes in the Willow Point Competitive Market						
Facility	Miles	City/Town	County	Beds		
				NH	Vent	Total
Broome County:						
Willow Point Nursing Home	-	Vestal	Broome	300		300
Jame G. Johnson Memorial Nursing Home	5.2	Johnson City	Broome	120		120
Susquahanna Nursing & Rehabilitation Center	5.3	Johnson City	Broome	160		160
Vestal Park Nursing Home and Rehabilitation Center	5.3	Vestal	Broome	60		60
Absolut Center for Nursing and Rehabilitation at Endicott (formerly The Waters)	6.46	Endicott	Broome	160		160
Good Shepard Village at Endwell	6.46	Endwell	Broome	32		32
Ideal Senior Living Center	6.46	Endicott	Broome	150		150
UHS - Binghamton General Transitional Care Unit	7.29	Binghamton	Broome	20		20
Bridgewater Center for Rehabilitation & Nursing (formerly River Mede HCRN)	8.56	Binghamton	Broome	369	12	381
Elizabeth Church Manor Nursing Home	8.56	Binghamton	Broome	120		120
Good Shepard Fairview Home	11.58	Binghamton	Broome	54		54
Total Facilities within Broome County = 11				1,545	12	1,557
Tioga County:						
Riverview Manor Health Care Center	11.88	Owego	Tioga	77		77
Total Facilities within 25 miles of Willow Point NH = 12				1,622	12	1,634

Long-Term Care Alternatives

The trends in long-term care services since the early 2000's has been away from traditional institutionalized care initially in response to the Olmstead decision and compliance with the American's with Disabilities Act (ADA) that promotes placement of individual's in the least restrictive and most fully integrated setting which meets the needs of the person's safety, welfare and medical need. Additionally, more recent pressure to minimize the cost associated with those need long-term care services has resulted in expansion of lower cost alternative Home and Community Based Services which now compete for certain portions of the once traditional nursing home population.

Alternative setting of care can be residential in nature or can be supportive services provided to the resident in their own home utilizing informal care-givers such as relatives and friends or more formal external supports such as home care agencies and adult day care programs. Residential programs include subsidized housing for the elderly and disabled, adult care facilities, assisted living programs among others depending upon the individual's level of independence typically measured by the assistance each individual requires with respect to Activities of Daily Living (ADL). Activities of daily living include: ambulation, dressing, bathing, toileting and eating. The more assistance an individual needs with respect to these activities generally results in that person requiring a higher level of care. It is for this reason that alternatives to nursing home care are not always a perfect substitute for medically necessary nursing home care.

Our survey of the Broome market area services available to seniors which could provide potential alternatives for those with lower care needs resulted in the identification of the alternatives presented in the following table and where available the capacity of each.

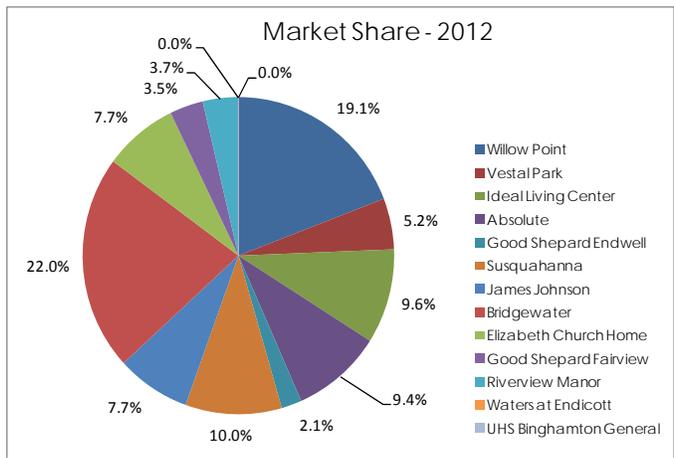
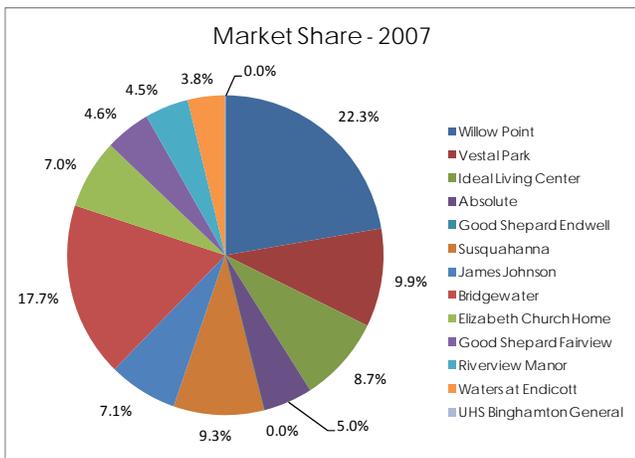
Other Broome County Nursing Home Alternative and Complementary Services		
Program	Capacity	
Residential		
Assisted Living	364	Beds
Adult Care	320	Beds
Adult Day Health Care	101	/Slots
Homecare Agencies		
Certified (Medicare)	2	Agencies
Long-Term	2	Agencies
Licensed/HHA - In County	14	Agencies
Licensed/HHA - Out of County	10	Agencies
Subsidized Housing Units	1,863	Units

Although the preceding services are not perfect complements to nursing homes, their existence and ability to care for members of the current nursing home population requiring lower levels of care have the capability reducing market demand for nursing home residents in the short and long-term.

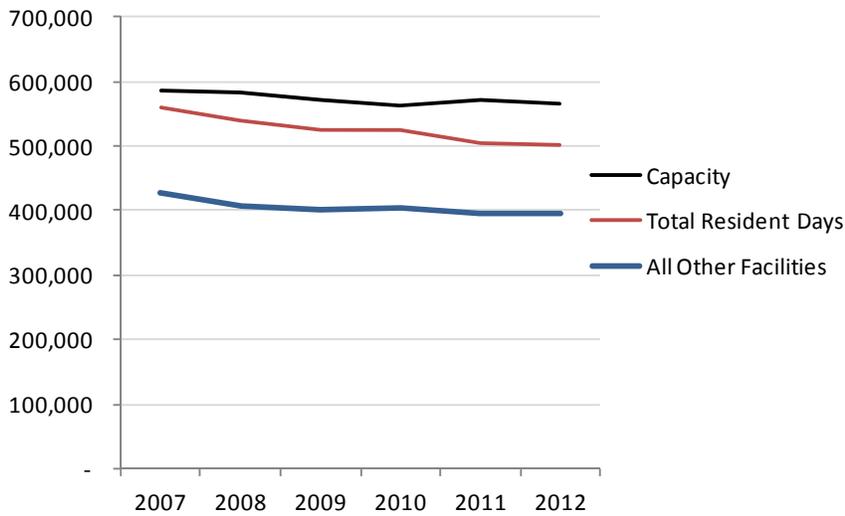
Structural Capacity of the Market

In order to identify Willow Point's historical and current market position and determine the level of competitive rivalry in the market we looked at both market share based on patient days, as well as overall market concentration of the competitors.

In the graphic below we can see the downward shift in overall market capacity from 1,789 beds providing a potential 652,985 available days of care in 2007 as compared to 1,699 licensed beds with a capacity of 620,135 resident days available in 2012. This reduction in market capacity was the result of voluntary facility downsizing in the market and also includes mandatory facility right-sizing under the 2007 Berger Commission recommendations. As can be seen in the illustration, even at current reduced market levels excess capacity exists in the market. Also, we can see the impact of Willow Point in the overall number of resident days provided over the period.

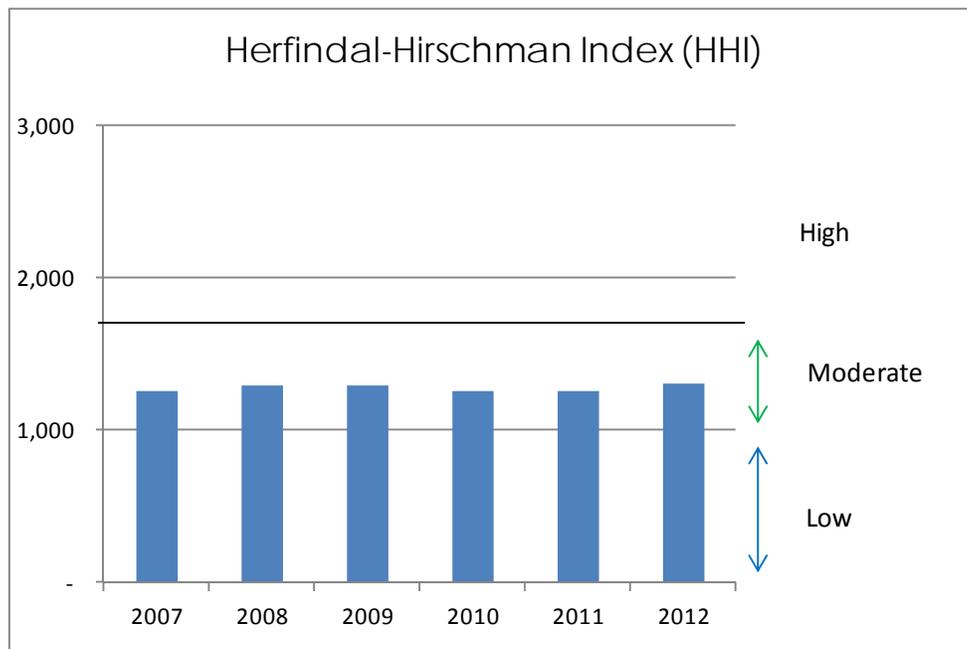


Broome Nursing Home Market Capacity and Resident Days



MARKET CONCENTRATION

To better understand the concentration or market power of the nursing homes competing within the Broome County market area we computed the Herfindal-Hirschman Index (HHI) which is an indicator of the strength of market competition between rival firms in a market. The HHI is developed by aggregating the squared relative market shares for each firm in a market. Markets with an HHI of less than 1,000 are considered to be un-concentrated suggesting an opportunity for new entrants to enter the market and gain market share. HHI scores between 1,000 and 1,800 are considered to be moderately concentrated and also provide the potential for new market competitors. HHI's that are over 1,800 indicate a highly concentrated market which would be difficult for new competitors to enter. The Broome market had an HHI of approximately 1,300 that is indicative of a moderately concentrated market that would be a potential opportunity for new entrants with a well developed strategy to enter based on data for 2012. This also suggests that existing competition in the market is not aggressive and it would be to the beneficial for Willow Point to be more aggressive in pursuing additional market share.



NEW YORK STATE BED NEED METHODOLOGY

The New York State Department of Health developed a new need methodology in 1989 for the purpose of determining the required regional resources necessary to properly service medically necessary demand for nursing home beds in the state (§ 709.3 10NYCRR). This methodology with adaptations to accommodate industry best practices, changes in federal and state legislation and other significant events impacting the delivery of care to the elderly and disabled such as the landmark 1999 *Olmstead v. Law* (527 U.S. 581 (1999)) has been utilized by the State to determine RHCf bed need for years beginning 1993 forward.

The latest bed need projections developed by New York State for the year 2016 utilize 2006 U.S. Census data and NYS DOH RHCf Cost Report data to develop normative utilization statistics to project regional need by county. The state methodology develops normative population need estimates for nursing homes, community based services and supportive housing based on both statewide and local (county) history rates of usage for these services. The historical normative rates are then applied against population projections. As seen in previous sections, utilization of services is often different at the national, regional, state and local levels.

There is considerable consensus in the industry that given improvements in medicine, technology, industry knowledge and the availability of alternatives that national rates of nursing home usage will remain relatively consistent or decline slightly despite increases in the aging population over the next 30 years. The utilization rate of nursing homes per 1,000 residents in the population in New York State based

on 2010 census data was 6.01 per thousand compared to 4.87 per thousand nationally. More significantly the rate per thousand in Broome County for the same year was estimated 8.74 residents per thousand total county residents. In order to adjust for downward trends in utilization NY State utilized a blended rate of utilization which combined statewide usage rates with rates calculated at the local level. The calculation of the 2016 Nursing Bed Need for Broome County and New York State is shown in the table below. Based on the New York State Department of Health calculation, Broome County has estimated excess capacity of approximately 208 beds as projected for the year 2016.

Although the NYS DOH need estimate provides a reasonable projection for Broome County Nursing Home beds through 2016, projections based on local, state and national trends through 2040 suggest a need closer to the market's current capacity, particularly for periods after 2030. This is primarily due to the increasing elderly female population in the Broome County market.

COMPARISON OF BROOME COUNTY BED NEED PROJECTIONS 2015 - 2040

	2015	2020	2025	2030	2035	2040	
County Population Est.	200,018	199,743	199,053	197,582	195,375	192,835	
Estimated Need Utilizing 2010 U.S. Census Data							
National	1,360	1,358	1,392	1,464	1,556	1,618	
State	1,547	1,550	1,588	1,666	1,763	1,826	
Broome	1,769	1,773	1,825	1,918	2,046	2,130	
Average	1,559	1,560	1,602	1,682	1,789	1,858	
Estimated Growth Rates							
National		-0.1%	2.5%	5.1%	6.3%	4.0%	3.6%
State		0.2%	2.5%	4.9%	5.9%	3.5%	3.4%
Broome		0.2%	2.9%	5.1%	6.7%	4.1%	3.8%
NYS DOH 2016 Need	1,380	1,427	1,475	1,526	1,577	1,631	
		Projected					

New York State Calculation of Estimated 2016 Need

	STATE	BROOME
Current RHCf Capacity	115,718	1,705
RHCf Planned Bed Additions	267	-
RHCf Planned Bed Reductions	(2,131)	(117)
Adjusted Existing Capacity	113,854	1,588
Estimated RHCf 2016 Need	121,350	1,380
Revised Ch 58 ALP Adjustment	(6,000)	-
Estimated Adjusted 2016 Need	115,350	1,380
Resources Under (Over) 2016 Need	1,496	(208)

Broome County / Binghamton MSA Largest Employers

Rank	Company	Local Employment	Sector	NAICS
1	Binghamton University	5,493	Government / Educational Services	-
2	United Health Services	5,428	Health Care	621/622
3	Lockheed Martin*	2,700	Manufacturing	334
4	Broome County Government	2,500	Local Government	-
5	Lourdes Hospital	2,311	Health Care	622
6	New York State Government	2,034	State Government	-
7	Broome Developmental Center	1,400	Social Assistance	624
8	BAE Systems	1,300	Manufacturing	334
9	Endicott Interconnect Technologies	1,100	Manufacturing	334
10	Maines Paper and Food Service	1,100	Wholesale Trade	424
11	Broome-Tioga BOCES	1,049	Local Government	-
12	NBT Bank	1,039	Financial Services	522
13	IBM	1,000	Manufacturing	334
14	Weis Markets	1,000	Retail Trade	445
15	Sanmina*	1,000	Manufacturing	334
16	NYSEG	800	Utilities	221
17	Wegmans	774	Retail Trade	445
18	Universal Instruments	700	Manufacturing	333
19	United Methodist Homes	621	Health Care	623
20	Frito-Lay	540	Manufacturing	311
21	Nationwide Credit Inc.	500	Financial Services	522
22	TimeWarner	500	Information	517
23	Broome Community College	454	Government / Educational Services	-
24	Country Valley Industries, Inc.	383	Social Assistance	624
25	MATCO Electric Corporation	350	Construction	238
26	Willow Run Foods	350	Wholesale Trade	424
27	National Pipe & Plastics, Inc.	350	Manufacturing	326
28	Security Mutual Life Insurance	330	Financial Services	524
29	Modern Marketing Concepts, Inc.	300	Professional and Technical Services	5416
30	Endicott Precision	130	Manufacturing	332
31	Innovation Associates	130	Professional and Technical Services	5413
32	Johnson Outdoors	130	Manufacturing	339
33	L-3 Communications (LinkSimulation and Training)	115	Manufacturing	333
34	Endicott Research Group, Inc.	100	Manufacturing	334
Total Jobs - Major Employers		38,011		
Total Jobs - Broome County MSA		103,098		

Willow Point
624 Employees

There are 3 primary acute care hospitals that service the Broome County market and act as referral sources for patients to the nursing homes in the Broome market area as depicted in the following table.

Hospitals Within 25 Miles of Willow Point

Hospital	Facility	Dist (mi.)	City	Zip
Our Lady of Lourdes Memorial Hospital Inc	A	2.7	Binghamton	13905
United Health Services Hospitals Inc. - Binghamton General Hospital	B	3.7	Binghamton	13903
United Health Services Hospitals Inc. - Wilson Medical Center	C	2.5	Johnson City	13790

Service	Beds by Service Line			Total
	A	B	C	
Medical / Surgical	194	86	190	470
Coma Recovery		1		1
Coronary Care			16	16
Intensive Care	12	8	12	32
Physical Medicine and Rehabilitation		24		24
Transitional Care				0
Traumatic Brain Injury		5		5
Maternity	25		34	59
Pediatric	11		14	25
Neonatal Continuing Care			2	2
Neonatal Intensive Care			6	6
Neonatal Intermediate Care			6	6
Psychiatric		20		20
Chemical Dependence - Rehabilitation		20		20
Total Beds	242	164	280	686

Source: NYS Department of Health Physician Profiles. <http://hospitals.nyhealth.gov>. April 7, 2014

We can see from the follow series of tables that approximately 3,612 discharges or 12.1% of the total hospital discharges in the Broome market area during 2012 were made to skilled nursing facilities as reported to the NY State Statewide Planning and Research Cooperative System (SPARCS). Further, upon examination of the data we note that discharges to skilled nursing facilities is relatively balanced based on the bed capacities of the hospitals such that Lourdes and UHS – Wilson each provide approximately 40% of the nursing home discharges and UHS – Binghamton General provides the remaining 20%.

We can also see that the top 10 Diagnosis Related Groups associated with nursing homes has remained relatively unchanged between 2011 and 2012.

Hospital Discharges by Disposition

2012

Discharged To	Lourdes		UHS - BG		UHS WMC		Total	
	Disch	Pct	Disch	Pct	Disch	Pct	Disch	Pct
Home or Self Care	7,860	70.2%	2,862	58.7%	9,818	71.2%	20,540	68.8%
Skilled Nursing Home	1,430	12.8%	745	15.3%	1,438	10.4%	3,613	12.1%
Home w/ Home Health Services	1,106	9.9%	699	14.3%	1,461	10.6%	3,266	10.9%
Expired	287	2.6%	103	2.1%	396	2.9%	786	2.6%
Short-term Hospital	219	2.0%	55	1.1%	101	0.7%	375	1.3%
Left Against Medical Advice	95	0.8%	139	2.9%	127	0.9%	361	1.2%
Inpatient Rehabilitation Facility	43	0.4%	52	1.1%	237	1.7%	332	1.1%
Psychiatric Hospital or Unit of Hosp		0.0%	111	2.3%	39	0.3%	150	0.5%
Hospice - Home	63	0.6%	12	0.2%	69	0.5%	144	0.5%
Hospice - Medical Facility	51	0.5%	2	0.0%	50	0.4%	103	0.3%
Cancer Center or Children's Hospital	17	0.2%	72	1.5%	9	0.1%	98	0.3%
Medicare Cert Long Term Care Hospital	6	0.1%	2	0.0%	22	0.2%	30	0.1%
Facility w/ Custodial/Supportive Care	11	0.1%	3	0.1%	10	0.1%	24	0.1%
Federal Health Care Facility	8	0.1%	6	0.1%	7	0.1%	21	0.1%
Court/Law Enforcement		0.0%	10	0.2%	5	0.0%	15	0.1%
Hosp Basd Medicare Approved Swing Bed		0.0%	4	0.1%	5	0.0%	9	0.0%
Grand Total	11,196	100.0%	4,877	100.0%	13,794	100.0%	29,867	100.0%
Percent of Total Market Discharges	37.5%		16.3%		46.2%		100.0%	

% of Market Discharges to Nursing Home 39.6% 20.6% 39.8% 100.0%

Source: NYS Department of Health Physician Profiles. <https://health.data.ny.gov/developers/docs/hospital-inpatient-discharges-sparcs-de-identified-2012>. April 7, 2014

Ranking of Hospital Nursing Home Discharges by APR DRG

2012

DRG CODE	Diagnosis Related Group (DRG)	2011		2012	
		Disch	Rank	Disch	Rank
302	KNEE JOINT REPLACEMENT	217	3	248	1
720	SEPTICEMIA & DISSEMINATED INFECTIONS	262	1	234	2
301	HIP JOINT REPLACEMENT	241	2	224	3
463	KIDNEY & URINARY TRACT INFECTIONS	177	4	183	4
308	HIP & FEMUR PROCEDURES FOR TRAUMA EXCEPT JOINT REPLACEMENT	141	7	148	5
139	OTHER PNEUMONIA	151	6	142	6
194	HEART FAILURE	155	5	133	7
45	CVA & PRECEREBRAL OCCLUSION W INFARCT	100	8	105	8
460	RENAL FAILURE	97	9	89	9
190	ACUTE MYOCARDIAL INFARCTION	95	10	77	10
140	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	89	11	69	11
201	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS	51	15	65	12
137	MAJOR RESPIRATORY INFECTIONS & INFLAMMATIONS	73	12	64	13
383	CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS	59	13	64	14
347	OTHER BACK & NECK DISORDERS, FRACTURES & INJURIES	52	14	61	15
861	SIGNS, SYMPTOMS & OTHER FACTORS INFLUENCING HEALTH STATUS	43	18	51	16
133	PULMONARY EDEMA & RESPIRATORY FAILURE	-	-	49	17
860	REHABILITATION	-	-	49	18
351	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE DIAGNOSES	-	-	40	19
342	FRACTURES & DISLOCATIONS EXCEPT FEMUR, PELVIS & BACK	-	-	38	20
304	DORSAL & LUMBAR FUSION PROC EXCEPT FOR CURVATURE OF BACK	46	16	-	-
341	FRACTURE OF PELVIS OR DISLOCATION OF HIP	44	17	-	-
425	ELECTROLYTE DISORDERS EXCEPT HYPOVOLEMIA RELATED	39	19	-	-
204	SYNCOPE & COLLAPSE	36	20	-	-
221	MAJOR SMALL & LARGE BOWEL PROCEDURES	36	21	-	-

Insurers – Paying for Care and Quality

In general, Medicaid and Medicare are the predominant payers for nursing home services nationally. Due to the skyrocketing costs of institutionalized based services in the U.S. and the resultant burden on both the Medicaid and Medicare systems federal and state programs have been introduced to migrate participation in traditional fee-for-service Medicaid and Medicare to privately operated Medicaid and Medicare Health Maintenance Organizations. As a result, providers of nursing home and other healthcare services serving these populations will need to negotiate rates of payment directly with privately sponsored insurance plans offering managed Medicare and Medicare products, subject to federal and state guidelines. Consumers generally benefit from lower premium costs and case

management services provided by the HMO or Managed Medicare/Medicaid Long-Term Care Program (MMLTCP), however the consumers' available choice of providers may be limited based on providers included in the HMO's network.

BASIC NURSING HOME THIRD PARTY PAYER COVERAGES

	Hospital Stay Required	Coverage	Patient Responsibility
Medicare	Yes	100 days = 1st 20 days covered in full; remaining 80 days covered at 80%	20% of Medicare Covered Charges if Patient has no supplemental coverage or is not Medicaid Eligible
Medicaid	No	Unlimited as long as eligibility requirements are met	Must Spend Down Personal Financial Resources to meet eligibility guidelines; Contribution of Monthly Income from all sources less \$ 50.
Commercial	Varies	Varies - generally covers stays of 20 - 100 days or less per episode of care. Often with an annual or lifetime limitation.	Up to 100% of Non-Covered Charges if Patient has no supplemental coverage or is not Medicaid Eligible.

As evidenced in the following table, Medicare admissions in the Broome market declined from 76.2% in 2005 to 65.5% or approximately 14% between 2005 and 2012. By comparison, Willow Point's Medicare admissions declined from 78.2% to 60.3% or approximately 29.7% over the same time period. Medicaid admissions at facilities within the Broome market area declined from 11.6% in 2005 to 9.5% in 2012, or 22.1% in total for the period. Willow Points Medicaid admissions declined from 4.1% to 0% in 2009 and have remained at 0% through 2012 according to statistics reported to the NYS Department of Healthy by the facility.

PAYOR SOURCE AT TIME OF ADMISSION

	2005	2007	2008	2009	2010	2011	2012
Broome Marekt Area							
Medicare	76.2%	75.9%	77.4%	68.1%	67.9%	62.3%	65.5%
Medicaid	11.6%	7.9%	8.0%	8.6%	7.6%	12.4%	9.5%
Private/Other	12.2%	16.2%	14.6%	23.3%	24.4%	25.3%	25.1%
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Willow Point							
Medicare	78.2%	72.8%	79.8%	60.3%	56.8%	63.2%	60.3%
Medicaid	4.1%	8.0%	0.8%	0.0%	0.0%	0.0%	0.0%
Private/Other	17.8%	19.3%	19.4%	39.7%	43.2%	36.8%	39.7%
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

By contrast, we see an increase in private and commercial payer admissions in the market which increased approximately 205.7% from 12.2% in 2005 to 25.1% of total nursing home admissions in 2012. Likewise, Willow Point's admissions attributed to these payer sources increased by 223.0% over the same period from 17.8% in 2005 to 39.7% in 2012.

These changes in payer source from government payers such as Medicare and Medicaid to private payers, either individuals or commercial insurance carriers is indicative of the movement away from traditional government payers and emphasis on commercial and managed care payers.

Other Payers of Care

In addition to Medicare and Medicaid a variety of indemnity, self-funded, commercial and community sponsored insurers pay at least partially for short and long-term nursing home care. According to the New York State Insurance Department approximately 106 insurance carriers are approved to provide health insurance coverage. Recently, as part of the national movement to provide access to affordable health insurance coverage under the Affordable Care Act (ACA), CMS and individual states have developed "insurance exchanges" which enable individuals and employers to identify health insurance plans which best address their unique needs and circumstances. According to Healthy New York, the New York States insurance exchange, four health insurers are identified as providing health insurance coverage to individuals in Broome County, of which three also provide coverage for small business employers.

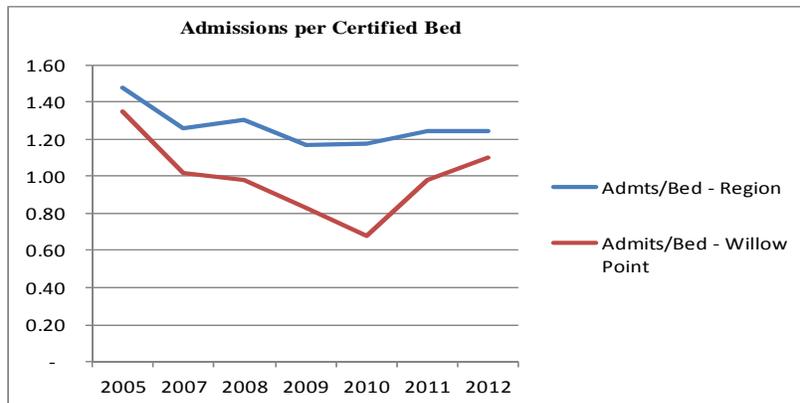
INSURANCE PLANS

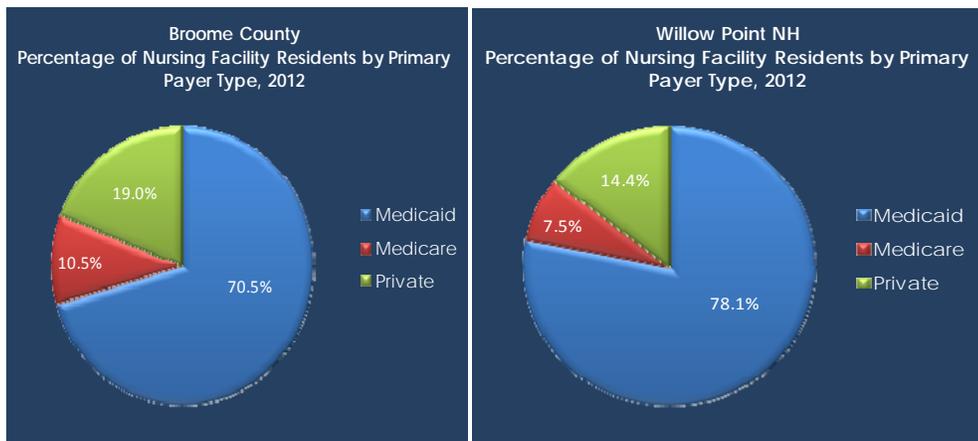
Commercial Health Insurance Plans Approved to Write Health Insurance in New York State

Accident and Health	36
Continuing Care Retirement Communities	11
Health Maintenance Organizations	24
Municipal Cooperative Health Benefit Plans	11
Dental Expense Indemnities (non profit)	1
Health Service Corporations (non profit)	9
Managed Long-Term Care	12
Medical Expense Indemnities	2
	106

Health Insurance Plans Listed on the NYS Health Insurance Exchange Providing Coverage in Broome County by Exchange Type

	Individual	Small Business
CDPHP	Y	Y
Excellus Blue Cross Blue Shield	Y	Y
MVP	Y	Y
Today's Options [American Progressive]	Y	N





SUPPLY SIDE – SUPPLIER POWER

Willow Point captured approximately 20.2% of the consumer demand for nursing home services in 2012 which is slightly better than the maximum market share which it could expect to capture at full market capacity given its bed size in relation to the market. By comparison, Willow Point's operations comprise 25.4% of the nursing home expenditures for labor, purchased services and supplies or approximately \$31.6 million of the Broome County market's \$124.6 million in aggregate nursing home operational spending.

Labor Market Force

Willow Point expended \$12.5 million in salaries in labor which represented 25.5% of the market's approximately \$49.1 million in expenditures for this category. The facility employed a reported 543 full and part-time employees which represented 29.6% of the County's nursing home labor force which was estimated to be approximately 1,836 persons during 2012. Further, the facility employed 83.0% or 543 of the County's 654 union nursing home workforce. The employees of the facility also represented approximately 21.7% of the estimated 2,500 CSEA workforce employed by the County. In addition to spending on salaries and wages, the facility also incurred \$9.6 million in related employee benefits which represented 52.2% of the total market spending for employee benefits by all facilities in the Broome service area.

WILLOW POINT - MARKET WORKFORCE IMPACT ON SUPPLIER POWER

	Willow Point		Other Facilities		Total Market	
	Employees	Mkt %	Employees	Mkt %	Employees	Mkt %
Labor - Union Employees by Category						
Service	344	79.1%	91	20.9%	435	100.0%
Maintenance	4	100.0%	-	0.0%	4	100.0%
Technical	20	100.0%	-	0.0%	20	100.0%
Clerical	28	100.0%	-	0.0%	28	100.0%
LPN	81	80.2%	20	19.8%	101	100.0%
RN	33	100.0%	-	0.0%	33	100.0%
Supervising Nurses	13	100.0%	-	0.0%	13	100.0%
Social Workers	5	100.0%	-	0.0%	5	100.0%
Other	15	100.0%	-	0.0%	15	100.0%
Total	543	83.0%	111	17.0%	654	100.0%
Employees by Status						
Full Time	366	27.8%	950	72.2%	1,316	100.0%
Part Time	177	31.2%	390	68.8%	567	100.0%
Casual		0.0%	115	100.0%	115	100.0%
Total	543	29.6%	1,293	70.4%	1,836	100.0%

The market as a whole expended approximately \$67.5 on salary and benefits or approximately 54.2% of the aggregate operational spending by nursing homes in the Broome market. In contrast, the facility

spent approximately 70.0% of its total expenditures on labor and benefits. Willow Point's salary and wages were 39.6% of its total operational expenditures which was comparable to remainder of the market which spent 39.3% on employee salary and wages. The major difference between the facility and the market relative spending on personnel related items was in the area of fringe benefits. Willow Point's employee benefit costs of \$9.6 million were 30.4% of total spending as compared the market's 14.9%.

Non-Labor Market Power

The Broome County nursing home market expended approximately \$57.1 million in non-labor costs in 2012 which represented approximately 45.8% of the estimated \$124.6 million total nursing home operating expenditures in the Broome service area. Willow Point reported and estimated \$ 9.5 in non-personnel and non-capital related operating expenditures which made up approximately 16.6% of the total market's expenditures for non-labor/non-capital expenditures. In comparison, non-labor expenditures account for approximately 30.0% of Willow Point's operating expenditures as compared to 51.2% for other facilities.

WILLOW POINT - MARKET IMPACT ON SUPPLIER POWER

	Willow Point	Mkt %	Other Facilities	Mkt %	Total Market	Mkt %
Salaries & Wages	\$12,527,301	25.5%	\$ 36,567,186	74.5%	\$ 49,094,487	100.0%
Phys Fees	136,620	26.1%	386,143	73.9%	522,763	100.0%
Employee Benefits	9,613,523	52.2%	8,798,828	47.8%	18,412,351	100.0%
Fees	106,827	1.1%	9,290,075	98.9%	9,396,902	100.0%
Supplies & Materials	1,941,023	18.5%	8,554,435	81.5%	10,495,458	100.0%
Purch & Contracted Svcs	2,429,122	11.8%	18,076,745	88.2%	20,505,867	100.0%
Other Direct	4,871,098	30.2%	11,272,119	69.8%	16,143,217	100.0%
Total Estimated Purchased Costs	<u>\$31,625,514</u>	<u>25.4%</u>	<u>\$ 92,945,531</u>	<u>74.6%</u>	<u>\$ 124,571,045</u>	<u>100.0%</u>
Total Reported Costs	<u>\$32,255,700</u>	<u>24.0%</u>	<u>\$ 101,987,421</u>	<u>76.0%</u>	<u>\$ 134,243,121</u>	<u>100.0%</u>
Potential Market Share at Full Market Capacity	<u>300</u>	<u>20.2%</u>	<u>1,183</u>	<u>79.8%</u>	<u>1,483</u>	<u>100.0%</u>
Actual 2012 Market Share	<u>105,969</u>	<u>22.0%</u>	<u>376,222</u>	<u>78.0%</u>	<u>482,191</u>	<u>100.0%</u>

Market Suppliers

As indicated in the following tables, the County of Broome is the 3rd largest supplier of purchased and contracted services in the market providing over \$ 1.8 million in services with respect to dietary, public works, information technology and administrative services which was 72.2% of Willow Point's total outlay for these expenditure categories. These services were provided solely to the County owned Willow Point Nursing Home. Included in the costs was approximately \$380,000 in County personnel services to Willow Point which ranked the County as the 7th largest supplier of personnel services to nursing homes in the Broome market. By comparison, UHS and Lourdes provided 1.7% and 1.3% of the fee based services in the market ranking them 10th and 16th respectively in this category. United Methodist/Good Shepherd Communities provided approximately \$4.1 million in purchased services to its related facilities ranking it as the second highest provider of contracted and purchased services in the market. Other market competitors, including UHS, Lourdes and Ideal Senior Living provided less than 1.0% of the total fees, contracted and purchased services in the market.

MARKET COMPETITION
Nursing Home Quality

<u>Nursing Home</u>	<u>1/1/2014 Rate (no capital)</u>	<u>Quintile Ranking</u>	<u>CMS 5 Star Ranking</u>	<u>7/2012 CMI</u>
Absolut at Endicott	174.24	5	1	1.0195
Bridgewater Center	179.63	4	1	0.9286
Elizabeth Church Manor	150.53	3	4	0.9316
Good Shepherd at Endwell	142.93	Excluded	3	0.7770
Good Shepherd Fairview Home	161.32	2	3	0.8488
Ideal Senior Living Center	149.60	3	2	0.9554
James G Johnston Memorial	161.83	3	5	1.0742
Susquehanna Nursing & Rehab	161.09	4	5	1.1486
Vestal Park Rehab	146.52	4	1	0.9686
Willow Point Nursing Home	175.42	J,K,L deficiency	1	0.8537

MARKET COMPARATIVES

WILLOW POINT



Willow Point Nursing Home

	Occupancy					
	2012		2011		2010	
		%		%		%
Beds	300		303		333	
Admissions	330		296		227	
Resident Days						
Medicaid	82,749	78.1	87,251	79.5	97,076	80.6
Medicare	7,936	7.5	9,101	8.3	9,805	8.1
Private	14,624	13.8	12,994	11.8	12,942	10.7
Other	660	0.6	391	0.4	571	0.5
Total	<u>105,969</u>	<u>100.0</u>	<u>109,737</u>	<u>100.0</u>	<u>120,394</u>	<u>100.0</u>

Occupancy % 96.5% 99.2% 99.1%

% of Market 19.9% 20.4% 21.8%

Location: 3700 Old Vestal Rd
 Vestal, NY
 Broome County

Year Built: 1990/Variou s

Acreage: 7.63

Gross Sq. Ft: 124,053

Rentable Sq. Ft: 159,264

	Financial					
	2012		2011		2010	
		<i>Per Diem</i>		<i>Per Diem</i>		<i>Per Diem</i>
Net Patient Revenue	\$ 21,455,851	202.47	\$ 21,502,689	195.95	\$ 24,183,280	200.87
Other Revenue	380,585	3.59	199,594	1.82	146,590	1.22
Total Revenue	<u>21,836,436</u>	<u>206.06</u>	<u>21,702,283</u>	<u>197.77</u>	<u>24,329,870</u>	<u>202.09</u>
Expense						
Admin & Support	17,910,768	169.02	15,364,340	140.01	14,007,471	116.35
Ancillary	1,784,895	16.84	1,895,426	17.27	1,967,284	16.34
Program Service	12,560,037	118.53	13,009,489	118.55	13,688,769	113.70
Total Operating Expense	<u>32,255,700</u>	<u>304.39</u>	<u>30,269,255</u>	<u>275.83</u>	<u>29,663,524</u>	<u>246.39</u>
Net Operating Profit	(10,419,264)	(98.32)	(8,566,972)	(78.07)	(5,333,654)	(44.30)
Other Income (Expense)	10,595,059	99.98	7,179,648	65.43	125,125	1.04
Net Profit (Loss)	<u>\$ 175,795</u>	<u>1.66</u>	<u>\$ (1,387,324)</u>	<u>(12.64)</u>	<u>\$ (5,208,529)</u>	<u>(43.26)</u>
EBITDA	<u>\$ (8,559,643)</u>	<u>(80.77)</u>	<u>\$ (6,498,076)</u>	<u>(59.21)</u>	<u>\$ (3,526,798)</u>	<u>(29.29)</u>

VESTAL PARK REHABILITATION AND NURSING CENTER



Vestal Park Rehabilitation And Nursing Center

	Occupancy					
	2012		2011		2010	
		%		%		%
Beds	180		180		180	
Admissions	110		245		221	
Resident Days						
Medicaid	21,269	73.7	33,813	70.9	40,769	68.4
Medicare	2,162	7.5	3,922	8.2	5,005	8.4
Private	5,046	17.5	8,192	17.2	10,715	18.0
Other	388	1.3	1,758	3.7	3,073	5.2
Total	<u>28,865</u>	<u>100.0</u>	<u>47,685</u>	<u>100.0</u>	<u>59,562</u>	<u>100.0</u>
Occupancy %	43.8%		72.6%		90.7%	
% of Market	5.4%		8.9%		10.8%	

Location: Opening New Location

Year Built:

Acreage:

Gross Sq. Ft:

Rentable Sq. Ft:

	Financial					
	2012		2011		2010	
		Per Diem		Per Diem		Per Diem
Net Patient Revenue	\$ 5,707,225	197.72	\$ 9,225,973	193.48	\$ 11,738,586	197.08
Other Revenue	13,479	0.47	29,724	0.62	31,798	0.53
Total Revenue	<u>5,720,704</u>	<u>198.19</u>	<u>9,255,697</u>	<u>194.10</u>	<u>11,770,384</u>	<u>197.62</u>
Expense						
Admin & Support	3,817,962	132.27	6,286,418	131.83	6,022,187	101.11
Ancillary	431,362	14.94	838,606	17.59	1,110,528	18.64
Program Service	2,384,898	82.62	3,649,220	76.53	4,457,167	74.83
Total Operating Expense	<u>6,634,222</u>	<u>229.84</u>	<u>10,774,244</u>	<u>225.95</u>	<u>11,589,882</u>	<u>194.59</u>
Net Operating Profit	(913,518)	(31.65)	(1,518,547)	(31.85)	180,502	3.03
Other Income (Expense)	-	-	(76,926)	(1.61)	(1,429,304)	(24.00)
Net Profit (Loss)	<u>\$ (913,518)</u>	<u>(31.65)</u>	<u>\$ (1,595,473)</u>	<u>(33.46)</u>	<u>\$ (1,248,802)</u>	<u>(20.97)</u>
EBITDA	\$ (371,964)	(12.89)	\$ (280,253)	(5.88)	\$ 1,109,387	18.63

UHS IDEAL SENIOR LIVING CENTER



Ideal Senior Living Center

Location: 601 High Ave
Endicott, NY
Broome County

Year Built: 1970

Acreage: 5.6

Gross Sq. Ft: 79,800

Rentable Sq. Ft: 96,480

	Occupancy					
	<u>2012</u>	<u>%</u>	<u>2011</u>	<u>%</u>	<u>2010</u>	<u>%</u>
Beds	150		150		150	
Admissions	169		163		173	
Resident Days						
Medicaid	40,806	76.4	41,982	78.7	41,397	78.5
Medicare	4,073	7.6	3,244	6.1	3,432	6.5
Private	8,368	15.7	8,007	15.0	7,537	14.3
Other	149	0.3	89	0.2	350	0.7
Total	<u>53,396</u>	<u>100.0</u>	<u>53,322</u>	<u>100.0</u>	<u>52,716</u>	<u>100.0</u>

Occupancy % 97.3% 97.4% 96.3%

% of Market 10.0% 9.9% 9.6%

	Financial					
	<u>2012</u>	<u>Per Diem</u>	<u>2011</u>	<u>Per Diem</u>	<u>2012</u>	<u>Per Diem</u>
Net Patient Revenue	\$ 13,384,033	250.66	\$ 13,510,172	253.37	\$ 12,591,127	238.85
Other Revenue	350,449	6.56	400,785	7.52	266,160	5.05
Total Revenue	<u>13,734,482</u>	<u>257.22</u>	<u>13,910,957</u>	<u>260.89</u>	<u>12,857,287</u>	<u>243.90</u>
Expense						
Admin & Support	6,802,674	127.40	6,622,812	124.20	6,711,941	127.32
Ancillary	605,727	11.34	596,983	11.20	596,868	11.32
Program Service	6,798,803	127.33	6,403,039	120.08	6,100,367	115.72
Total Operating Expense	<u>14,207,204</u>	<u>266.07</u>	<u>13,622,834</u>	<u>255.48</u>	<u>13,409,176</u>	<u>254.37</u>
Net Operating Profit	(472,722)	(8.85)	288,123	5.40	(551,889)	(10.47)
Other Income (Expense)	46,180	0.86	(21,131)	(0.40)	1,334,500	25.31
Net Profit (Loss)	<u>\$ (426,542)</u>	<u>(7.99)</u>	<u>\$ 266,992</u>	<u>5.01</u>	<u>\$ 782,611</u>	<u>14.85</u>
EBITDA	<u>\$ 1,102,129</u>	<u>20.64</u>	<u>\$ 1,802,940</u>	<u>33.81</u>	<u>\$ 984,885</u>	<u>18.68</u>

ABSOLUT CENTER FOR NURSING AND REHABILITATION AT ENDICOTT



Absolut Center for Nursing and Rehabilitation at Endicott

Location: 301 Nantucket
Endicott, NY
Broome County

Year Built: 1974

Acreage: 5.7

Gross Sq. Ft: 40,084

Rentable Sq. Ft: 72,369

	Occupancy					
	2012		2011		2010	
		%		%		%
Beds	160		160		160	
Admissions	114		130		111	
Resident Days						
Medicaid	44,182	84.9	44,442	85.6	47,573	85.8
Medicare	3,515	6.8	4,829	9.3	5,243	9.5
Private	3,483	6.7	2,236	4.3	2,128	3.8
Other	834	1.6	431	0.8	507	0.9
Total	<u>52,014</u>	<u>100.0</u>	<u>51,938</u>	<u>100.0</u>	<u>55,451</u>	<u>100.0</u>
Occupancy %	88.8%		88.9%		95.0%	
% of Market	9.8%		9.6%		10.1%	

	Financial					
	2012		2011		2012	
		<i>Per Diem</i>		<i>Per Diem</i>		<i>Per Diem</i>
Net Patient Revenue	\$ 10,555,426	202.93	\$ 12,190,239	234.71	\$ 10,073,392	181.66
Other Revenue	66,466	1.28	69,644	1.34	37,348	0.67
Total Revenue	<u>10,621,892</u>	<u>204.21</u>	<u>12,259,883</u>	<u>236.05</u>	<u>10,110,740</u>	<u>182.34</u>
Expense						
Admin & Support	6,520,055	125.35	6,512,330	125.39	6,582,328	118.71
Ancillary	697,397	13.41	757,912	14.59	705,788	12.73
Program Service	3,565,658	68.55	3,466,309	66.74	3,462,401	62.44
Total Operating Expense	<u>10,783,110</u>	<u>207.31</u>	<u>10,736,551</u>	<u>206.72</u>	<u>10,750,517</u>	<u>193.87</u>
Net Operating Profit	(161,218)	(3.10)	1,523,332	29.33	(639,777)	(11.54)
Other Income (Expense)	1,279	0.02	488	0.01	253	0.00
Net Profit (Loss)	<u>\$ (159,939)</u>	<u>(3.07)</u>	<u>\$ 1,523,820</u>	<u>29.34</u>	<u>\$ (639,524)</u>	<u>(11.53)</u>
EBITDA	<u>\$ 839,420</u>	<u>16.14</u>	<u>\$ 2,666,687</u>	<u>51.34</u>	<u>\$ 356,519</u>	<u>6.43</u>

GOOD SHEPARD VILLAGE AT ENDWELL



Good Shepard Village at Endwell

Location: 14 Village Drive
Endwell, NY
Broome County

Year Built: 2011

Acreage: 7.63

Gross Sq. Ft: N/A

Rentable Sq. Ft: N/A

	Occupancy					
	2012	%	2011	%	2010	%
 Beds 	32		32			
 Admissions 	31		48			
 Resident Days 						
 Medicaid 	3,540	30.5	2,676	23.7		
 Medicare 	834	7.2	1,000	8.8		
 Private 	7,154	61.7	7,523	66.6		
 Other 	75	0.6	104	0.9		
 Total 	<u>11,603</u>	<u>100.0</u>	<u>11,303</u>	<u>100.0</u>		
 Occupancy % 	99.1%		96.8%			
 % of Market 	2.2%		2.1%			

	Financial					
	2012	Per Diem	2011	Per Diem	2012	Per Diem
 Net Patient Revenue 	\$ 10,742,744	925.86	\$ 10,008,959	885.51		
 Other Revenue 	394,633	34.01	512,096	45.31		
 Total Revenue 	<u>11,137,377</u>	<u>959.87</u>	<u>10,521,055</u>	<u>930.82</u>		
 Expense 						
 Admin & Support 	10,462,398	901.70	10,507,455	929.62		
 Ancillary 	297,891	25.67	329,804	29.18		
 Program Service 	2,248,485	193.78	2,133,902	188.79		
 Total Operating Expense 	<u>13,008,774</u>	<u>1,121.16</u>	<u>12,971,161</u>	<u>1,147.59</u>		
 Net Operating Profit 	(1,871,397)	(161.29)	(2,450,106)	(216.77)		
 Other Income (Expense) 	398,852	34.37	(272,000)	(24.06)		
 Net Profit (Loss) 	<u>\$ (1,472,545)</u>	<u>(126.91)</u>	<u>\$ (2,722,106)</u>	<u>(240.83)</u>		
 EBITDA 	<u>\$ 2,654,290</u>	<u>228.76</u>	<u>\$ 2,082,040</u>	<u>184.20</u>		

GOOD SHEPARD FAIRVIEW HOME



Good Shepard Fairview Home

Location: 80 Fairview
Binghamton, NY
Broome County

Year Built: 1970

Acreage: 3.27

Gross Sq. Ft: 61,294

Rentable Sq. Ft: 61,294

	Occupancy					
	2012	%	2011	%	2010	%
Beeds	54		54		54	
Admissions	170		145		170	
Resident Days						
Medicaid	9,769	50.7	10,403	54.0	9,159	48.8
Medicare	4,842	25.1	4,168	21.6	4,476	23.8
Private	4,067	21.1	4,223	21.9	4,620	24.6
Other	582	3.0	480	2.5	527	2.8
Total	<u>19,260</u>	<u>100.0</u>	<u>19,274</u>	<u>100.0</u>	<u>18,782</u>	<u>100.0</u>
Occupancy %	97.4%		97.8%		95.3%	
% of Market	3.6%		3.6%		3.4%	

	Financial					
	2012	Per Diem	2011	Per Diem	2012	Per Diem
Net Patient Revenue	\$ 9,492,112	492.84	\$ 9,752,646	506.00	\$ 8,754,149	466.09
Other Revenue	176,122	9.14	139,961	7.26	264,078	14.06
Total Revenue	<u>9,668,234</u>	<u>501.99</u>	<u>9,892,607</u>	<u>513.26</u>	<u>9,018,227</u>	<u>480.15</u>
Expense						
Admin & Support	5,741,243	298.09	5,218,408	270.75	5,489,253	292.26
Ancillary	950,236	49.34	811,669	42.11	934,680	49.76
Program Service	3,333,491	173.08	3,620,490	187.84	3,329,017	177.25
Total Operating Expense	<u>10,024,970</u>	<u>520.51</u>	<u>9,650,567</u>	<u>500.70</u>	<u>9,752,950</u>	<u>519.27</u>
Net Operating Profit	(356,736)	(18.52)	242,040	12.56	(734,723)	(39.12)
Other Income (Expense)	277,949	14.43	206,340	10.71	273,167	14.54
Net Profit (Loss)	<u>\$ (78,787)</u>	<u>(4.09)</u>	<u>\$ 448,380</u>	<u>23.26</u>	<u>\$ (461,556)</u>	<u>(24.57)</u>
EBITDA	<u>\$ 451,948</u>	<u>23.47</u>	<u>\$ 1,112,524</u>	<u>57.72</u>	<u>\$ 88,517</u>	<u>4.71</u>

SUSQUEHANNA NURSING HOME & REHABILITATION CENTER



Susquehanna Nursing Home & Rehabilitation Center

Location: 282 Riverside Dr
Johnson City, NY
Broome County

Year Built: 1973

Acreage: 2.71

Gross Sq. Ft: 55,932

Rentable Sq. Ft: 55,932

Occupancy						
	2012	%	2011	%	2010	%
Beds	160		160		160	
Admissions	264		268		312	
Resident Days						
Medicaid	35,320	63.8	33,765	64.5	32,748	60.3
Medicare	8,309	15.0	7,989	15.3	9,676	17.8
Private	9,567	17.3	8,445	16.1	9,108	16.8
Other	2,153	3.9	2,151	4.1	2,732	5.0
Total	<u>55,349</u>	<u>100.0</u>	<u>52,350</u>	<u>100.0</u>	<u>54,264</u>	<u>100.0</u>
Occupancy %	94.5%		89.6%		92.9%	
% of Market	10.4%		9.7%		9.8%	

Financial						
	2012	Per Diem	2011	Per Diem	2012	Per Diem
Net Patient Revenue	\$ 14,142,158	255.51	\$ 14,255,548	272.31	\$ 12,604,326	232.28
Other Revenue	57,249	1.03	350,748	6.70	57,036	1.05
Total Revenue	<u>14,199,407</u>	<u>256.54</u>	<u>14,606,296</u>	<u>279.01</u>	<u>12,661,362</u>	<u>233.33</u>
Expense						
Admin & Support	7,524,548	135.95	6,895,338	131.72	6,859,762	126.41
Ancillary	1,440,472	26.03	1,427,226	27.26	1,306,611	24.08
Program Service	4,951,858	89.47	4,676,382	89.33	4,285,609	78.98
Total Operating Expense	<u>13,916,878</u>	<u>251.44</u>	<u>12,998,946</u>	<u>248.31</u>	<u>12,451,982</u>	<u>229.47</u>
Net Operating Profit	282,529	5.10	1,607,350	30.70	209,380	3.86
Other Income (Expense)	203,356	3.67	198,996	3.80	197,049	3.63
Net Profit (Loss)	<u>\$ 485,885</u>	<u>8.78</u>	<u>\$ 1,806,346</u>	<u>34.51</u>	<u>\$ 406,429</u>	<u>7.49</u>
EBITDA	<u>\$ 1,726,986</u>	<u>31.20</u>	<u>\$ 3,045,614</u>	<u>58.18</u>	<u>\$ 1,563,254</u>	<u>28.81</u>

JAMES G JOHNSTON MEMORIAL NURSING HOME



James G Johnston Memorial Nursing Home

Location: 285 Deyo Hill Road
Johnson City, NY
Broome County

Year Built: 1993
Acreage: 4.6

Gross Sq. Ft: 20,905
Rentable Sq. Ft: 20,905

Occupancy						
	2012	%	2011	%	2010	%
Beds	120		120		120	
Admissions	184		199		145	
Resident Days						
Medicaid	19,927	47.0	22,966	54.8	24,916	58.2
Medicare	4,854	11.4	5,204	12.4	4,446	10.4
Private	17,140	40.4	13,669	32.6	13,351	31.2
Other	514	1.2	57	0.1	87	0.2
Total	<u>42,435</u>	<u>100.0</u>	<u>41,896</u>	<u>100.0</u>	<u>42,800</u>	<u>100.0</u>
Occupancy %	96.6%		95.7%		97.7%	
% of Market	8.0%		7.8%		7.8%	

Financial						
	2012	Per Diem	2011	Per Diem	2012	Per Diem
Net Patient Revenue	\$ 11,547,050	272.11	\$ 11,446,774	273.22	\$ 10,193,971	238.18
Other Revenue	103,492	2.44	39,875	0.95	108,574	2.54
Total Revenue	<u>11,650,542</u>	<u>274.55</u>	<u>11,486,649</u>	<u>274.17</u>	<u>10,302,545</u>	<u>240.71</u>
Expense						
Admin & Support	6,091,360	143.55	6,052,295	144.46	6,122,344	143.05
Ancillary	851,129	20.06	934,278	22.30	794,713	18.57
Program Service	4,284,887	100.98	4,185,004	99.89	4,071,125	95.12
Total Operating Expense	<u>11,227,376</u>	<u>264.58</u>	<u>11,171,577</u>	<u>266.65</u>	<u>10,988,182</u>	<u>256.73</u>
Net Operating Profit	423,166	9.97	315,072	7.52	(685,637)	(16.02)
Other Income (Expense)	-	-	-	-	-	-
Net Profit (Loss)	<u>\$ 423,166</u>	<u>9.97</u>	<u>\$ 315,072</u>	<u>7.52</u>	<u>\$ (685,637)</u>	<u>(16.02)</u>
EBITDA	<u>\$ 1,350,541</u>	<u>31.83</u>	<u>\$ 1,186,420</u>	<u>28.32</u>	<u>\$ 203,317</u>	<u>4.75</u>

BRIDGEWATER CENTER FOR REHAB & NURSING ELIZABETH CHURCH MANOR NURSING



Bridgewater Center For Rehab & Nursing

Location: 159-163 Front St
Binghamton, NY
Broome County

Year Built: 1975/1960

Acreage: 2.92

Gross Sq. Ft: 137,757

Rentable Sq. Ft: 163,259

	Occupancy					
	2012	%	2011	%	2010	%
Beds	324		344		319	
Admissions	461		369		363	
Resident Days						
Medicaid	93,693	77.1	87,974	80.6	83,617	79.7
Medicare	15,400	12.7	13,838	12.7	12,554	12.0
Private	8,963	7.4	6,785	6.2	6,949	6.6
Other	3,508	2.9	521	0.5	1,735	1.7
Total	<u>121,564</u>	<u>100.0</u>	<u>109,118</u>	<u>100.0</u>	<u>104,855</u>	<u>100.0</u>
Occupancy %	102.5%		86.9%		90.1%	
% of Market	22.8%		20.3%		19.0%	

	Financial					
	2012	<i>Per Diem</i>	2011	<i>Per Diem</i>	2012	<i>Per Diem</i>
Net Patient Revenue	\$ 28,146,496	231.54	\$ 28,221,696	258.63	\$ 21,790,405	207.81
Other Revenue	68,382	0.56	26,519	0.24	22,476	0.21
Total Revenue	<u>28,214,878</u>	<u>232.10</u>	<u>28,248,215</u>	<u>258.88</u>	<u>21,812,881</u>	<u>208.03</u>
Expense						
Admin & Support	16,029,769	131.86	17,292,944	158.48	10,653,541	101.60
Ancillary	3,247,659	26.72	2,837,405	26.00	2,933,497	27.98
Program Service	8,382,431	68.95	8,023,401	73.53	8,009,956	76.39
Total Operating Expense	<u>27,659,859</u>	<u>227.53</u>	<u>28,153,750</u>	<u>258.01</u>	<u>21,596,994</u>	<u>205.97</u>
Net Operating Profit	555,019	4.57	94,465	0.87	215,887	2.06
Other Income (Expense)	-	-	-	-	-	-
Net Profit (Loss)	<u>\$ 555,019</u>	<u>4.57</u>	<u>\$ 94,465</u>	<u>0.87</u>	<u>\$ 215,887</u>	<u>2.06</u>
EBITDA	<u>\$ 2,109,832</u>	<u>17.36</u>	<u>\$ 1,719,741</u>	<u>15.76</u>	<u>\$ 1,287,777</u>	<u>12.28</u>

ELIZABETH CHURCH HOME



Elizabeth Church Manor Nursing

Location: 861 Upper Front St
Dickenson, NY
Broome County

Year Built: 1972

Acreage: 5.85

Gross Sq. Ft: 51,202

Rentable Sq. Ft: 73,685

Occupancy						
	<u>2012</u>	<u>%</u>	<u>2011</u>	<u>%</u>	<u>2010</u>	<u>%</u>
Beds	120		120		120	
Admissions	155		151		150	
Resident Days						
Medicaid	24,587	57.7	24,175	57.4	27,206	64.4
Medicare	4,016	9.4	4,429	10.5	3,555	8.4
Private	13,703	32.1	13,228	31.4	11,400	27.0
Other	328	0.8	269	0.6	76	0.2
Total	<u>42,634</u>	<u>100.0</u>	<u>42,101</u>	<u>100.0</u>	<u>42,237</u>	<u>100.0</u>
Occupancy %	97.1%		96.1%		96.4%	
% of Market	8.0%		7.8%		7.7%	

Financial						
	<u>2012</u>	<u>Per Diem</u>	<u>2011</u>	<u>Per Diem</u>	<u>2012</u>	<u>Per Diem</u>
Net Patient Revenue	\$ 10,562,597	247.75	\$ 11,029,705	261.98	\$ 9,609,367	227.51
Other Revenue	104,766	2.46	24,381	0.58	61,466	1.46
Total Revenue	<u>10,667,363</u>	<u>250.21</u>	<u>11,054,086</u>	<u>262.56</u>	<u>9,670,833</u>	<u>228.97</u>
Expense						
Admin & Support	5,916,720	138.78	5,853,996	139.05	5,465,387	129.40
Ancillary	866,292	20.32	885,537	21.03	738,437	17.48
Program Service	3,744,238	87.82	3,787,347	89.96	3,830,739	90.70
Total Operating Expense	<u>10,527,250</u>	<u>246.92</u>	<u>10,526,880</u>	<u>250.04</u>	<u>10,034,563</u>	<u>237.58</u>
Net Operating Profit	140,113	3.29	527,206	12.52	(363,730)	(8.61)
Other Income (Expense)	-	-	-	-	-	-
Net Profit (Loss)	<u>\$ 140,113</u>	<u>3.29</u>	<u>\$ 527,206</u>	<u>12.52</u>	<u>\$ (363,730)</u>	<u>(8.61)</u>
EBITDA	<u>\$ 1,195,176</u>	<u>28.03</u>	<u>\$ 1,664,943</u>	<u>39.55</u>	<u>\$ 733,412</u>	<u>17.36</u>

RIVERVIEW MANOR HEALTH CARE CENTER



Riverview Manor Health Care Center

	Occupancy					
	2012		2011		2010	
		%		%		%
Beds	77		77		77	
Admissions	129		53		69	
Resident Days						
Medicaid	14,731	72.3	13,445	74.6	19,815	74.4
Medicare	2,972	14.6	2,470	13.7	2,848	10.7
Private	2,664	13.1	2,096	11.6	3,975	14.9
Other	9	0.0	-	-	-	-
Total	<u>20,376</u>	<u>100.0</u>	<u>18,011</u>	<u>100.0</u>	<u>26,638</u>	<u>100.0</u>
Occupancy %	72.3%		64.1%		94.8%	
% of Market	3.8%		3.3%		4.8%	

Location: 510 Fifth Avenue
Owego, NY
Tioga County

Year Built: 1966

Acreage: 3.0

Gross Sq. Ft: 15,888

Rentable Sq. Ft: 23,832

	Financial					
	2012		2011		2010	
		Per Diem		Per Diem		Per Diem
Net Patient Revenue	\$ 3,702,409	181.70	\$ 4,080,204	226.54	\$ 4,933,133	185.19
Other Revenue	9,013	0.44	18,788	1.04	28,783	1.08
Total Revenue	<u>3,711,422</u>	<u>182.15</u>	<u>4,098,992</u>	<u>227.58</u>	<u>4,961,916</u>	<u>186.27</u>
Expense						
Admin & Support	2,686,897	131.87	2,642,599	146.72	2,803,393	105.24
Ancillary	484,387	23.77	434,062	24.10	381,176	14.31
Program Service	1,634,574	80.22	1,358,456	75.42	1,923,932	72.23
Total Operating Expense	<u>4,805,858</u>	<u>235.86</u>	<u>4,435,117</u>	<u>246.24</u>	<u>5,108,501</u>	<u>191.77</u>
Net Operating Profit	(1,094,436)	(53.71)	(336,125)	(18.66)	(146,585)	(5.50)
Other Income (Expense)	(1,515)	(0.07)	1,825	0.10	(906)	(0.03)
Net Profit (Loss)	<u>\$ (1,095,951)</u>	<u>(53.79)</u>	<u>\$ (334,300)</u>	<u>(18.56)</u>	<u>\$ (147,491)</u>	<u>(5.54)</u>
EBITDA	<u>\$ (535,326)</u>	<u>(26.27)</u>	<u>\$ 537,921</u>	<u>29.87</u>	<u>\$ 553,120</u>	<u>20.76</u>

OPTIONS FOR CONSIDERATION

STATUS QUO

- Keep the Status Quo – This option will allow for the County to maintain control over the facility going forward as currently designed. As made clear in the financial performance section of this report, the residents of Broome County and the key decision makers will have to understand the need to subsidize the facility on a go forward basis barring a significant, and highly unlikely, change in reimbursement methodology or benefit package structure.

PROS – STATUS QUO

Consistency and continuity related to the care given to the residents. No unnecessary additional stress is added to the workforce, and by extension passed on to the residents.

The positive reputation of the facility in the community will remain intact, and the quality of care delivered is highly valued.

Demographics of Broome and the surrounding Counties suggest the long-term care beds will be needed for the short and medium range terms.

Cons – Status Quo

Cost to the County - The facility will continue to need resources from the County. In addition, significant capital improvements will be needed in the next few years to keep the facility modern and efficient. Due to the changing reimbursement system in NYS to managed care, it is unknown how capital investments will be reimbursed in the future.

Federal and State initiatives suggest the method and cost of how care is delivered will continue to be under significant pressure. Programs such as DSRIP and Quality Initiative are focusing on transforming how services are the delivered and premiums are being placed on outcomes and the overall quality of care.

Pressure from lower levels of care to keep potential facility residents in the traditional community setting longer. The status quo option doesn't account for how the County is reacting to this pressure.

Negotiated and mandated benefit levels will continue to place the County at a competitive disadvantage when it comes to new admissions of residents who could potentially have managed care companies recommending where the resident goes for long term care services.

Review Existing Cost Structure

- While costs are currently evaluated on a regular basis through the budget process, a more clearly defined process could gain efficiencies for Willow Point. These could include the following: evaluating the benefit of a management contract agreement, potential gains through union contract negotiation, cost sharing with other departments within the County, and/or exploring affiliation agreements with surrounding facilities or Counties to help spread costs.
- Unfortunately, due to some of the benefit costs in place related to pension and other post employment benefits, the County will always be at a competitive disadvantage. Salary levels appear in line compared to the other facilities in the market. There are only so many places to look for cost savings in an industry where such a large percentage of the cost of doing business is tied up in human capital in the form of salaries and benefits.

Pros – Review Existing Cost Structure

Work with the union and vendors on available options that could reign in costs or provide opportunities. Many unions throughout the state have been willing to work with County facilities to help facilities try and remain viable long term options.

Cons – Review Existing Cost Structure

As briefly described above, union negotiated contracts and mandates from the State level often put County facilities at a salary and benefit level that far exceeds what is seen in the for-profit and nonprofit competitors in the market place. It is often hard to reach agreements on the actual cost savings needed to have a meaningful impact when over 70% of the costs of doing business are directly related to payroll and benefits. In addition, with salary levels excluding benefits consistent with the market place, savings tied into pension and post employment benefits are increasingly unlikely due to the State mandates and union contracts currently in place.

Change in Facility Structure/Operation

- The current environment is incentivizing facilities to evaluate how they operate and deliver services in the coming years. Through DSRIP, HEAL Grants and the Vital Access Provider (VAP) program, facilities are encouraged to consider the levels of care they are providing and transform the process by which it gets delivered. These programs all offer some type of grant funding or additional reimbursement for participation and in some cases documented positive outcomes.
- For Willow Point, this could include converting existing skilled nursing facility beds to a combination of assisted living beds, independent housing, or adult day care services. These services would be run by the County or through some type of affiliation.

Pro – Change in Facility Structure/Operation

Reduced levels of care often do not need the same level of staffing to provide quality service. This can help reduce largest expense Willow Point currently has, which is salary and benefits.

It is widely believed that Medicaid managed care companies will view the whole continuum of care organizations as an attractive option to contract with.

Cons – Change in Facility Structure/Operation

Reduction below 300 skilled nursing beds would cause an immediate Medicaid rate reduction of approximately \$14 per day as a result of losing the 300+ bed facility status.

No guarantees that the state will approve HEAL or VAP grant requests or that Willow Point will be included as part of a region wide DSRIP plan.

New Building

- The current facility is dated with a layout that causes inefficiencies related to delivering quality resident care. Substantial investment is needed to bring Willow Point in to the twenty-first century. One option available is the construction of a new state of the art facility to replace the existing building. In fact, one of the outcomes of the NYS DOH Berger commission report was the recommendation of a new smaller facility with an Adult Day Health Care program.

Pros – New Building

A new building will bring substantial “curb appeal” and the potential to attract the all important private pay resident. In addition, the new facility would have a designated state of the art rehab space that could improve third party and Medicare occupancy and revenue.

Interest rates remain near historic lows. Borrowing costs could be minimized as part of a massive construction project.

Cons – New Building

Loss of, or reduced capital reimbursement as a result of the transition to Medicaid managed care could make an already risky construction project completely unrealistic from a financial standpoint.

Closure

- Based on the bed need of Broome and the surrounding counties, and the number of potential buyers willing to purchase other County facilities in the current environment, this does not appear to be a realistic option. As such, no further time will be spent outlining the potential pros and cons related to this option.

Establishment of a Public Benefit Corporation.

Public Benefit Corporations (PBC) have been set up in a few counties in New York State that have the skilled nursing facility tied into a hospital system. If approved, the County would transfer oversight responsibility of the Facility. This responsibility would be ceded to a separate governing board.

Pros – PBC

Responsibility for the operation of the facility would no longer rest with the County. The County would no longer bear responsibility to subsidize the operations.

Cons – PBC

The County would still be responsible for their share of the IGT payment to the State along with the funding of legacy pension and other post employment benefits. That type of financial commitment without financial control has left many counties steering away from the PBC as a viable alternative.

Limited history and success surrounding facilities transferred to PBCs.

The process of transferring a stand alone County nursing home to a PBC is rare, and would have to go through a cumbersome bureaucratic process at the local and state level to obtain necessary approvals.

Merger/Affiliation

Merger with Nonprofit

- As many long term care providers navigate their way through the impending transition to Medicaid managed care, conversations have begun to discover ways to remain financially viable into the future. This has taken different forms. Some organizations have entered in to merger agreements to become part of larger organizations, others have explored the possibility of entering into Individual Practice Associations (IPA's), while other facilities of all sponsorships have contemplated the possibility of exiting the industry.
- Affiliation with other county facilities in the region to share services, reduce costs, gain economies of scale for better purchasing power, and help with negotiations with managed care companies, could be an option.

Pros – Merger/Affiliation

Sharing resources could position Willow Point for financial savings on the purchasing side of things as well as from the payroll and benefit aspect.

The use of "Best Practices" and sharing of ideas could stimulate new ideas and efficiencies throughout the facility.

Cons – Merger/Affiliation

Loss of complete control when other entities are involved.

Are there enough areas to gain efficiencies to make it work while? Broome County decision makers will ultimately need to evaluate the overall financial commitment it is willing to make to the facility.

Sale

- This option would allow the County to sell some or all of the assets related to Willow Point. A new operator would take over and administer the operations at the existing site or at a location determined by the new operator if negotiated with the County and approved by the State. This option would eliminate the County's IGT contribution and any subsidy needed to operate the facility. Based on recent transactions seen at different Counties throughout the state, it is widely assumed there would be a number of qualified interested parties in purchasing Willow Point.
- Under this option, there are a few different variations available to the County:
 - 1) Sale of the license and the related assets of the Willow Point including the land and building.
 - 2) Sale of the license, but the County would maintain the land and building for potential repurposing.
 - 3) Sale of the license and operations to a third party, but the County maintains ownership of the land and building. In this option, the County would enter into a lease arrangement with the third party operator.

Pros – Sale

The County could receive a cash payment to offset legacy costs, and no longer bear responsibility for oversight of the organization.

Depending on the type of agreement the County could receive rent income if the land and building are maintained, or receive property taxes if the facility were sold to a for profit entity.

The County would no longer need to support the annual IGT payment or any financial subsidy to the facility.

Experienced operator could come in and start implementing changes and overseeing management of the facility before DOH final approval is obtained.

Increased quality of care and service provided to the residents by an experienced operator

Cons – Sale

Lack of protection for the current employees in terms of job security and salary and benefit levels. There are some protections that can be written in to the purchase agreement

Potential drawn out legal battle with those in opposition to the sale.

Loss of control over Willow Point. This could impact employees, residents and the community at large.

Disruption in care related to the transfer if not planned and executed properly. There is increased risk for turnover at key positions.

Additional burden to the County for shared services currently absorbed by Willow Point.

The expected timeframe to transfer ownership from time of agreement to the close of the sale and approval from the DOH ranges from 12 to 24 months. Often times, new operators will enter in to management agreements to get into the facilities prior to close in preparation of taking ownership.

Recommendations

Based on changing reimbursement methodology and continued pressure on margins, it would be in the best interest of the facility to consider a few of the options above. Ultimately, the key decision makers at the County need to identify what level of financial commitment to Willow Point makes the most sense to the citizens of Broome County.

Short Term

Willow Point should explore cost saving opportunities through a detailed analysis of the benchmarking section earlier in the report. A few areas where Willow Point exceeds the market were; laundry and linen, resident food service, and housekeeping. Consideration of contract services in these areas may allow the facility to lower the overall cost of provider services a few dollars per day.

Bad debt expense the past two years has far exceeded the average of other facilities in the area. We strongly recommend that Willow Point establish and adhere to strict policies regarding accounts receivable collection, which would include; verifying a resident's payor source at time of admission, having adequate and knowledgeable collections staff, regularly working claims for collection to prevent disallowance for untimely claims, and utilize a collection agency or attorney (preferably, on a commission basis) for claims that are beyond the capability of the collections staff.

As illustrated in the financial projection section of this report, there will be a significant financial commitment needed from the County of Broome and by extension the residents of Broome. Even with the projected best case scenarios, the County will be responsible for approximately \$5 million dollars per year.

Medium to Long Term

The Medicaid managed care transition is the great unknown and will pose numerous obstacles for Willow Point. Going forward the long term care industry nationally and at the State level is expected to put increased emphasis on documented quality, positive outcomes and cost of care. From a pure numbers perspective, not taking reputation in the community, Willow Point does not match up favorably to the local competition.

As described in the above chart on page 76, Willow Point currently ranks near the high end in terms of cost and on the low end in terms of quality. Consumers of skilled nursing facilities are using the information available to become educated consumers in terms of where to get their needed rehabilitation services or where to place a loved one.

In addition, managed care companies will struggle to recommend its members go to a high cost low quality option when more desirable local alternatives exist. This could be a problem for other providers in the area, but the problem is magnified at Willow Point because of the higher percentage of residents they admit already on Medicaid or pending Medicaid approval. With the incentive to manage costs, managed care companies will undoubtedly use their influence on their members to select a nursing facility option that has quality and cost at the forefront of the decision.

Another hurdle for Willow Point to overcome is the fact its Medicaid rate is already near the high end of the competition, and that includes only a small amount for capital reimbursement. As touched on earlier in the report, Willow Point is in need of major capital improvements or possibly a complete new facility. There is significant uncertainty related to how those major capital projects will be reimbursed by managed care companies. Even if capital is reimbursed in the future similar to existing methodology, a major renovation would only increase the cost of the Medicaid rate the managed care company would

be obligated to compensate Willow Point making it more likely they recommend another facility it has contracted with.

Based on the number of sale transactions, entered into over the past few years surrounding County nursing homes, along with nonprofit and for-profit facilities, it is abundantly clear that there are buyers of all types of facilities active in the acquisition of skilled nursing facilities. It would not be surprising to see Broome County receive numerous purchase offers if it decides to solicit them. What is not clear however, is how long the window will remain open. In other words, once the transition to managed care takes place, interest rates and the cost of borrowing start to rise, and some of the unknowns surrounding reimbursement start to become clear, potential buyers may become more risk averse and refrain from acquiring facilities.

Due to the factors outlined above, it is recommended Broome County explore the sale of the facility. The ability to maximize purchase price may be near its peak in the current environment. Due to the age of the facility and the current outdated layout, some potential buyers may prefer to purchase only the bed licenses and not undertake a large capital improvement project at the existing location. As a result, any and all combinations of a potential sale should be considered.

The County could proactively select from a group of known interested organizations that have recently been active in purchasing facilities or it could entertain a wider scope purchase offers through a Request for Proposal (RFP) to gauge the interest among potential buyers. Interested parties may include entities of all sponsorships. This will allow County decision makers to see if there is a potential buyer that best aligns with the existing mission at Willow Point.

The County should gain a clear understanding surrounding the terms under which it would be willing to sell the facility. This means the County wouldn't have to or shouldn't necessarily accept the highest offer without going through an extensive due diligence process surrounding potential buyers. This could include expectations surrounding the protection of existing residents and staff. The RFP could be designed to ensure that there would be no obligation on the part of the County to transfer ownership unless it meets specific expectations and criteria established by the County. Any sale would have to be approved by the State Department of Health.

The ultimate goal is make sure the needs of the residents and employees of Willow Point are carefully considered, and the taxpayers of Broome County are served in the best manner possible.

1. IBISWorld Industry Report 62311 – Nursing Care Facilities in the U.S. October, 2013.
2. CMS 2012 Long-Term Care Initiatives
3. Cornell, PAD
4. CMS Nursing Home Provider Profiles
5. CMS CMS-2540-10 and 2540-96 Cost Reports
6. US Census Bureau
7. Porter, M. (January, 2008). Harvard Business Review. The Five Competitive Forces that Shape Strategy
8. EFP Rotenberg Consulting. (n.d.). Feasibility Study Prepared for Broome County.
9. Dennison, T. H. (August, 2013). New York's Nursing Homes: Shifting Roles and New Challenges. Medicaid Institute at the United Hospital Fund. Accessed at <http://www.uhfny.org>.