Edward J. Healey Rehabilitation and Nursing Center Feasibility Study

Prepared for the Health Care District of Palm Beach County
October 2008

with
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Separate Documents


- **Attachment II** – Outline Specifications Outline Specifications For Edward J. Healey Rehabilitation and Nursing Center Palm Beach County, Florida by O’Keefe Architects Inc. October 2, 2008.

- **Attachment III** - Palm Beach County SNF, ALF and ADCC Locations.
Executive Summary
The Health Care District of Palm Beach County (HCD) contracted with Health Management Associates (HMA) to conduct a feasibility study for the Edward J. Healey Rehabilitation and Nursing Center, an aging skilled nursing facility operated by the HCD. The HMA team included Dennis O’Keefe, President of O’Keefe Architects Inc., and Glen Mitchell, Ph.D. and Larry Polivka, Ph.D., with the State Data Center on Aging (SDCA) at the University of South Florida (USF).

Phase I of this project consisted of information gathering and development of specific findings and recommendations regarding the future of the Healey Center. The recommendations presented are those that the HMA team believes represent the most appropriate and feasible models of care designed to address the needs of two groups of Palm Beach County residents:

- Residents currently served at the Healey Center; and
- Residents likely to seek admission to the Healey Center in the future.

This report includes:

- The Community Needs Assessment that provides a profile of the Healey Center residents compared to residents in other nursing homes in the state and projects future bed need at the Healey Center;
- An assessment of options for “outsourcing care”, by placing residents in other community nursing homes or in alternative community-based settings such as assisted living facilities (ALFs) or housing with supports, as an alternative to placement at the Healey Center;
- The options for the Healey Center building (renovation or new construction);
- Discussion regarding the mission of the Healey Center;
- The cost of care at the Healey Center; and
- Recommendations to meet the projected future needs including construction of a replacement facility that includes, at a minimum, an assisted living component and that leverages available and appropriate community alternatives when possible (including community nursing home beds, ALFs and housing).

This Phase I report is designed to enable the HCD to select and recommend a facility and/or program model to the HCD Board that is designed to meet the future needs of Healey Center residents and those who will turn to the HCD in the future to meet their LTC needs. Upon approval of the model, HMA will undertake Phase II: completion of a master facility/program plan(s).

The Healey Center is Unique
The Edward J. Healey Rehabilitation and Nursing Center (Healey Center) is licensed and certified as a skilled nursing facility (SNF) and is owned by Palm Beach County. The
Health Care District (HCD) of Palm Beach County operates the facility under the terms of a forty-year, interlocal agreement. The HCD began operating the Healey Center in 1995. The Healey Center is an important part of the County safety net. It is one of only nine county, hospital district or city-owned nursing homes in the state. The Healey Center has 198 licensed skilled nursing facility (SNF) beds, but only uses about 125 of these beds. The remainder of the beds are not currently being used for residents, with some being used as offices or for storage.

The facility building dates back to 1917 (as the Palm Beach County Home) and is in a state of continual deterioration. There have been five studies completed in the last 12 years discussing the future options for the Healey Center, the most recent completed in 2006. The prior reports have considered renovating the facility, outsourcing care and building a new facility. All prior studies concluded that renovating the facility and outsourcing care were cost-prohibitive and therefore not feasible.

The case-mix of residents at the Edward J. Healey Rehabilitation and Nursing Center is very different from other SNFs. Comparisons were made to Florida SNFs, Palm Beach County SNFs, and county-/city-owned SNFs in Florida.

- 8.26% of Healey Center residents had a length of stay (LOS) longer than ten years. Comparable fractions are much smaller for Florida county-/city-owned SNFs (2.12%), Palm Beach County SNFs (0.27%), and Florida SNFs (0.37%).
- The pattern reverses when shorter LOS is considered. At the Healey Center, 16.5% of residents had a LOS less than 90 days – less than one-half the rate for more traditional SNFs.
- The typical Florida SNF resident is a frail woman in her eighties or nineties. The typical Healey Center resident is male and in his fifties.
- The typical Florida SNF is similar to national trends in nursing home case-mix. The typical resident is geriatric with chronic conditions such as asthma/chronic obstructive pulmonary disease (COPD), end-stage dementia, heart disease, or stroke. Healey Center residents, in contrast, are more likely to be quadriplegic/paraplegic secondary to traumatic injury or hemiplegic from stroke.
- The Healey Center residents have higher than average per member per month (PMPM) Medicaid claims than other SNF residents in Florida, including residents of other government-owned SNFs. PMPM Medicaid claims for Healey Center residents averaged $5,455 (for all services including SNF, physician services, hospital services, etc.) during SFY 2005-06 (an annual average of $58,358). Healey Center residents have an annual Medicaid claims experience that is more than 60% higher than Florida SNF residents ($3,396 PMPM) and more than 50% higher than Palm Beach County SNF residents ($3,548 PMPM).
Projected Need

Population forecasts out to 2030 were made for the general population, Medicaid population, nursing home population, Florida-subsidized long-term care (LTC) population, and Florida-subsidized LTC population receiving home and community-based services (HCBS). Population forecasts were developed by University of South Florida researchers using a statistical technique called Box-Jenkins ARIMA modeling. ARIMA is an acronym for Auto-Regressive Integrated Moving Average. The strength of ARIMA modeling is its ability to generate separate estimates for auto-regressive, integrated, and moving average time-series components.

A crude estimate of the 2030 resident population at the Healey Center (if the HCD committed to serve the same fraction of the Palm Beach County population as it does now at the Healey Center) is 363 residents. Given the mix of short-term and long-term stays, 186 beds is the estimated need to serve 363 residents during the year 2030. The crude estimate considers only trends in general population growth for Palm Beach County. A more refined estimate of the size of the future resident population was developed and included the general population, the aged and disabled adult fractions of the Florida-subsidized LTC population, and the aged and disabled adult fractions of the Florida-subsidized HCBS population. The refined estimate is a population of 415 residents annually by 2030 requiring 212 beds. This estimate does not account for efforts that might be undertaken to fund alternative community-based settings such as assisted living or housing with supports or efforts to divert persons who are seeking access to the Healey Center to other community nursing homes.

Healey Cost of Care

The HCD covers the cost of care for “charity patients” (persons with no other payor source) at a cost of $346/day in 2007. Thirty percent (30%) of residents in July 2008 were not covered by Medicaid or any other payor source, but were instead “charity care” covered. The HCD also subsidizes the cost of care for Medicaid residents. Medicaid reimbursement in 2007 was $201.66/day. In addition, Medicaid residents are required to contribute their income less a personal needs allowance ($35/month), toward the cost of their care. This averaged about $13/day in 2007. The HCD receives approximately $75.60/day in Upper Payment Limit (UPL) funds from Medicaid (disbursed in quarterly payments) for a total Medicaid reimbursement of $277.26 using the January 2007 Medicaid per diem rate ($201.66+$75.60). The overall Medicaid shortfall was about $56/day in 2007 ($346 minus the sum of $201.66+$75.60+$13). The shortfall is likely to worsen this year and next as additional cuts are made to Medicaid nursing home rates. About 69% of all resident days at the Healey Center were reimbursed by Medicaid for the year ending September 30, 2007.

1 The term “Florida-subsidized LTC population” refers to persons receiving LTC services funded in part or whole by the State of Florida. Examples of this population include persons receiving home care services funded through the Department of Elder Affairs, the Department of Children and Families or the Agency for Health Care Administration, Medicaid program.
Medicare has, in the past, comprised a very small portion of patient days at the Healey Center (less than 1% in prior years).

**Mission**

There is a lack of clarity and specificity regarding the mission of the Healey Center. However, there is a general agreement that the Healey Center is operated in order to ensure that the LTC needs of trauma patients and other Palm Beach County residents who are not served (for whatever reasons) in other SNFs are met. Development of a more specific “mission statement” appears especially important now because of the projected future need for increased beds at the Healey Center (or alternative care) and the increasing cost to provide care at the Healey Center.

The HCD does not have adequate funds to cover the cost of charity care or to offset the Medicaid losses in the future if operating the Healey Center at the current census levels and with the current resident mix and payor sources (even considering the existing reserve fund). NF inflation is projected to continue at 3% annually. In addition, the Medicaid “gap” changes each time the per diem is reset (twice yearly), and the UPL payment fluctuates based on the number of Medicaid days.

Some specific considerations that bear upon the future of the Healey Center include:

- Is the Healey Center a charity care facility that takes all persons needing SNF care who have no payor source?
- Should the Healey Center seek to achieve a specific payor mix in order to improve financial viability of the facility?
- Does the HCD (and County) intend to limit their contribution to the existing number of beds at the Healey Center or to the current amount of the County subsidy?
- The Healey Center is not big enough to meet the future projected need (212 beds). How will projected future increases in demand be met?
- Does the County/HCD mission include providing and/or funding alternatives to NF LOC (like assisted living or housing with on-site supports) and if so, what would be the limits for alternatives or for total LTC services expenditures?
- Does the County and HCD want to transform the County-funded LTC services provided at the Healey Center from the more traditional nursing home to an alternative nursing home model and if so, how “transformative” should the change be?

**Changes in Long-Term Care Services**

There have been important changes in both the way publicly funded LTC services are delivered and the cost to deliver these services since the interlocal agreement was signed in 1995.

- SNF costs continue to rise and Medicaid reimbursement continues to cover less than the cost of care. In addition, Medicaid reimbursement has been reduced this
year and is expected to be further reduced in the coming fiscal year. The County contribution is fixed and eventually (despite access to a reserve amount) costs will exceed the amount available through the County subsidy.

- The Americans with Disabilities Act (ADA), passed in 1990, and the Olmstead Supreme Court ruling issued in 1999, have contributed to a shift in the provision of LTC services funded by Medicaid, away from institutional settings to community-based settings.

- There is a clear preference for community-based LTC versus institutional LTC among most persons today.

- States and counties have been the subject of recent litigation filed on behalf of NF residents who wish to be served in alternative community-based settings.
  - The Florida Department of Elder Affairs and the Agency for Health Care Administration are named defendants in a lawsuit recently brought by seven Medicaid eligible adults who are currently residing, or have recently resided, in a nursing home. The individuals have alleged that their continued placement in a skilled nursing facility is a violation of the Americans With Disabilities Act (ADA).
  - In San Francisco, a settlement agreement was recently announced with the city/county in the Chambers lawsuit. The Chambers lawsuit sought to compel the city/county to fund alternatives to care at Laguna Honda Hospital and Rehabilitation Center, the largest single-site nursing home in the country. The settlement provides for assessment, referral and provision of subsidized housing, attendant and nursing care, case management, substance abuse treatment, mental health services, and assistance with meals to disabled San Franciscans. In addition, several hundred Medi-Cal Home and Community-Based Services waiver slots will be made available to eligible persons. The city/county will, over the next five years, secure and subidize scattered-site, accessible, independent housing for approximately 500 people with disabilities and seniors who are eligible for community-based services.

- There are several initiatives underway nationally that seek to change the way nursing homes are designed and operated, emphasizing more home-like environments where residents have more control over their daily lives.

The changes in LTC and nursing home models should be considered, along with financing considerations and projected need for LTC services, as the Commission ponders the future of the Healey Center.

**Outsourcing of Care**

The Healey Center is not large enough (even if all 198 licensed beds were usable) to meet the projected future need.
There are potential alternatives by which to meet some of the projected future need by “outsourcing” of care: placing people in other community nursing homes or in alternative community-based settings including assisted living facilities or housing with supports. Outsourcing of care (by placement in other facilities or in the community) was examined in 2005 and was determined not feasible. We re-examined outsourcing and determined:

- There are not enough community nursing home beds available in nursing homes with a comparable quality of care rating to that of the Healey Center to outsource nursing home care. There may be some limited opportunities to do so on a person-by-person and nursing home-specific basis.

- Some residents could likely be served in alternative community-based settings (such as shared houses, apartments or in assisted living facilities), less expensively than at the Healey Center, but these alternatives are not readily available. (We suggest inclusion of at least assisted living at the Healey Center, should a new facility be constructed, to provide a readily available option for alternative care.)

**Use of Other Community Nursing Homes**

The 2005 report included an assessment of community nursing homes willing to serve residents then residing at the Healey Center. The 2005 study found only three NFs in Palm Beach County willing to accept residents from the Healey Center (a maximum of 55 residents) and determined that the cost to provide alternatives to NF care exceeded the cost to build a new facility.

We reexamined this option. In order to identify potential NFs for outsourcing we compiled a list of all Palm Beach County SNFs and then excluded SNFs that:

1. Do not accept Medicaid (CMS data);
2. Have an occupancy rate of 90% or higher (CMS data);
3. Have religious or ethnic limitations (CMS data, White Paper);
4. Are part of a continuing care retirement center (CCRC), including “upscale” SNFs (CMS data, Internet search);
5. Serve only short-term residents (take only “rehab” patients) – (Phone interview);
6. Have become inactive Medicaid providers since their last survey (AHCA data);
7. Were on the AHCA NF watch list as of July 31, 2008 (AHCA data); or
8. Had a Quality of care Score on their last survey as posted on the AHCA website of less than 3 stars (AHCA data). (The Healey Center has a 4-star quality of care rating.)

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2 The Watch List identifies nursing homes that are operating under bankruptcy protection or met the criteria for a conditional status during the past 30 months. A conditional status indicates that a facility did not meet, or correct upon follow-up, minimum standards at the time of an inspection. Immediate action is taken if a facility poses a threat to resident health or safety.

3 Star ratings are used as a way to compare one nursing home to other nursing homes in a region. For example, a 3-star rating means the nursing home ranked better than 41% to 60% of the facilities in its region on a specific measure. A 4-star score means the nursing home ranked better than 61-80% of nursing homes in a region. The Healey Center is compared to nursing homes in Region 9, which consists of Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie counties. Measures that are included in the scoring
The full SNF list from CMS contained information for 56 facilities. These facilities had 6,497 certified beds with 5,450 beds occupied or 1,047 vacancies. The vacancies are an estimate – not all certified beds can be occupied (like the Healey Center they may have been taken off-line or be unusable) and they represent a point in time count (the date of which varied based on each SNFs survey date).

After removing facilities that were in one or more categories above (items 1 through 8), there were 13 facilities remaining with 1,703 certified beds, of which 1,426 were occupied at the time of the survey leaving 295 unoccupied beds. We obtained June 2008 reported nursing home census from the HCD for each SNF and revised the count of available beds. Because of a drop in occupancy among SNFs in the past eighteen months, there were now a reported 358 beds potentially available. Some providers in the nursing home industry believe that the decline in occupancy is a “blip” and is not likely to continue. Factors that can effect nursing home occupancy include a changing economy and changes in third party payors.

We contacted a sample of SNFs with 3-star or 4-star ratings. SNF administrators made a number of comments related to the Healey Center, including:

- “We don’t take County residents” (meaning residents funded by the county);
- “We serve mostly very old residents who are frail – we could not take younger residents with behavior problems”;
- “This is an upscale facility”; and
- “Healey is a valuable resource - needed in the community. They do a good job.”

The 3-star facilities reported interest in discussing contracting with the HCD and had significant bed availability. However, their lower quality of care rating is of concern and contracting with such facilities is not recommended. If we limit the potential NFs to those on this list with a quality of care rating at least as high as that of the Healey Centers (4-star), there are 6 facilities with 753 licensed beds, and a potential 82 vacancies. However, 3 of these facilities when contacted reported no openings for long-term care clients or were not able to take patients with the types of needs common to Healey Center residents, reducing potentially available beds in the 4 or 5 star facilities to 50 beds.

The Healey Center staff believe that 55% of residents require 24/7 care. This care would need to be provided in a SNF. This is about 62 residents (varying slightly depending on census). In addition, a portion of the 41 residents who need daily assistance and supervision, but less than 24/7 care, would also need to be served in a SNF.

**Use of Alternative Settings**

A portion of residents, many who are non-elderly persons who have sustained a traumatic injury, are consistently identified by the Healey Center staff as being able to be served at lower levels of care (such as assisted living or residences with wrap around supports).

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for Quality of Care include receiving appropriate treatment to prevent or heal pressure sores, providing adequate nutrition and fluids, etc. Nursing home ratings are posted at: www.FloridaHealthFinder.gov
These residents have not been able to be discharged, since such settings are not readily available and/or suited to their unique needs. The 2005 study determined the cost to place residents in alternative placements exceeded the cost of care at the Healey Center.

In 2007, the HCD incurred costs of $346/day for residents covered through “charity care” and $56/day for residents covered by Medicaid. HMA developed a variety of cost models to serve elders or persons with disabilities in either assisted living facilities or housing with supports (like personal care). We believe the use of alternative settings can be financially viable for some residents if managed carefully. Access to other sources of payment or supports, including rental subsidies (using United States Department of Housing and Urban Development (HUD) vouchers), and Medicaid home and community-based (HCBS) waiver services (for residents who are Medicaid eligible), can improve the cost-effectiveness of alternatives.

Table 1 is a summary of the estimated cost to the HCD for various community based alternatives compared to the cost of care at the Healey Center. Detailed cost information and some additional scenarios are provided starting on pages 79-90 of this report.

**Scenarios**

- **Scenario A.** Three individuals with quadriplegia sharing a house and services:

  The cost for each individual if fully subsidized by the HCD (non-Medicaid, no income, no other payors) is cost-effective compared to the charity care cost at the Healey Center: $127/day compared to $346/day. For Medicaid eligibles, this option is more expensive than the HCD cost at the Healey Center: $179/day the first year and $120/day the second year and thereafter compared to $56/day. This option would be cost-effective if the individual were able to access services and/or funds through the BSCIP or TBI/SCI Waiver when slots are available and perhaps through some other funding sources.

  Medicaid eligibles would need to access substantial additional supports to make this cost-effective. This is possible through the BSCIP or TBI/SCI Waiver when slots are available and perhaps through some other funding sources.

- **Scenario B -** One Individual with quadriplegia and a Personal Care Attendant 24/7: This option is not cost-effective, with the lowest daily cost of $596/day compared to $346/day at the Healey Center if charity care and $589/day compared to $56/day if Medicaid eligible.

- **Scenario C -** Two individuals with TBI sharing a residence and services: The cost for each individual if fully subsidized by the HCD (non-Medicaid, no income, no other payors) is cost-effective compared to the charity care cost at the Healey Center: $102/day compared to $346/day. For Medicaid eligibles, this option would be cost-effective if the individual were able to access services and supports to reduce the HCD cost. This is possible through the BSCIP or TBI/SCI Waiver when slots are available and perhaps through some other funding sources.
### Table 1: Placement Scenarios and HCD Costs – Summary Table

<table>
<thead>
<tr>
<th>Charity Care Residents (Not Eligible for Medicaid/SSI or HUD Rental Vouchers)</th>
<th>A</th>
<th>B</th>
<th>C = B - A</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HCD 2007</strong></td>
<td><strong>Healey Center Cost Per Day</strong></td>
<td><strong>HCD Scenario Cost Per Day</strong></td>
<td><strong>HCD Cost (Savings)/Day</strong></td>
</tr>
<tr>
<td>Scenario A: Individual with Quadriplegia Sharing a House and Services</td>
<td>$346</td>
<td>$127</td>
<td>($219)</td>
</tr>
<tr>
<td>Scenario B: Individual with Quadriplegia with 24/7 Personal Care Attendant</td>
<td>$346</td>
<td>$596</td>
<td>$250</td>
</tr>
<tr>
<td>Scenario C: Individual with TBI Sharing a Residence and Services</td>
<td>$346</td>
<td>$102</td>
<td>($244)</td>
</tr>
<tr>
<td>Scenario D: Individual with Some Special Care Needs at HCD-Operated ALF</td>
<td>$346</td>
<td>$122</td>
<td>($224)</td>
</tr>
<tr>
<td>Scenario E: Individual with Quadriplegia in a HCD Apartment</td>
<td>$346</td>
<td>$187</td>
<td>($159)</td>
</tr>
</tbody>
</table>

*Scenarios that include Medicaid-funded supports are not included for Charity Care residents as they are not Medicaid eligible.*

<table>
<thead>
<tr>
<th>Residents with Medicaid/SSI</th>
<th>A</th>
<th>B</th>
<th>C=B - A</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HCD 2007</strong></td>
<td><strong>Healey Center Cost Per Day</strong></td>
<td><strong>HCD Scenario Cost/Day</strong></td>
<td><strong>Additional Cost (Savings)/Day</strong></td>
</tr>
<tr>
<td>Scenario A: Individual with Quadriplegia Sharing a House and Services</td>
<td>$56</td>
<td>$120</td>
<td>$64</td>
</tr>
<tr>
<td>Scenario B: Individual with Quadriplegia with 24/7 Personal Care Attendant</td>
<td>$56</td>
<td>$589</td>
<td>$533</td>
</tr>
<tr>
<td>Scenario C: Individual with TBI Sharing a Residence and Services</td>
<td>$56</td>
<td>$95</td>
<td>$39</td>
</tr>
<tr>
<td>Scenario D: Individual with Some Special Care Needs at HCD-Operated ALF</td>
<td>$56</td>
<td>$91</td>
<td>$35</td>
</tr>
<tr>
<td>Scenario D (1) with ALE Waiver</td>
<td>$56</td>
<td>$49</td>
<td>($7)</td>
</tr>
<tr>
<td>Scenario E: Individual with Quadriplegia in a HCD Apartment with SSI and HUD Rental Voucher</td>
<td>$56</td>
<td>$147</td>
<td>$91</td>
</tr>
<tr>
<td>Scenario E (1) with TBI/SCI Waiver</td>
<td>$56</td>
<td>$42</td>
<td>($14)</td>
</tr>
</tbody>
</table>
• **Scenarios D** - Assisted Living Scenarios: An ALF is a cost-effective alternative when compared to charity care costs at the Healey Center. Medicaid eligible residents who need limited supports cost more in an ALF (including a HCD-operated ALF) than at the Healey Center ($91/day compared to $56/day at a HCD-operated ALF). The more services a person needs, the less cost-effective the model becomes.

However, there are several waivers that can fund services in an ALF, including the ALE Waiver, TBI/SCI Waiver, and the NHD Waiver. It seems likely that Medicaid eligibles would be able to access some additional supports to reduce the cost. (See scenario D (1).)

• **Scenario E** – HCD Apartment Scenarios: Charity care residents capable of living in independent housing with supports could do so cost-effectively even without a HUD Voucher or SSI compared to the cost incurred by the HCD for care at the Healey Center. (See scenario E (1).)

Apartments operated by the HCD could be a cost-effective option for Medicaid residents if they have access to HUD vouchers and a HCBS Waiver.

Because the HCD funds the entire cost of nursing home care for charity care residents, there are potentially more cost-effective community-based alternatives for charity care residents than for Medicaid residents. However, a resident who requires immediate access to a personal care assistant for health and safety reasons cannot be served cost-effectively in the community unless they hire a live-in worker (and it can be difficult to hire live-in workers for a variety of reasons). For example, if a personal care attendant is needed 24 hours a day, seven days a week and workers come in and out to provide 24/7 coverage, we estimate a cost of an additional $250/day to the HCD for a resident funded entirely by the HCD (“charity care”). (The total daily cost we estimate to be $596, which is $250 more than the $346 a day for care at the Healey Center.)

The HCD spends much less per day for a Medicaid resident. Therefore, cost-effective alternatives for these residents depend on being able to enroll the resident into one of the Medicaid HCBS waivers (for which there are waiting lists). The Healey Center staff do arrange community placements for Healey Center residents when resources are available. If Healey Center residents could more readily access one of the Medicaid HCBS waivers, it would be feasible to serve significantly more residents in alternative settings. Having said this, however, it is important to note that Palm Beach County has very limited access to low-income housing (the housing waiting list is currently closed, for example). In addition, most ALFs either will not accept low-income or no-income residents or cannot meet the special needs of residents such as those at the Healey Center. Therefore, outsourcing of care to alternative community-based options such as ALFs and housing with supports is generally difficult at present (although would be feasible for some residents if the HCD operated an ALF unit and/or housing).

Counties that operate nursing homes often debate whether they should be a “provider” of services or a “payor” of services. Some counties convert from providers to payors of NF services when:
There are large numbers of vacant beds in community NFs and their residents are primarily covered by Medicare or Medicaid;
They serve a more “traditional type” of nursing home resident;
They have serious problems with quality of care; and
They are losing large amounts of money operating the facility.

Furthermore, some counties have experienced significant problems after divesting themselves of the county-owned nursing home. In Eau Claire County Wisconsin, the Chair of the County Human Services Board reported a range of adverse outcomes and problems resulting from sale of their facility, concluding:

“The impact of the decision to sell the county nursing home has significantly escalated our county cost and more importantly denied the appropriate level of care to the individuals for whom we are responsible”.4

While limiting the county role to a payor appears reasonable to some (and in some circumstances would be sensible) there are many reasons Palm Beach County is likely to find this difficult:

- Even if adequate numbers of SNF beds are located, SNF providers are likely to charge a “premium” to accept some Healey Center residents.
  - Some Healey Center residents have serious behavior problems. SNFs located in states where Medicaid pays enhanced rates to serve patients with behavioral problems may be reimbursed between $300 and $600 a day for care on behavioral units or TBI units. Unfortunately, the Florida Medicaid program does not make enhanced or supplemental payments for these types of units. The HCD would absorb any additional payments for both charity care and Medicaid residents with significant behavioral problems.
- Even if the HCD contracted with SNFs to serve all residents, the HCD would retain some costs for:
  - Referral assessment and screenings
  - Case management
  - Quality-of-care oversight
- Some residents have care needs that some SNFs do not meet, such as having a new tracheostomy or requiring oxygen. The supply of SNF beds for these residents is, therefore, reduced.
- There is a limited supply, and recently a decline in the supply, of ALF beds.
- There is extremely limited to no access to subsidized housing and/or Section 8 housing vouchers. In addition, wraparound services funded by Medicaid are not readily available.

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• There is no assurance of access to contracted SNF beds even with executed contracts. SNFs can refuse referrals on the basis of “not being able to meet needs” or because “problem behaviors or history place other residents at risk”, and so on.
• Some SNFs may attempt to charge the HCD increasing supplements or high per diems once a resident is admitted as a result of special care needs the SNF provider did not adequately anticipate. This could also occur in ALFs.
• The HCD has experience as a “payor” for inpatient hospital services for the trauma care system. This year the HCD reports being asked to increase rates they pay for inpatient services by 100%. The HCD has limited leverage in this type of situation.
• SNF and ALF providers are not likely to sign a contract that includes specific rates for more than a 2-year period.
• It is easier to limit expenditures by the HCD when there is a “building” (a limited number of beds at the Healey Center). The HCD will have to manage a waiting list for “slots” more rigorously than for “beds.”

While “outsourcing” of care to community nursing homes appears reasonable for a small number of residents and can be part of a future solution to meeting the increased need for SNF services, we do not believe full outsourcing is possible or desirable.

If utilization of community-based settings as an alternative to nursing home services is to significantly reduce the need for beds at the Healey Center, the HCD will need to offer a continuum of care by developing ALF beds and/or providing access to housing. One significant advantage to the HCD operation of an ALF and/or housing is, in our opinion, a higher likelihood that residents will do well in these settings on a “Healey campus”. Existing relationships can be maintained, Healey Center staff could provide care in the ALF and in the apartments (staff who know the residents and understand their special needs), and ready access to the alternative levels of care will likely be of benefit to residents who may need intermittent or occasional access to SNF services. A continuum of care model is our recommendation and this model is discussed in more detail in the recommendations section of this Executive Summary.

**Renovation of the Healey Center**

Renovation of the Healey Center has been suggested as an alternative to new construction. Renovation was previously determined to cost upwards of 60-70% of the cost for new construction and some portions of the facility are believed to be unsuitable for renovation (i.e. would not meet existing building code requirements for a NF). The Healey Center facility is old and, in our opinion, should not be refurbished. Problems include the immediate costs to bring the facility up to compliance with essential fire and safety codes, the ongoing costs associated with maintaining such an old building, the inefficiencies of operating a SNF in this building and the general poor physical environment, which is not suited to the needs of residents. In addition, there are significant safety and efficiency issues that cannot be resolved adequately by refurbishing the facility.
The Florida Building Code allows for a great deal of grandfathering of existing conditions, but this is permitted only as long as no remodeling work is undertaken. The Code requires that once remodeling begins, anything that is touched or modified must be upgraded/replaced in order to meet current code minimums. This is not a problem for minor redecorating, but it is a major problem for electrical or mechanical system upgrades.

Almost all of the electrical wiring in the existing facility is substandard by today’s code requirements. The electrical panels do not have adequate fault protections and the wiring does not have the required redundant grounding system. It would be extremely difficult to upgrade the entire electrical system, and even if it were physically possible, the cost would be between $2 and $3 million. Improvements to the existing mechanical system can be completed in a slightly more piece meal fashion, although the code requires that improvements made to an area must be accompanied by making the entire “smoke compartment” compliant with current standards. For example, as soon as an area is “touched”, it must be brought up to current standards completely.

Because the facility is so old and the configuration so poor, areas would need to be completely gutted and then completely retrofit and redesigned. The redesign would be less than ideal, since you would be working within the constraints of the existing structure. After complete gutting and renewal of everything within the gutted area (estimated to cost $18.1 M), the facility would still be functionally obsolete and lacking in appeal. The following estimate is based upon a virtual gutting of the existing interior construction, using the exterior walls and roof where possible. This includes replacing all the windows with hurricane rated assemblies, installing all new mechanical, plumbing and electrical systems and some exterior upgrades to improve the appearance. (See Table 2.) An inflation factor and contingency fee have been applied and are conservatively estimated at 5% and 15%, respectively.

### Table 2: Estimated Cost to Renovate the Healey Center

<table>
<thead>
<tr>
<th>Task</th>
<th>Estimated Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site development, for accel / decel lane</td>
<td>$50,000</td>
</tr>
<tr>
<td>Landscaping improvements</td>
<td>$75,000</td>
</tr>
<tr>
<td>Interior demolition of 87,000 sq ft</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Interior rebuild @ $100 per sq ft</td>
<td>$8,700,000</td>
</tr>
<tr>
<td>Exterior facelift</td>
<td>$2,000,000</td>
</tr>
<tr>
<td>Architectural and engineering fees</td>
<td>$900,000</td>
</tr>
<tr>
<td>New furniture and furnishings</td>
<td>$950,000</td>
</tr>
<tr>
<td>Kitchen equipment all replaced</td>
<td>$150,000</td>
</tr>
<tr>
<td>Interior designer</td>
<td>$50,000</td>
</tr>
<tr>
<td>20% premium for phasing</td>
<td>$2,140,000</td>
</tr>
<tr>
<td>Inflation for 1 year at 5%</td>
<td>$535,000</td>
</tr>
<tr>
<td>Contingency at 15%</td>
<td>$1,605,000</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$18,155,000</strong></td>
</tr>
</tbody>
</table>
The following are specific areas of concern.

1. Most of the facility does not have central air conditioning and is dependent on in-room air conditioning units. The air conditioning units require almost constant maintenance to keep them functioning (and they are inadequate). A new central air conditioning system is required. We estimate the current cost to install a system in an 87,000 square foot existing and operating facility to be approximately $1.75 million.

2. The plumbing in portions of the building is well over 50 years old and it can be expected that the fixtures and both water supply lines and drain lines will continue to deteriorate causing significant maintenance problems. The water lines can be replaced overhead but replacing drain lines under the slab could be devastating to ongoing operations. We estimate that the current cost to replace the water lines overhead and all fixtures would be approximately $600,000. This does not address the cost or problems associated with replacement of the underground drainage piping. The cost for this cannot be reasonably estimated since the entire floor and subfloor would need to be torn up and replaced throughout the facility. This would pose a significant safety concern in addition to expense.

3. The electrical system is functioning, but the wiring and electrical panels do not meet current code requirements for a new facility. Most of the items that are deficient deal with safety issues. For example, a fire hazard exists without a redundant grounding system and panels with proper fault protection. The system can be left alone, but once any significant remodeling is undertaken, the affected portions of the electrical system must be brought up to today’s standards as per the building code requirements. We estimate the cost to upgrade all the branch wiring and panel gear to be in excess of $1.2 million and up to $2 million.

4. Fire Protection Sprinkler system: As you are probably aware, the State of Florida has mandated that all existing nursing homes have a complete automatic sprinkler system. We understand that this expense is already being undertaken. However, this is yet another example of renovation costs that are going to continue to grow with the existing facility since refurbishing the facility will make changes to the new system no matter how efficiently one tries to plan the current fire sprinkler upgrade. It is likely to be completed before refurbishment of the Healey Center would be underway, if selected as the desired option.

5. The roofing is a problem that has required ongoing maintenance. The estimate to replace the entire roofing system is in excess of $400,000

A major remodeling could be undertaken and at the conclusion you would still have a 40-year old building with a design layout that is functionally outdated. The public perception of these improvements as a remodeling project would be negligible as compared to a replacement facility that could gain prominence as a progressive facility with modern design and technology.

A New Facility

We believe the Healey Center meets a critical need in the County and should be replaced with a new facility. Ideally, the Healey Center should include SNF, ALF and housing.
options. There are multiple advantages to building a new facility. Briefly, a few of these are:

1. Reduced energy bills due to better insulation and more efficient operating equipment.
2. Lower water bills with the use of water savings fixtures.
3. Lower cost of hot water through the use of energy efficient equipment and recycling potential.
4. Lower cost of staff due to better design layout for effective daily operation of the facility.
5. Reduced maintenance costs without the burden of constant upkeep of old systems. (For example, the existing facility is utilizing eight full time equivalent (FTE) positions for plant operations (ongoing maintenance). A new SNF would require fewer FTEs.
6. Increased protection from hurricane and other weather-related problems.
7. Increase in positive public perception of a new structure.
8. Anticipated increase in revenue resulting from:
   - More short-stay residents receiving rehabilitative services with a resulting increase in revenue generated from Medicare billing.
   - Ability to provide outpatient rehabilitation services (Medicaid, Medicare, private insurance).
   - Potential to attract some additional private pay patients.

The architect is proposing a preliminary conceptual design for a new SNF that incorporates advancements in nursing home design and that includes an ALF and on-site housing to offer a continuum of care. A new facility that includes these alternatives is consistent with national trends and the preferences of persons with LTC needs (including residents at the Healey Center).

O’Keefe Architects estimate a new Healey Center that is built using advanced NF design concepts, that is fully ADA compliant and that would include a state of the art rehabilitation department, can be constructed for between $22 and $31.8 million. An inflation factor and contingency fee have been applies and are conservatively estimated at 5% and 15%, respectively. The cost varies by configuration and size, $31.8 million being the cost for a larger SNF/ALF/housing combination with a total capacity of 212 beds. A cost breakdown for three models (a 120-bed SNF/ALF, a 140-bed SNF/ALF/housing combination and a 212 SNF/ALF/housing combination) is provided in Appendix 1. Appendix 2 provides schematics for each model. Attachment II provides the specifications for the construction.

**Multiple Sites**

One issue raised in the previous feasibility study was whether or not the HCD should operate two or three smaller nursing homes in different locations within Palm Beach County, one being located in the southern end of the County in addition to the more
northerly location of the existing facility. We cannot identify a compelling reason that a second site is required in the Southern part of the County. While the area of the county where the Healey Center is located has more NF beds in nursing homes that have at least a 3-star rating, that accept Medicaid patients and that have an occupancy rate below 90%, than other areas of the County, the number of beds in the northern and southern ends of the County are similar. There is no demonstrated need for additional NF beds in the western part of the county.

Operating Costs – Multiple Nursing Homes versus Single Nursing Home

The requirements for nursing home management do not vary by size. This means that if you build two or three separate nursing homes, you will increase and in some instances double or triple (respectively) your costs in certain areas. Location of a second “Healey” facility at either the northern or southern ends of the County would double the management costs because of excessive travel time between facilities.

If multi-site nursing homes are located within a reasonable travel time from each other, management requirements would include the following:

- Nursing Home Administrator - an administrator will be required at each facility/location.
- A Director of Nursing will also be required for each facility/location.
- A social services, activities and therapy director at each location would be recommended unless each site were small (less than 60 beds, for example).
- Plant management – While there is no specific requirement to have plant management at all sites there will need to be someone responsible at each site for the physical plant, leading to something less than a tripling of costs.
- Dietary staffing – This will be higher. How much higher will depend on if each facility has its own food preparation or whether you utilize a centralized kitchen and transport food. This needs to be carefully analyzed in terms of costs and quality.
- Ancillary service providers – Multiple facilities/locations could have minimal increased costs as the therapists can move from location to location depending on need. Based on resident groupings (residents admitted primarily for rehabilitative care at one location) this cost could be further reduced.
- Regulatory compliance functions should be centralized, so there would be no additional cost. In addition, since most compliance citations are reported as gross violations per facility and not violations per bed, overall quality scores might rise since there should be fewer non-compliance findings in a smaller facility relative to a larger facility.
- The facilities would use a single business office and finance function, leading to no additional costs between models for this cost center.

The largest cost center in any nursing home (and to some extent, the primary factor that affects resident satisfaction and quality of care), is the ratio of direct care staff (including...
nurses) to residents. Staffing levels are not impacted by having a single large facility or three smaller facilities (assuming the smaller facilities reach a minimal scale). Costs for utilities and other services would generally be higher, since some services are priced by site or facility or incur a base cost that does not vary by size of facility.

Operation of multi-site nursing homes in Palm Beach County that are located within different and distinct parts of the County would result in a loss of efficiencies that might otherwise be available in smaller counties. Because of the size of the County and time required to travel from one end of the County to another, suggestions for location of another “Healey” site in the far northern or southern parts of the County would require a complete duplication of functions and is not recommended.

The HCD would also incur higher construction costs by losing some efficiencies during construction. For example, the construction of two 106-bed SNFs costs about $1.4 million more than a single 212-bed SNF. (See Table 3.)

Table 3: Estimated Costs for Two 106-bed SNFs versus One 212 bed SNF

<table>
<thead>
<tr>
<th>Detail</th>
<th>106 Beds</th>
<th>212 beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site Development</td>
<td>$400,000</td>
<td>$500,000</td>
</tr>
<tr>
<td>Soil Borings</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Survey</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Level 1 Environmental report</td>
<td>$6,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>Civil Engineering</td>
<td>$40,000</td>
<td>$50,000</td>
</tr>
<tr>
<td>Landscape Architect</td>
<td>$6,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>Landscaping and lawn sprinkler system</td>
<td>$75,000</td>
<td>$100,000</td>
</tr>
<tr>
<td>Kitchen designer</td>
<td>$9,000</td>
<td>$9,000</td>
</tr>
<tr>
<td>Kitchen equipment</td>
<td>$150,000</td>
<td>$150,000</td>
</tr>
<tr>
<td>Interior designer</td>
<td>$35,000</td>
<td>$35,000</td>
</tr>
<tr>
<td>Furnishings and movable equipment</td>
<td>$600,000</td>
<td>$1,150,000</td>
</tr>
<tr>
<td>Architectural and Building Engineering</td>
<td>$565,000</td>
<td>$1,090,000</td>
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<tr>
<td><strong>Construction</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SNF 57,000 sq ft/110,000 sq ft x $180 sq ft</td>
<td>$10,260,000</td>
<td>$19,800,000</td>
</tr>
<tr>
<td>Demolition of half of existing facility</td>
<td>$750,000</td>
<td>$1,500,000</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>$12,906,000</td>
<td>$24,406,000</td>
</tr>
<tr>
<td>2-106 bed SNFs</td>
<td></td>
<td>$25,812,000</td>
</tr>
</tbody>
</table>

**Difference in cost for 2-106 bed SNFs and 1 - 212 bed SNF**

$1,406,000*

*Excluding contingency fee and inflation factor

The increased cost does not include the cost required for two sites compared to a single site. Unless the County owns a suitable site in a different part of the County, additional funds will be required to purchase property. The cost to purchase and develop a 2-acre parcel of land would likely be about $2 million.
There are no nursing homes for sale in Palm Beach County at present, another method that might otherwise be used to secure a second facility.

**Recommendations**

Considering all factors and options, we developed three recommended models of care for the Healey Center. These models are those determined to be consistent with the County and HCD mission in regard to the Healey Center based on the interlocal agreement and statements of HCD and county interviewees. The models of care are also, to the maximum extent feasible, consistent with the stated desires of the residents of the Healey Center and staff of the Healey Center and are consistent with national trends in the provision of LTC services and nursing home design. They are provided in order of preference. We developed the following guiding principles:

- The County is committed to meeting the LTC needs of Palm Beach County residents by operating the Healey Center.
- Since the Healey Center was originally built as the “County Home” (and county homes traditionally serve low-income persons with no other options for care) the Healey Center is designed to serve residents whose needs cannot be met elsewhere.
- The HCD may provide other services to expand, enhance or provide nursing home care and long-term care services. Expansion must take into account available resources, including the available sites for location of a facility or facilities and the amount of funding (both reserve and anticipated revenue). Alternatives to SNF services must be cost-effective.

Desired enhancements include: a more homelike environment in which to receive LTC services (whether at the Healey Center or an alternative setting); a facility that incorporates to the maximum extent feasible the most advanced nursing home design features; an upgraded rehabilitation capability; and access to alternative levels of care or settings for persons who would otherwise have received skilled nursing facility services at the Healey Center.

For these reasons, we recommend that no matter which model is selected, should a new facility be constructed, it be constructed using a modified pod design as explained in this report. We estimate a new facility with three types of care (SNF, ALF and housing) comprising 212 beds in total could be constructed for about $31.8 million at the existing site. A smaller facility with 100 SNF beds and 20 ALF beds could be constructed for about $22 million.

- A mixed-use facility (SNF/ALF plus perhaps housing) is viewed as desirable by some residents and staff and is consistent with nationwide trends for provision of LTC services.
- We do not recommend inclusion of: adult day care, medical respite, outpatient dialysis, or a ventilator dependent unit. The reasons for this are discussed in the report.
- If the Healey Center were a new facility with a state of the art rehabilitation department (and since the Healey Center has a higher quality of care rating than
most facilities that take large numbers of Medicaid recipients), we believe that it is feasible to attract more dually-eligible persons to a new facility and increase revenue by increasing Medicare service billing. In addition, the ability to provide outpatient rehabilitation at the Healey Center is another area of potential revenue growth.

- We believe inclusion of at least an on-site ALF (and ideally housing) is highly desirable. This option can be cost-effective but will require careful management. Healey Center staff or HCD social workers will need to provide enhanced case management services in order to pursue and secure access to HCBS waiver services and to rental subsidies, for example. The staff of the Florida BSCIP has offered their assistance to the HCD. They are willing to come to the Healey Center, to conduct assessments of persons with TBI or SCI, to work with the residents and staff to develop a community-based care plan, and to provide access to BSCIP program funding and TBI/SCI Waiver slots to support transition and residency in alternative community-based settings. The HCD will also need to work with local and state agencies to pursue improved access to HCBS waivers such as the A/DA and ALE Waivers.

- If a new facility is constructed, we recommend the County and HCD consider including a special unit for persons with challenging behaviors who are not currently served at the Healey Center but who meet NF LOC.

Below are the three recommended models. Following the models is a high-level financial analysis for each model that estimates revenue and expenses using the modeling described in the scenarios and assuming current Medicaid and charity care costs. (See Tables 4 through 7.)

**Recommended Model 1 (Mixed Provider/Payor Model)**

Build a new but smaller “Healey Center” that includes a SNF and a distinct part ALF that in total meet a portion of the projected future need and use outsourcing to meet any future additional LTC service need or set a limit on SNF/ALF beds at a size smaller than projected future need.

- The SNF – 100 beds. Retain additional SNF bed licenses in the event the HCD determines that the ALF is not feasible and/or the need for SNF beds is so great, that conversion of the ALF is needed and/or construction of an additional wing is needed. The facility would be designed to allow for future addition of an additional 30-bed pod (comprised of two 15-bed semi-pods). The HCD may request continuation of “licenses” from AHCA annually. However, the request is limited to the number of beds physically available for conversion at the time of the request. Therefore, only 20 SNF licenses could be retained (for conversion of the 20 ALF beds) unless an exception was granted by the State.

- The ALF – 20 beds. A SNF may include an ALF as long as the ALF is a “distinct part.” Staff from the SNF may work at the ALF as long as they are not assigned to both parts simultaneously – staff may not float between facilities. The nursing home administrator may administer the ALF, but in this case there must be an
ALF manager. The ALF should be constructed compliant with NF regulations to allow conversion to SNF licensure in the event this becomes necessary in the future.

- Use private SNFs, ALFs and housing whenever feasible to meet additional need or set a limit on need to be met by the HCD of a fixed number of beds.

**Recommended Model 2 (Provider Model)**
Build a new “Healey Center” that includes a SNF, a distinct part ALF and on-site efficiency apartments (non-licensed) that in total meet a portion of the projected future need.

- The SNF – 100 beds. Retain additional SNF bed licenses in the event the HCD determines that the ALF is not feasible and/or the need for SNF beds is so great, that conversion of the ALF is needed and/or construction of an additional wing is needed. The facility would be designed to allow for future addition of an additional 30-bed pod (comprised of two 15-bed semi-pods). The HCD may request continuation of “licenses” from AHCA annually. However, the request is limited to the number of beds physically available for conversion at the time of the request. Therefore, only 20 SNF licenses could be retained (for conversion of the 20 ALF beds) unless an exception was granted by the State.

- The ALF – 20 beds. A SNF may include an ALF as long as the ALF is a “distinct part”. Staff from the SNF may work at the ALF as long as they are not assigned to both parts simultaneously – staff may not float between facilities. The nursing home administrator may administer the ALF, but in this case there must be an ALF manager. The ALF should be constructed compliant with NF regulations to allow conversion to SNF licensure in the event this becomes necessary in the future.

- Efficiency apartments – 20 beds. The housing should be compliant with HUD housing requirements to ensure that residents may access HUD Section 8 vouchers should they be available. HUD financing might be available to construct the housing although the financing is complex and reportedly very difficult to access. The HCD reports there have been about 20 residents each year who could have been served in housing but who remain at the SNF due to lack of access to resources in the community.

**Recommended Model 3 (Provider Model)**
Build a new “Healey Center” that includes a SNF, a distinct part ALF and housing that in total meet the projected future need.

- The SNF – 172 beds.

- The ALF – 20 beds. A SNF may include an ALF as long as the ALF is a “distinct part”. Staff from the SNF may work at the ALF as long as they are not assigned to both parts simultaneously – staff may not float between facilities. The nursing home administrator may administer the ALF, but in this case there must be an ALF manager. The ALF should be constructed compliant with NF regulations to
allow conversion to SNF licensure in the event this becomes necessary in the future. However, only six additional SNF bed licenses would be available for future conversion – potential conversion of all 20 ALF beds to SNF beds would require a new CON for the balance of the beds (14) to be converted.

- Efficiency apartments – 20 beds. The housing should be compliant with HUD housing requirements to ensure that residents may access HUD Section 8 vouchers should they be available. HUD financing might be available to construct the housing although the financing is complex and reportedly very difficult to access. The HCD reports there have been about 20 residents each year who could have been served in housing but who remain at the SNF due to lack of access to resources in the community.

### Table 4: Per Diem Revenues and Expenditures by Setting

<table>
<thead>
<tr>
<th></th>
<th>ALF Medicaid</th>
<th>ALF Charity</th>
<th>SNF Medicaid</th>
<th>SNF Charity</th>
<th>APT Medicaid</th>
<th>APT Charity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OSS</td>
<td>$2.61</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALE Waiver</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSI</td>
<td>$13.00</td>
<td>$13.00</td>
<td>$13.00</td>
<td></td>
<td>$13.22</td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td></td>
<td>$277.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HUD Voucher</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$26.84</td>
<td></td>
</tr>
<tr>
<td>TBI Waiver</td>
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<td></td>
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<td>$105.00</td>
<td></td>
</tr>
<tr>
<td>Total Revenue</td>
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<td>$290.00</td>
<td>$0.00</td>
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<td>$0.00</td>
</tr>
<tr>
<td><strong>Expenditures</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$122 per day</td>
<td>$122.00</td>
<td>$122.00</td>
<td>$346.00</td>
<td>$346.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$346 per day</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$212 per day</td>
<td>$122.00</td>
<td>$122.00</td>
<td>$346.00</td>
<td>$346.00</td>
<td>$187.00</td>
<td>$212.00</td>
</tr>
<tr>
<td>Total Expenditures</td>
<td>$122.00</td>
<td>$122.00</td>
<td>$346.00</td>
<td>$346.00</td>
<td>$187.00</td>
<td>$212.00</td>
</tr>
<tr>
<td><strong>Net (Shortfall)</strong></td>
<td>($54.52)</td>
<td>($122.00)</td>
<td>($56.00)</td>
<td>($346.00)</td>
<td>($41.93)</td>
<td>($212.00)</td>
</tr>
</tbody>
</table>

Note: The model proposes 92% occupancy in a SNF (higher than current occupancy) and 100% occupancy in the ALF. If occupancy were lower, the model results in a lower overall cost to the HCD because every bed day, whether Medicaid or charity care, incurs a loss paid for by the HCD. Because the model is simplistic, it does not reflect variable cost changes that would occur with changes in occupancy or size. (These types of changes will be taken into account for the detailed financial projections to be completed during Phase II of this project.)
### Table 5: Model 1 Revenues and Expenditures – 100 Bed SNF and 20-Bed ALF versus 120-Bed SNF

<table>
<thead>
<tr>
<th></th>
<th>ALF</th>
<th>SNF</th>
<th>TOTAL</th>
<th>Annualized</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OSS</td>
<td>$26.13</td>
<td></td>
<td>$26.13</td>
<td>$9,408.00</td>
</tr>
<tr>
<td>ACS</td>
<td>$92.80</td>
<td></td>
<td>$92.80</td>
<td>$33,408.00</td>
</tr>
<tr>
<td>ALE Waiver</td>
<td>$518.67</td>
<td></td>
<td>$518.67</td>
<td>$186,720.00</td>
</tr>
<tr>
<td>SSI</td>
<td>$130.00</td>
<td></td>
<td>$130.00</td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td></td>
<td>$801.32</td>
<td></td>
<td>$335,275.20</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>$647.80</td>
<td>$17,074.28</td>
<td>$17,552.08</td>
<td>$6,678,114.00</td>
</tr>
<tr>
<td><strong>Expenditures</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$122 per day</td>
<td>$2,440.00</td>
<td></td>
<td>$2,440.00</td>
<td>$878,400.00</td>
</tr>
<tr>
<td>$346 per day</td>
<td></td>
<td>$31,832.00</td>
<td></td>
<td>$11,459,520.00</td>
</tr>
<tr>
<td>Total Expenditures</td>
<td>$2,440.00</td>
<td>$31,832.00</td>
<td>$34,272.00</td>
<td>$12,337,920.00</td>
</tr>
<tr>
<td><strong>Net (Shortfall)</strong></td>
<td>($1,765.20)</td>
<td>($13,956.40)</td>
<td>($15,724.80)</td>
<td>($5,659,776.00)</td>
</tr>
</tbody>
</table>

**Comparison: 120 Bed SNF (92% Occupancy, 2/3 Medicaid)**

<table>
<thead>
<tr>
<th></th>
<th>Per Day</th>
<th>Annualized</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSI</td>
<td>$961.58</td>
<td>$346,170.24</td>
</tr>
<tr>
<td>Medicaid</td>
<td>$20,489.14</td>
<td>$7,376,088.96</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>$21,450.72</td>
<td>$7,722,259.20</td>
</tr>
<tr>
<td><strong>Expenditures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$346 per day</td>
<td>$38,198.40</td>
<td>$13,751,424.00</td>
</tr>
<tr>
<td>Total Expenditures</td>
<td>$38,198.40</td>
<td>$13,751,424.00</td>
</tr>
<tr>
<td><strong>Net (Shortfall)</strong></td>
<td>($16,747.68)</td>
<td>($6,029,164.80)</td>
</tr>
</tbody>
</table>

*Note: 120 Beds = 100 Bed SNF (92% Occupancy – 2/3 Medicaid), 20 Bed ALF (100% Occupancy – 50% Medicaid)*
Table 6: Model 2 – 140 Beds (100 Bed SNF, 20 Bed ALF and 20 Apartments)

<table>
<thead>
<tr>
<th></th>
<th>ALF</th>
<th>SNF</th>
<th>APT</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
<td></td>
<td>Annualized</td>
</tr>
<tr>
<td>OSS</td>
<td>$26.13</td>
<td>$26.13</td>
<td>$9,408.00</td>
<td>$26.13</td>
</tr>
<tr>
<td>ALE Waiver</td>
<td>$518.67</td>
<td>$518.67</td>
<td>$186,720.00</td>
<td>$518.67</td>
</tr>
<tr>
<td>SSI</td>
<td>$130.00</td>
<td>$801.32</td>
<td>$1,063.54</td>
<td>$801.32</td>
</tr>
<tr>
<td>Medicaid</td>
<td>$17,074.28</td>
<td>$17,074.28</td>
<td>$6,146,740.80</td>
<td>$17,074.28</td>
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<tr>
<td>HUD Voucher</td>
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<td>$268.45</td>
<td>$96,640.80</td>
<td>$268.45</td>
</tr>
<tr>
<td>TBI Waiver</td>
<td>$1,050.00</td>
<td>$1,050.00</td>
<td>$378,000.00</td>
<td>$1,050.00</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>$674.80</td>
<td>$17,875.60</td>
<td>$1,450.67</td>
<td>$20,001.07</td>
</tr>
</tbody>
</table>

| **Expenditures**       |     |     |     | Annualized     |
| $122 per day           | $2,440.00 | $2,440.00 | $878,400.00 | $2,440.00 |
| $346 per day           | $31,832.00 | $31,832.00 | $11,459,520.00 | $31,832.00 |
| $212 per day           | $3,740.00 | $3,740.00 | $1,346,400.00 | $3,740.00 |
| **Total Expenditures** | $2,440.00 | $31,832.00 | $3,740.00 | $38,012.00 |
| **Net (Shortfall)**    | ($1,765.20) | ($13,956.40) | ($2,289.33) | ($18,010.93) |

Note: 100 Bed SNF (92% Occupancy – 2/3 Medicaid), 20 Bed ALF (100% Occupancy – 50% Medicaid), 20 Apartments (50% Medicaid)

Comparison: 140 Bed SNF (92% Occupancy, 2/3 Medicaid)

<table>
<thead>
<tr>
<th></th>
<th>Per Day</th>
<th>Annualized</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSI</td>
<td>$1,121.85</td>
<td>$403,865.28</td>
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<tr>
<td>Medicaid</td>
<td>$23,903.99</td>
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</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>$25,025.84</td>
<td>$9,009,302.40</td>
</tr>
</tbody>
</table>

| **Expenditures**       |         |                                  |
| $346 per day           | $44,564.80 | $16,043,328.00                   |
| **Total Expenditures** | $44,564.80 | $16,043,328.00                   |
| **Net (Shortfall)**    | ($19,538.96) | ($7,034,025.60)                  |
### Table 7: Model 3 - 212 Beds (172 Bed SNF, 20 Bed ALF and 20 Apartments)

#### Revenues and Expenditures Per Day

<table>
<thead>
<tr>
<th></th>
<th>ALF</th>
<th>SNF</th>
<th>APT</th>
<th>TOTAL</th>
<th>Annualized</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OSS</td>
<td>$26.13</td>
<td>$26.13</td>
<td></td>
<td>$9,408.00</td>
<td></td>
</tr>
<tr>
<td>ALE Waiver</td>
<td>$518.67</td>
<td>$518.67</td>
<td></td>
<td>$186,720.00</td>
<td></td>
</tr>
<tr>
<td>SSI</td>
<td>$130.00</td>
<td>$1,378.27</td>
<td>$132.22</td>
<td>$1,640.49</td>
<td>$590,576.54</td>
</tr>
<tr>
<td>Medicaid</td>
<td></td>
<td>$29,367.76</td>
<td>$29,367.76</td>
<td>$10,572,394.18</td>
<td></td>
</tr>
<tr>
<td>HUD Voucher</td>
<td></td>
<td>$268.45</td>
<td>$268.45</td>
<td>$96,640.80</td>
<td></td>
</tr>
<tr>
<td>TBI Waiver</td>
<td></td>
<td>$1,050.00</td>
<td>$1,050.00</td>
<td>$378,000.00</td>
<td></td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>$674.80</td>
<td>$30,746.03</td>
<td>$1,450.67</td>
<td>$32,871.50</td>
<td>$11,833,739.52</td>
</tr>
</tbody>
</table>

|                                |     |              |     |       |             |
| **Expenditures**               |     |              |     |       |             |
| $122 per day                   | $2,440.00 |             |     | $878,400.00 |
| $346 per day                   | $54,751.04 |             | $54,751.04 | $19,710,374.40 |
| $212 per day                   | $3,740.00 | $3,740.00   | $1,346,400.00 |
| **Total Expenditures**         | $2,440.00 | $54,751.04   | $3,740.00 | $60,931.04 | $21,935,174.40 |
| **Net (Shortfall)**            | ($1,765.20) | ($24,005.01) | ($2,289.33) | ($28,059.54) | ($10,101,434.88) |

**Note:** 172 Bed SNF (92% Occupancy – 2/3 Medicaid), 20 Bed ALF (100% Occupancy – 50% Medicaid), 20 Apartments (50% Medicaid)

### Comparison: 212 Bed SNF (92% Occupancy, 2/3 Medicaid)

<table>
<thead>
<tr>
<th></th>
<th>Per Day</th>
<th>Annualized</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
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<td></td>
</tr>
<tr>
<td>SSI</td>
<td>$1,698.80</td>
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</tr>
<tr>
<td>Medicaid</td>
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</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>$37,896.27</td>
<td>$13,642,657.92</td>
</tr>
</tbody>
</table>

|                                |         |              |
| **Expenditures**               |         |              |
| $346 per day                   | $67,483.84 | $24,294,182.40 |
| **Total Expenditures**         | $67,483.84 | $24,294,182.40 |
| **Net (Shortfall)**            | ($29,587.57) | ($10,651,524.48) |
Additional Recommendations

The following recommendations are suggested for further exploration:

- Consider seeking legislation to require full cost-based reimbursement of county-owned SNFs through the Medicaid program consistent with Medicaid reimbursement of “exempt” hospitals (including county and rural hospitals).

- No matter the decision made regarding the future of the Healey Center, we suggest that Healey Center and/or HCD social workers undertake more intensive efforts to place residents with TBI/SCI in the community by working with the BSCIP.

- Consider the possibility of developing a county-specific Medicaid HCBS waiver for county residents residing in or at imminent risk of entering the Healey Center, where the HCD would contribute funds to pull down FFP. HMA is assisting a county in California with development of this type of waiver at present.

- Explore the possibility of becoming a managed integrated acute/LTC provider funded through both Medicaid and Medicare (as a Medicare Advantage Plan). Such a program would need to include disabled non-elderly adults.
Resident Stories
As part of this study we interviewed residents of the facility who agreed to share their stories with us for inclusion in the report. We have changed the names of the interviewed residents to protect their identity. However, David Terry asked that we provide his name and story without alteration and this is included below. Other residents’ stories are included throughout the report.

David’s Story
David Terry is 33 years old. David asked that we use his own name in this summary for our report. David has lived at the Healey Center 10 years this June. David is at the Healey Center as a result of a car accident. He suffered a Traumatic Brain Injury (TBI) and was in a coma for 30 days.

He was taken to a hospital where a tracheostomy was performed and was in a coma at the time of his transfer to the Healey Center. After he awakened from the coma he was able to eventually have the tracheostomy closed.

Prior to his accident, David worked in the construction industry for several years. David reports his memory is good for the last 4-year period, but he has no memory of about a twenty-year period. He initially received therapy every day at the Healey Center, but this has ended now.

David is not sure what his goals are for the next year. When asked if he would like to leave the Healey Center, David says it would be hard to leave.

David provided the interviewers with a typed statement of suggestions for a new Healey Center. He believes a “new and improved facility” is best. He is especially concerned that a new building be elevated sufficiently to be outside of the flood zone. His suggestions also included:

- We have good therapists – we need a good therapy room with all kinds of equipment.
- Two residents to a room is good so you don’t feel alone, although some people like privacy and loud roommates can be a problem.
- A good dining room and kitchen is needed.
- Paper products are wasteful – we should be using cloth napkins for example.
- We need more washing machines for our laundry.
- A one-floor facility is best.
Background

The Health Care District of Palm Beach County (HCD) contracted with Health Management Associates (HMA) to conduct a feasibility study for the Edward J. Healey Rehabilitation and Nursing Center, an aging skilled nursing facility operated by the HCD. The HMA team included Dennis O’Keefe, President of O’Keefe Architects Inc., and Glen Mitchell, Ph.D. and Larry Polivka, Ph.D., with the State Data Center on Aging (SDCA) at the University of South Florida (USF).

Phase I of this project consisted of information gathering and development of specific findings and recommendations regarding the future of the Healey Center. The recommendations presented are those that the HMA team believes represent the most appropriate and feasible models of care designed to address the needs of two groups of Palm Beach County residents:

- Residents currently served at the Healey Center; and
- Residents likely to seek NF services at the Healey Center in the future.

Phase II will include the completion of one or more Master Facility Plans based on the outcomes of Phase I and development of a ten-year operating budget pro-forma.

Phase I Activities

Between November 2007 and February 2008, Health Management Associates (HMA) conducted site visits, interviews and information gathering designed to enable us to identify the specific populations and services/settings that should be included in the Long-Term Care (LTC) Community Needs Projection and Outlook to be completed by researchers from the University of South Florida (USF).

During the month of November, Marshall Kelley, Susan Tucker and Nicky Moulton of Health Management Associates, Dennis O’Keefe of O’Keefe Architects Inc. and Glen Mitchell of the University of South Florida, visited the Health Care District staff, met with the staff of the Healey Center and toured the Healey Center. During the month of December, HMA received initial data and documents from the Health Care District for review and analysis. Nicky Moulton, Susan Tucker and Dennis O’Keefe completed a second site visit during January 2008 interviewing HCD staff, the County liaison, County housing staff, community based organizations, and key Healey Center staff.

During February, Nicky Moulton and Marshall Kelley of HMA visited the Healey Center, interviewing residents and conducting a resident council meeting attended by twenty-five residents, to obtain resident input regarding facility design. We also completed some supplemental interviews and reviewed additional data from the Healey Center.

The residents we interviewed agreed to provide their personal stories. These stories are inserted throughout the report and are intended to provide the reader with another view of the Healey Center – the view from the residents’ perspectives.
The information gathered during this time period was also utilized to develop guidelines for the USF researchers, who prepared the LTC Community Needs Projection and Outlook.

From May through July of 2008, USF researchers gathered and analyzed LTC data in order to complete the Community Needs Projection and Outlook. Their report “Edward J. Healey Rehabilitation and Nursing Center Community Needs Assessment” (August 2008), is incorporated into Part I of this study with additional data and information added by HMA when appropriate. The report is also provided in its entirety as Attachment 1 for easy reference.

We also conducted a review of SNFs to identify those that might be willing to serve Healey Center residents and developed estimated costs to serve Healey Center residents in alternative community-based settings.

The completion of these tasks enabled us analyze the range of options concerning the future of the Healey Center including:

- Outsourcing of care;
- Renovation of the existing facility;
- Construction a new single NF at the existing site of the Healey Center; and
- Alternative scenarios, including:
  - A new site
  - Multiple sites
  - NF/ALF combination
  - A continuum of care model (NF/ALF/housing)
  - Partial outsourcing

At the conclusion of this Phase I report, we provide a list of options that include advantages and concerns specific to each option and provide our recommendations specific to the future of the Healey Center.

The Phase I report is designed to enable the HCD to select and recommend a facility and/or program model to the Board designed to meet the future needs of Healey Center residents and those who will turn to the HCD in the future to meet their LTC needs. Upon approval of the model, HMA will undertake Phase II: completion of a master facility/program plan(s).

**Profile of Healey Center Residents**

The Edward J. Healey Health and Rehabilitation Center (Healey Center) is owned by Palm Beach County. It is subsidized and operated by the Health Care District (HCD) of Palm Beach County. The Healey Center is an important part of the County safety net. It is one of only nine county, hospital district or city-owned nursing homes in the state. The Healey Center currently has 198 licensed skilled nursing facility (SNF) beds.
Approximately 125 beds are currently available for residents. The remainder of the beds are not currently being used for residents with some being used as offices or for storage.

**Government-Owned Nursing Facilities**

Nine Florida SNFs (just over 1%) are operated by county or municipal governments. Nationwide, 6% of SNFs are government owned (including city, county, state and federal ownership). Table 8 provides the distribution of SNFs by ownership in each state for 2006.

**Table 8: 2006 SNF Ownership**

<table>
<thead>
<tr>
<th>State</th>
<th>For Profit</th>
<th>Non-Profit</th>
<th>Government-Owned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska</td>
<td>0%</td>
<td>39%</td>
<td>62%</td>
</tr>
<tr>
<td>Wyoming</td>
<td>43%</td>
<td>14%</td>
<td>43%</td>
</tr>
<tr>
<td>Hawaii</td>
<td>46%</td>
<td>28%</td>
<td>26%</td>
</tr>
<tr>
<td>Idaho</td>
<td>65%</td>
<td>14%</td>
<td>22%</td>
</tr>
<tr>
<td>Nebraska</td>
<td>48%</td>
<td>30%</td>
<td>22%</td>
</tr>
<tr>
<td>Montana</td>
<td>38%</td>
<td>46%</td>
<td>17%</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>50%</td>
<td>34%</td>
<td>16%</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>48%</td>
<td>37%</td>
<td>15%</td>
</tr>
<tr>
<td>Minnesota</td>
<td>28%</td>
<td>58%</td>
<td>14%</td>
</tr>
<tr>
<td>Mississippi</td>
<td>68%</td>
<td>18%</td>
<td>14%</td>
</tr>
<tr>
<td>Kansas</td>
<td>50%</td>
<td>37%</td>
<td>13%</td>
</tr>
<tr>
<td>Nevada</td>
<td>77%</td>
<td>11%</td>
<td>13%</td>
</tr>
<tr>
<td>South Carolina</td>
<td>73%</td>
<td>15%</td>
<td>12%</td>
</tr>
<tr>
<td>Colorado</td>
<td>66%</td>
<td>24%</td>
<td>10%</td>
</tr>
<tr>
<td>Delaware</td>
<td>52%</td>
<td>38%</td>
<td>10%</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>35%</td>
<td>55%</td>
<td>10%</td>
</tr>
<tr>
<td>Michigan</td>
<td>65%</td>
<td>25%</td>
<td>10%</td>
</tr>
<tr>
<td>West Virginia</td>
<td>64%</td>
<td>26%</td>
<td>10%</td>
</tr>
<tr>
<td>Georgia</td>
<td>65%</td>
<td>27%</td>
<td>9%</td>
</tr>
<tr>
<td>Alabama</td>
<td>81%</td>
<td>11%</td>
<td>8%</td>
</tr>
<tr>
<td>New York</td>
<td>50%</td>
<td>42%</td>
<td>8%</td>
</tr>
<tr>
<td>Washington</td>
<td>71%</td>
<td>21%</td>
<td>8%</td>
</tr>
<tr>
<td>Missouri</td>
<td>66%</td>
<td>27%</td>
<td>7%</td>
</tr>
<tr>
<td>New Jersey</td>
<td>65%</td>
<td>29%</td>
<td>6%</td>
</tr>
<tr>
<td>New Mexico</td>
<td>67%</td>
<td>27%</td>
<td>6%</td>
</tr>
<tr>
<td>Tennessee</td>
<td>73%</td>
<td>21%</td>
<td>6%</td>
</tr>
<tr>
<td>Iowa</td>
<td>52%</td>
<td>43%</td>
<td>5%</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>84%</td>
<td>12%</td>
<td>5%</td>
</tr>
<tr>
<td>Oregon</td>
<td>81%</td>
<td>15%</td>
<td>5%</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>48%</td>
<td>47%</td>
<td>5%</td>
</tr>
</tbody>
</table>
Like the Healey Center, county-/city-owned SNFs serve a resident population that is different from the residents served by more traditional skilled nursing facilities (SNFs). Unlike commercial and not-for-profit SNFs, the Healey Center and other county-/city-owned SNFs in Florida function as a “safety-net,” offering SNF services to individuals who would otherwise be rejected by commercial and not-for-profit SNFs for lack of a payer source (or lack of a desirable payor source) or as a result of having special needs (often behavioral health needs). County-/city-owned SNFs are also more likely to accept resource-intensive residents than more traditional commercial and not-for-profit SNFs.

**Length of Stay**

One major difference between county-/city-owned SNFs and more traditional SNFs is resident length of stay (LOS). This is evident in Table 9, which presents a frequency distribution for resident length of stay (LOS). County-/city-owned SNFs have a larger proportion of residents with longer LOS. 36.5% of residents in county-/city-owned SNFs have a LOS greater than one year, compared with 18.5% for Palm Beach County and 19.8% for all Florida SNFs.
Table 9: Nursing Home Length of Stay, 2006

<table>
<thead>
<tr>
<th>Length of Stay</th>
<th>County-/City-Owned</th>
<th>Palm Beach County</th>
<th>Florida</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 PLUS YEARS</td>
<td>2.12%</td>
<td>0.27%</td>
<td>0.37%</td>
</tr>
<tr>
<td>5 TO 10 YEARS</td>
<td>6.91%</td>
<td>1.86%</td>
<td>2.26%</td>
</tr>
<tr>
<td>1 TO 5 YEARS</td>
<td>27.42%</td>
<td>16.40%</td>
<td>17.16%</td>
</tr>
<tr>
<td>180 THRU 364 DAYS</td>
<td>31.19%</td>
<td>30.64%</td>
<td>32.66%</td>
</tr>
<tr>
<td>90 THRU 179 DAYS</td>
<td>10.68%</td>
<td>12.49%</td>
<td>14.44%</td>
</tr>
<tr>
<td>30 THRU 89 DAYS</td>
<td>6.29%</td>
<td>9.90%</td>
<td>10.14%</td>
</tr>
<tr>
<td>LESS THAN 30 DAYS</td>
<td>15.39%</td>
<td>28.44%</td>
<td>22.97%</td>
</tr>
</tbody>
</table>

*Source: MDS II, CMS.*

Figure 1: Nursing Home LOS, 2006

The Healey Center is even more extreme in terms of LOS. (See Table 10.) A larger fraction of the resident population residing at the Healey Center in January 2008 had LOS greater than five years compared with the entire category of Florida county-/city-owned SNFs. 8.26% of Healey Center residents had a LOS in excess of ten years. This is four times the proportion for county-/city-owned SNFs (2.12%) and more than sixteen times the proportion for Palm Beach County SNFs (0.27%) and Florida SNFs (0.37%).\(^5\)
<table>
<thead>
<tr>
<th>Length of Stay</th>
<th>Healey Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 PLUS YEARS</td>
<td>8%</td>
</tr>
<tr>
<td>5 TO 10 YEARS</td>
<td>21%</td>
</tr>
<tr>
<td>1 TO 5 YEARS</td>
<td>42%</td>
</tr>
<tr>
<td>180 THRU 364 DAYS</td>
<td>11%</td>
</tr>
<tr>
<td>90 THRU 179 DAYS</td>
<td>6%</td>
</tr>
<tr>
<td>30 THRU 89 DAYS</td>
<td>6%</td>
</tr>
<tr>
<td>LESS THAN 30 DAYS</td>
<td>6%</td>
</tr>
</tbody>
</table>

Source: Edward J. Healey Health and Rehabilitation Center.

Because the Healey Center serves a much younger population than other nursing homes, (and many of these residents were homeless before admission or had few if any resources), the residents are more likely to remain there for many years.

Figure 2: Healey Center Residents LOS January 2008 (N=107)

Source: Edward J. Healey Health and Rehabilitation Center.

Longer LOS is reported by other county nursing homes in other states. Wisconsin, which has 49 county-owned nursing homes in 40 counties reported that at the end of 2005, 40.9% of private nursing home residents in Wisconsin had been residing in the nursing home for less than a year, while 19.7% had lived there for at least four years. By comparison, in Wisconsin public nursing homes, 30.4% of residents had been there for less than a year, while 30.6% had been there for more than four years.6

The pattern is reversed when shorter LOS is considered. Palm Beach County SNF residents and Florida SNF residents are more likely to have the shorter LOS typically associated with rehabilitation after hospitalization for an acute care episode. 33.1% of Florida SNF residents during 2006 had a LOS less than 90 days. The percentage was higher for Palm Beach County SNF residents: 38.3%. For county-/city-owned SNFs, the

percentage falls to 21.7%. At the Healey Center, 16.5% of the residents had a LOS less than 90 days – less than one-half of the proportion for more traditional SNFs.

The “under ninety days” residents are an important consideration in terms of public subsidy for the costs of their nursing home care. For Medicare-eligible residents, the Medicare program is the expected payer for short-term post-hospital stays in a SNF. The Healey Center, and thereby the Palm Beach County Health District, has not utilized Medicare as a significant payor source compared with other Florida SNFs, even county-/city-owned SNFs.

**James’ Story**

James (not his real name) is 56 years old. He has lived at the Healey Center for 11 years. Prior to coming to the Healey Center he had a stroke and was hospitalized. The stroke impacted his left side, resulting in left sided weakness. He now uses a wheelchair and needs assistance with his daily care.

James was originally from Haiti, having come to the United States to work and earn money to send home to his wife and children. He has not seen his family recently and would very much like to visit them or have them visit him. He also would like to leave the Healey Center but says he does not have the money he needs to do this. He has just the $35/month personal needs allowance the State of Florida authorizes for nursing home residents. (James is Medicaid eligible.)

James is not sure it matters whether or not the Healey Center is repaired or a new facility is built. His greatest concern is how to find a way to see his family.

**Demographics**

Demographics are another important difference between the Healey Center and other SNFs. If we know nothing else about a Florida SNF resident, the typical expectation would be a frail woman in her eighties or nineties (Sahyoun et al. 2001). The resident mix at the Healey Center is very different in terms of both age and gender. The typical resident is male and in his fifties.

**Figure 3: Nursing Home Resident Median Age, 2006**

![Bar chart showing median ages](source: MDS II, CMS.)

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The median age of 54 years at the Healey Center is much younger than other Florida SNFs. Even county-/city-owned SNFs have a median resident age of 77 years. Among Florida SNFs generally, the median age is 80. It is slightly older (82 years) for Palm Beach County SNFs.

<table>
<thead>
<tr>
<th>Ages</th>
<th>Number of Residents</th>
<th>Percentage of Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 25</td>
<td>4</td>
<td>4%</td>
</tr>
<tr>
<td>25 - 54</td>
<td>43</td>
<td>40%</td>
</tr>
<tr>
<td>55 - 64</td>
<td>32</td>
<td>30%</td>
</tr>
<tr>
<td>65 - 74</td>
<td>18</td>
<td>17%</td>
</tr>
<tr>
<td>75 - 84</td>
<td>7</td>
<td>7%</td>
</tr>
<tr>
<td>85+</td>
<td>3</td>
<td>3%</td>
</tr>
</tbody>
</table>

Source: Edward J. Healey Health and Rehabilitation Center.

An interesting finding was the tendency for the median age of SNF populations to drop over the previous five years of data. This was true for the Healey Center, where the median resident age dropped from 62 to 55. It was also true for county-/city-owned SNFs, Palm Beach County SNFs, and Florida SNFs generally. Much of the reduction in median age was the result of fewer residents age 85+ residing in SNFs relative to younger residents.

This pattern is consistent with several explanations: delaying/diverting long-term nursing home residence, transitioning nursing home residents back to the community, and earlier discharge from hospitals with a resulting shift from longer hospital stays to short-term SNF stays. HCBS alternatives are generally less expensive than long-term nursing home residency.

Florida has added a number of HCBS programs, both Medicaid and Florida general revenue (GR) only, to delay or prevent SNF admissions and to allow some SNF residents to transition to care settings in the community, such as to senior housing and housing for persons with disabilities, adult foster care settings and assisted living facilities (ALFs). The incentives are quite different, however, with respect to short-term nursing home stays.

For the Medicare-eligible population, moving people from the hospital to the nursing home can reduce costs. It can also save hospital days under the lifetime inpatient restriction. The discussion of short-term nursing home stays in the next section of the report demonstrates that the ratio of short-term to long-term stays for Florida is shifting in the direction of short-term stays.

As mentioned previously, the gender distribution is also reversed at the Healey Center, with more male residents than female.
The Healey Center gender distribution contrasts with other county-/city-owned SNFs, where slightly more than one-half of the resident populations (55.7%) are female. The gender distributions for Palm Beach County and Florida SNFs are consistent with national experiences, with women being present at higher proportions than the general population: a 2:1 ratio of women to men (Sahyoun et al. 2001).

**Chronic Conditions**

The case-mix of chronic conditions at the Healey Center is the likely explanation for the longer LOS and demographic differences at the Center. Table 12 displays chronic conditions with substantial proportional variation when comparing the Healey Center to other SNFs.

<table>
<thead>
<tr>
<th>Chronic Condition</th>
<th>Healey Center</th>
<th>Palm Beach County</th>
<th>County-/City-Owned</th>
<th>Florida Statewide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td>27.05%</td>
<td>17.08%</td>
<td>17.65%</td>
<td>19.72%</td>
</tr>
<tr>
<td>HIV</td>
<td>5.33%</td>
<td>0.86%</td>
<td>1.79%</td>
<td>0.63%</td>
</tr>
<tr>
<td>Spinal Cord Injury</td>
<td>10.66%</td>
<td>0.78%</td>
<td>2.34%</td>
<td>0.94%</td>
</tr>
<tr>
<td>Traumatic Brain Injury</td>
<td>5.33%</td>
<td>0.21%</td>
<td>2.25%</td>
<td>0.40%</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>3.69%</td>
<td>18.92%</td>
<td>15.40%</td>
<td>21.01%</td>
</tr>
<tr>
<td>Asthma/COPD</td>
<td>4.51%</td>
<td>18.14%</td>
<td>16.41%</td>
<td>24.24%</td>
</tr>
<tr>
<td>Dementia</td>
<td>7.38%</td>
<td>26.17%</td>
<td>20.10%</td>
<td>29.20%</td>
</tr>
</tbody>
</table>

Source: MDS II, CMS.

The Healey Center has a larger proportion of residents with traumatic brain injuries (TBI) and spinal cord injuries (SCI) than other Florida SNFs. Patients with stroke, typically hemiplegic, are also more prevalent at the Healey Center. (See Figures 5, 6 and 7.)
The typical Florida SNF resident has similar chronic conditions to SNF residents nationwide. The typical SNF resident is geriatric with chronic conditions such as asthma/COPD, end-stage dementia, heart disease, or stroke. Healey Center residents, in...
contrast, are more likely to be younger persons with quadriplegia/paraplegia secondary to traumatic injury or hemiplegia secondary to stroke.

The Healey Center is markedly different from national trends for specific chronic conditions. Less than 5% of Healey Center residents have congestive heart failure or arteriosclerotic heart disease. Among Palm Beach County SNFs, for example, the rate is 31.8%. For Florida SNFs, heart disease (including congestive heart failure and myocardial infarction) runs higher at 36.6%. Even among county-/city-owned SNFs, the rate is 24.6%. That’s more than four times the prevalence reported for the Healey Center.

Dementia, another common condition among SNF residents, is less prevalent at the Healey Center, where 7.4% of residents are identified as having dementia. The prevalence of dementia among Palm Beach County and Florida SNFs is 26.2% and 29.2% respectively. Again, the Healey Center experience is atypical even among county-/city-owned SNFs, where dementia is reported as a diagnosis for 20.1% of residents.

The Healey Center also has a larger percentage of residents receiving certain types of special care – most noticeably, ostomy care.

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>July 2008</th>
<th>Florida SNF Rate</th>
<th>National SNF Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Healey Residents</td>
<td>% of Healey Residents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ostomy care</td>
<td>34</td>
<td>32%</td>
<td>5%</td>
</tr>
<tr>
<td>Tube feedings</td>
<td>23</td>
<td>21%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Source: Edward J. Healey Health and Rehabilitation Center.

In 2006, 4.9% of Florida nursing home residents and 4.3% of all nursing home residents were reported to be receiving ostomy care compared to 32% of Healey Center residents. Tube feeding of Healey Center residents is also much more common than in the average Florida nursing home or nursing homes nationwide (18.8% compared to 7.2% and 5.8%, respectively). The high rate of ostomy care and tube feedings at the Healey Center likely reflects the needs of residents at the center with spinal cord injuries, traumatic brain injuries and strokes.

(National and Florida-specific nursing home data is available at present only through 2006. While nursing homes have seen a slight increase in ostomy care incidence (and a decrease in tube feeding), the changes have been small historically. Therefore, comparison to 2008 Healey Center data is considered reliable.)

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**Medicaid Paid Claims**

The Healey Center residents have higher than average per member per month (PMPM) Medicaid claims than residents in other SNFs.8

**Figure 8: PMPM Total Medicaid Claims**

![Chart showing PMPM total Medicaid claims for Healey Center, Palm Beach County, County-/City-Owned, and Florida.](chart)

**Source:** Florida Medicaid, Claims, SFY 2005-06.

PMPM Medicaid claims for Healey Center residents averaged $5,455 during SFY 2005-06. As an annual average of total claims per Medicaid resident, this translates into $58,358. Healey Center residents have an annual Medicaid claims experience that is more than 60% higher than Florida SNF residents ($3,396 PMPM) and more than 50% higher compared to Palm Beach County SNF residents ($3,548 PMPM). When contrasted against county-/city-owned SNFs ($4,290 PMPM), the Healey Center claims experience remains a large outlier, running nearly 30% higher.

The case-mix at the Healey Center is more likely to generate additional Medicaid claims beyond nursing home per diems. Residents with SCI, for example, are more likely than many other residents, to develop pressure sores, phlebitis, and pneumonia (Gabella et al. 2007).

Nursing home per diem accounted for 73.7% of total Medicaid claims for Healey Center residents. This contrasts with 79.4% for Palm Beach County SNF residents and 79.6% for Florida SNF residents. Even on this measure, the Healey Center is different from other county-/city-owned SNFs, where the pattern was much closer to the Florida and Palm Beach County experiences (with the nursing home per diem accounting for 79.1% of total Medicaid claims).

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8 PMPM claims are per capita measures. They are calculated by summing the Medicaid claims for the residents and then dividing the sum by the number of Medicaid case months for the residents. PMPM claims are a familiar metric for Medicaid cost analyses. They are easily converted into average annual claims experiences by multiplying PMPM claims by the average number of Medicaid case months.
Higher PMPM claims at the Healey Center are also explained by Healey Center staffing at higher ratios. Health Care District officials report that the Healey Center began staffing at a higher level (owing to the needs of its resident case-mix) before Florida’s enhanced staffing requirements were widely implemented among other SNFs. The health care market costs are also more expensive for Palm Beach County than many places in Florida and government-owned facilities typically incur higher costs for personnel than non-government-owned facilities. These factors in combination result in higher salary and benefit costs for management and staff.

Population Forecasts for Palm Beach County

Methodology
Population forecasts for the State of Florida were constructed by analysts at the State Data Center on Aging from county-level forecasts using U.S. population reports from the National Center for Health Statistics (NCHS). These are the same population reports used by NCHS for official U.S. government reports, such as the annual series *Health, United States.*

Time-series analysis was used to generate the forecasts. Time-series analysis assumes that there is reliable information about the past, the process that drives the previous pattern can be identified, and the same process will continue in the future. The analyst looks backwards to detect the pattern and separate it from random fluctuations. The identified pattern is then used to predict future values. The more information about the past and the greater the reliability of the data, the better the forecasts will be. The population forecasts in this report used annual data from 1990 through 2007. Forecasts were made through 2030.

Population forecasts were developed with a statistical technique called Box-Jenkins ARIMA modeling. ARIMA is an acronym for Auto-Regressive Integrated Moving Average. The technique is used to understand and predict future values for a time-series population. The strength of ARIMA modeling is its ability to generate separate estimates for auto-regressive, integrated, and moving average time-series components. For a more detailed explanation of ARIMA modeling see the complete “Edward J. Healey Rehabilitation and Nursing Center Community Needs Assessment” provided as Attachment I.

Hispanic and non-Hispanic were treated as ethnicities in this report. Ethnicity was forecast separately from race. Age from birth to 84 was broken into five year cohorts (*e.g.*, 0 to 4 through 80 to 84). Ages 85 and older were a separate cohort. Population estimates used age, gender, race/ethnicity crossings. Each demographic crossing had a separate forecast. To do otherwise, would be to assume that birth rates, net migration, and death rates were constant for all gender, race, ethnicity, and age groups. This means that a separate ARIMA analysis was undertaken for each demographic crossing.
The forecasts for the separate demographic crossings were aggregated at the county level to forecast county total population and the populations for major demographic groups: gender, age, race, and ethnicity. The Florida population forecasts then aggregated the results from the individual Florida counties.

It is one thing to generate forecasts. It is another to generate accurate forecasts. To assess the accuracy of the forecasts used in this report, the estimates were compared with population forecasts generated by the Florida Demographic Estimating Conference. The Florida Demographic Estimating Conference uses not only the population time-series but also separate time-series for births, deaths, and net migration to forecast Florida’s statewide population.

The estimates in this report used only population itself, since reliable county-level records were available for population. Births and deaths are also available at the county-level. Net migration was the missing component for county-level estimates and why analysts at the State Data Center on Aging generated their own population estimates.

The longer the forecast, the less accuracy expected. Estimates for 2020 vary by approximately 1% generally. Out to 2030, the method used by analysts at the State Data Center on Aging generated estimates that were generally consistent with those from the Florida Demographic Estimating Conference.

<table>
<thead>
<tr>
<th></th>
<th>State Data Center on Aging Estimate for 2020</th>
<th>Florida Demographic Estimating Conference</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>22,961,304</td>
<td>22,551,446</td>
<td>1.02%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>State Data Center on Aging Estimate for 2030</th>
<th>Florida Demographic Estimating Conference</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>2030</td>
<td>26,428,061</td>
<td>25,405,602</td>
<td>4.02%</td>
</tr>
</tbody>
</table>

**General Population Forecasts**

The total general population for Palm Beach County was 1,299,166 during 2007. Using the methodology described above, the population forecast for 2030 is 1,877,693. This is a 44.53% increase, which translates into an expected annual population growth of 1.94%. This is faster than the expected increase in Florida statewide population (32.77% between 2005 and 2030, 1.31% annually).

**Table 14: Population Forecast**

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<tbody>
<tr>
<td><strong>Florida</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Palm Beach</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>County</td>
<td>1,135,822</td>
<td>1,264,956</td>
<td>1,374,626</td>
<td>1,500,393</td>
<td>1,626,159</td>
<td>1,751,926</td>
<td>1,877,693</td>
</tr>
<tr>
<td>Florida</td>
<td>16,050,166</td>
<td>17,768,191</td>
<td>19,479,728</td>
<td>21,225,622</td>
<td>22,961,304</td>
<td>24,699,149</td>
<td>26,428,061</td>
</tr>
</tbody>
</table>

Health Management Associates 40 October 9, 2008
The aged population is growing at a slower rate in Palm Beach County relative to the Florida statewide population. During 2007, Palm Beach County population age 65+ was 275,783. This is expected to increase to 363,476 in 2030. For the age 65+ population, this is an overall growth of 31.8% (annually, a growth of 1.38%).

This is a slightly slower growth rate than expected for the Florida statewide population where the age 65+ is expected to increase by 33.54% between 2007 and 2030 (1.46% annually).

There are two cross-cutting trends to population change in Palm Beach County. Overall population in Palm Beach County is expected to increase as the population between 65 and 74 years is expected to decline. The population between 30 and 34 years is also expected to remain relatively stable through 2030.

Increase in the age 85+ population for both Palm Beach County and for Florida statewide merits particular attention. The age 85+ population is most at risk for both long-term care and acute care. The near doubling of the age 85+ population between 2007 and 2030 means that county resources for medical services and for long-term care will need to increase at a similar rate just to maintain parity with 2007 levels (absent significant improvement in disability-free life years).
A crude estimate of the expected 2030 population for the Healey Center (if the Palm Beach County Health Care District committed to serve the same fraction of the Palm Beach County population as it does now), is 363 residents. This crude rate is estimated by taking the changes in population and multiplying them by the Healey Center resident count during 2006.

The crude estimate is based solely on general population trends. If the long-term care population (and the SNF population, in particular) grows at a rate that is different from the general population, then the crude estimate will be over- or under-forecast. The crude estimate makes several important assumptions:

- There is a direct relationship between county population growth and county residents turning to the Healey Center for skilled nursing facility services;
- Factors impacting this growth will remain proportional in the future;
- There will be a constant trend for NF diversion efforts by Florida Medicaid;
- There will be no increased availability to Florida General Revenue HCBS alternatives;
- There will be no improvements in outcomes for chronic conditions like ischemic stroke; and
- There will be no improvement in disability-free life years.

Population forecasts are probabilistic. Accurate forecasts depend on identification of the process driving growth, and identification of the process depends on the quality of the data. Random sampling fluctuations affect data quality. Short histories for data series affect process identification.

Rather than relying on just one estimate for future need at the Healey Center, this report triangulates among multiple estimates. Consistency among the estimates increases confidence in the accuracy of the forecasts and can better guide decisions about the future of the Healey Center and the Palm Beach County Health Care District’s decisions regarding community LTC needs. The crude estimate is refined in subsequent discussions in this report.

Another important demographic trend that merits discussion is the increasing percentage of the age 85+ population among persons aged 65+. In 2007, the age 85+ population was 8.56% of the Palm Beach County population. The 65+ population was 21.23%. The fraction of the age 85+ among persons aged 65+ was 40.32%. By 2030, that fraction is forecast to increase to 57.43%. The greater preponderance of the 85+ among the aged can be expected to be accompanied by greater frailty and a corresponding increase in the demand for county-subsidized nursing home care. The comparable fraction projected for the Florida statewide population 85+ among the aged is just 44.54%.
This lends additional support to the expectation that the demand for long-term care can be expected to grow substantially through 2030 owing to the aging of the Palm Beach County population. Statewide efforts at diversion to HCBS alternatives would need greater intensity in Palm Beach County.

Populations for Palm Beach County and for Florida are slightly more female than male. This is forecast to change by 2030, with male and female being at rough parity in Florida and the population being slightly more male than female in Palm Beach County. (See Figure 9.)

For both Florida statewide and Palm Beach County, individuals of Hispanic ethnicity are forecast to increase relative to non-Hispanics, comprising just over one-quarter of the Palm Beach County population by 2030 and just under one-third of the Florida population. (See Figure 10.)

A similar pattern is evident for race. Whites will be less preponderant in both the Florida statewide and Palm Beach County populations by 2030. In 2007, Whites comprised 81% of the population statewide and in Palm Beach County. The forecast for 2030 is just over three-quarters in Palm Beach County and 79% statewide. (See Figure 11.)
Figure 9: Population Projections by Gender
Figure 10: Population Projections by Ethnicity
Figure 11: Population Projections by Race

Palm Beach County, Population, 2007
- White: 81%
- African American: 17%
- Native American: 0%
- Asian, Pacific Islander: 2%

Florida, Population, 2007
- White: 81%
- African American: 16%
- Native American: 3%
- Asian, Pacific Islander: 0%

Palm Beach County, Population, 2030
- White: 76%
- African American: 20%
- Native American: 1%
- Asian, Pacific Islander: 3%

Florida, Population, 2030
- White: 79%
- African American: 18%
- Native American: 1%
- Asian, Pacific Islander: 2%
**Nursing Home Population Forecasts**

Unduplicated counts of Florida nursing home residents were compiled from the Centers for Medicare and Medicaid Services (CMS) Minimum Data Set II (MDS II) data. Unduplicated counts were calculated by county, using breakdowns by age, gender, and race to construct forecasts.

MDS II data available for this project runs from 1999 through 2006. ARIMA estimates are not stable with such a short history. Therefore, simpler trends were used. It also means that short-term fluctuations have a large effect on forecasts. MDS II data is helpful because it includes nursing home admissions from all payers, not just nursing home admissions with public subsidy. Facilities that only accept private payer sources and skilled units without Medicare or Medicaid residents can be excluded from MDS II. However, few nursing home residents are excluded in this way, making the MDS II resident counts an excellent instrument for determining growth or decline in the overall nursing home population.

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</tr>
</thead>
<tbody>
<tr>
<td>Palm Beach</td>
<td>18,400</td>
<td>21,250</td>
<td>23,555</td>
<td>26,605</td>
<td>29,804</td>
<td>33,153</td>
<td>36,652</td>
</tr>
<tr>
<td>County</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Florida</td>
<td>214,161</td>
<td>226,388</td>
<td>232,064</td>
<td>238,444</td>
<td>242,344</td>
<td>244,213</td>
<td>247,483</td>
</tr>
</tbody>
</table>

The nursing home population in Palm Beach County is growing at a faster rate than the general population: 3.3% v. 2.2% annually. Between 2000 and 2030, the Palm Beach County population resident in a nursing home is expected very nearly to double as a consequence. As a percentage of the total population, nursing home residents in Palm Beach County are expected to increase from 1.6% to 2.0%.

Nursing home resident population growth in Florida is expected to be slower than the growth in Palm Beach County. While Florida and Palm Beach County have near identical expectations for the growth in their total populations, nursing home population growth in Florida is expected to be slower than it is for the overall population. Between 2000 and 2030, total population is forecast to grow by 64.7% in Florida while the nursing home population is forecast to grow by 15.6% over the same period.

Differences in nursing home residency can be affected by efforts by the State of Florida to divert aged and disabled adults from long-term nursing home care. State policymakers have created an assortment of Medicaid state plan services, Medicaid waivers and demonstration projects, and Florida GR programs to prevent or delay nursing home residency.

The penetration of HCBS alternatives to nursing home care has been uneven in Florida. Some residents of Palm Beach County enrolled in Medicaid would have been eligible, for example, to participate in the Nursing Home Diversion Waiver. The Nursing Home
Diversion (NHD) Waiver provides case management and HCBS services as well as Medicaid acute care services (primarily crossover payments to cover Medicare co-payments) to persons who are dually eligible for Medicaid and Medicare. Impairment requirements are more stringent than the requirements for other Medicaid HCBS waivers and demonstration projects. More important to this report, Nursing Home Diversion was originally a demonstration project in just three counties in the Orlando area (later expanded to other areas including Daytona, Palm Beach, Ft. Lauderdale, and Miami), and still does not include more than one-half of Florida’s counties. This has an important implication. Forecasts of the nursing home population assume that factors affecting nursing home utilization between 1999 and 2006 will have a similar continuing effect. If the effort by Florida policymakers to divert or delay nursing home admission change, so will the trends in nursing home utilization, leading to different forecasts of future growth.

Further evidence for increased diversion from long-term nursing home care is evident when the nursing home populations are broken out by long-term (six months or more) and short-term stays.

Short-term stays are largely post-acute, rehabilitation stays. For aged and disabled adults with Medicare eligibility, short-term stays can be reimbursed by Medicare when a physician certifies the need for daily skilled nursing services following hospitalization. It is the long-term care costs that are shifted largely to Medicaid and other public subsidies, such as county health districts.

Table 18: Long-Term Nursing Home Resident Forecast

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</thead>
<tbody>
<tr>
<td>Palm Beach County</td>
<td>84.34%</td>
<td>79.12%</td>
<td>75.14%</td>
<td>71.30%</td>
<td>67.46%</td>
<td>63.63%</td>
<td>59.79%</td>
</tr>
<tr>
<td>Florida</td>
<td>89.03%</td>
<td>86.27%</td>
<td>84.31%</td>
<td>82.56%</td>
<td>80.74%</td>
<td>78.79%</td>
<td>76.81%</td>
</tr>
</tbody>
</table>

In 2000, the pattern of long-term v. short-term utilization was not substantially different in Palm Beach County and in Florida statewide. Somewhere between 84% and 89% of nursing home stays were long-term. By 2030, the patterns are anticipated to be very different, with approximately 60% of nursing home stays expected to be short-term in Palm Beach County and 77% in Florida statewide.

The difference in these patterns likely owes more to expected demographic shifts affecting nursing home utilization than the result of uneven penetration of HCBS programs in Palm Beach County and in Florida generally during the period between 1999 and 2005. HCBS penetration was consistently higher among the aged and disabled adult population in state-subsidized long-term care for Florida generally than it was for Palm Beach County. (See Figure 12.)
Medicaid data from the SDCA data warehouse begin with SFY 1998-99 and end in SFY 2005-06. Eligibility information was aggregated at the county level with breakdowns by age, gender, and race. These were used to make county-wide and Florida-wide projections of the Medicaid aged and disabled adult populations through 2030.

The same caveat applies here that applied to nursing home resident forecasts: ARIMA estimates are not stable with such a short history. Two different methods were employed to forecast the Medicaid populations. For most counties, the average annual change in the fraction of the population enrolled in Medicaid was used. In a small number of counties, these estimates were less stable than calculating the average change in the count of Medicaid participants. The counties using average change in counts included Bay, Duval, Gilchrist, Liberty, Wakulla, and Walton. Florida estimates were the aggregated counts of the county-level projections.

Separate forecasts were made for the aged and adult disabled populations. Those forecasts were combined for the overall aged and disabled Medicaid populations. This allowed growth forecasts for the aged and the disabled populations to use different rates.

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</thead>
<tbody>
<tr>
<td>Palm Beach County</td>
<td>64,860</td>
<td>83,871</td>
<td>102,057</td>
<td>126,547</td>
<td>153,576</td>
<td>183,148</td>
<td>215,259</td>
</tr>
<tr>
<td>Florida</td>
<td>1,389,427</td>
<td>1,744,398</td>
<td>2,105,198</td>
<td>2,553,683</td>
<td>3,045,462</td>
<td>3,581,337</td>
<td>4,161,076</td>
</tr>
</tbody>
</table>

The aged and disabled adult Medicaid population grew faster than the general population between SFY 1999 and SFY 2005. As a consequence, the Medicaid population is projected to grow faster than the general population through 2030. Between 2000 and
2030, Florida-wide aged and disabled adult Medicaid population growth is projected at 199%. In Palm Beach County, this trend is even more exaggerated: 232% growth in the Medicaid population is expected. These translate into 6.6% and 7.7% annual growth.

<table>
<thead>
<tr>
<th>Table 20: Medicaid Population Forecast (Aged)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palm Beach County</td>
</tr>
<tr>
<td>Florida</td>
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</tbody>
</table>

The aged Medicaid population was approximately one-quarter of the overall aged and disabled adult Medicaid population in 2000. This was true for Florida overall and for Palm Beach County. The Florida-wide aged fraction is forecast to remain relatively stable, increasing from 25.26% to 25.66%. The aged fraction in Palm Beach County, however, is expected to increase from 25.95% to 30.16% of the aged and disabled adult Medicaid population.

**Long-Term Care Population Forecasts**

The long-term care populations include both Medicaid and Florida (GR) program populations, combining unduplicated counts from the Florida Medicaid and Florida DOEA CARES/CIRTS databases. Long-term care subpopulations include the following:

- Medicaid long-term nursing home services
- Assistive Care Services
- Medicaid long-term home health services
- Medicaid Hospice services
- PACE
- Aged & Disabled Adult (ADA)Waiver
- Project AIDS Care (PAC) Waiver
- Alzheimer’s Disease Waiver
- Assisted Living for the Elderly (ALE) Waiver
- Traumatic Brain Injury and Spinal Cord Injury (TBI/SCI)Waiver
- Channeling Waiver
- Comprehensive Adult Health Day Care (ADHC) Waiver
- Frail Elder Project (FEP)
- Nursing Home Diversion Waiver
- Alzheimer’s Disease Initiative (ADI)
- Community Care for the Elderly (CCE)
- Home Care for the Elderly (HCE)
- Older American’s Act services (OAA)

The long-term care population is an important component for the estimation of future community needs for a county-owned nursing facility, such as the Healey Center. Future
growth in the long-term care population generally is likely to be strongly predictive of future demand for skilled nursing care at the Healey Center.

The ratio of aged and disabled adults in the overall Medicaid population reverses when the long-term care population is considered. The aged are a larger proportion of the long-term care population. In 2000, the proportions were similar for Florida and for Palm Beach County (77.6% and 75.2% respectively). For both Florida and Palm Beach County, the disabled adult population is growing faster than the aged population. By 2030, the ratios will drop to 56.4% for Florida and 64.6% for Palm Beach County.

Table 21: LTC Population Forecast (Aged and Disabled)

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</tr>
</thead>
<tbody>
<tr>
<td>Palm Beach County</td>
<td>8,878</td>
<td>10,462</td>
<td>12,172</td>
<td>14,127</td>
<td>16,307</td>
<td>18,727</td>
<td>21,403</td>
</tr>
<tr>
<td>Florida</td>
<td>175,625</td>
<td>195,513</td>
<td>227,198</td>
<td>263,182</td>
<td>303,179</td>
<td>347,185</td>
<td>395,191</td>
</tr>
</tbody>
</table>

Growth in long-term care population is forecast to grow at a slower rate than the overall adult aged and disabled Medicaid population. 4.2% annual growth is expected for Florida state-wide and 4.7% for Palm Beach County.

13.7% of the Palm Beach County aged and disabled adult Medicaid population received long-term care during 2000. This is forecast to decline to 9.9% by 2030.

Table 22: LTC Population Forecast (Aged)

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</tr>
</thead>
<tbody>
<tr>
<td>Palm Beach County</td>
<td>6,892</td>
<td>7,895</td>
<td>8,830</td>
<td>9,877</td>
<td>11,047</td>
<td>12,356</td>
<td>13,820</td>
</tr>
<tr>
<td>Florida</td>
<td>132,003</td>
<td>137,094</td>
<td>150,157</td>
<td>165,376</td>
<td>182,585</td>
<td>201,749</td>
<td>222,875</td>
</tr>
</tbody>
</table>

When the aged are broken out separately, the growth rate among the long-term care population is slower than the adult disabled population. The annual growth rates through 2030 for the aged long-term care population is 2.3% for Florida state-wide and 3.4% for Palm Beach County. Given the reductions in funding for the Medically Needy eligibility category, increases in the growth rate for Medicaid generally, and slower growth in participation by the aged and disabled adult populations, this leaves much of the growth in Medicaid enrollment to be found among children and pregnant mothers.

**HCBS Population Forecasts**

Persons enrolled in home and community-based services (HCBS) are a subpopulation of the long-term care population. In the case of Medicaid HCBS waivers and demonstration projects targeted to elders and persons with physical disabilities, HCBS waiver participants must meet nursing home Level of Care (LOC). The Project Aids Care (PAC) Waiver includes persons who meet hospital LOC (who would otherwise be hospitalized) and persons who meet NF LOC.
The HCBS population is distinct from the long-term care population through the exclusion of long-term nursing home care and, in some programs, hospice care. The HCBS population is composed of individuals with a demonstrated ability to be served in the community through a combination of case management and services offered at home or locations such as adult day care centers. The HCBS population includes individuals participating in the following:

- Medicaid long-term nursing home services
- Assistive Care Services
- Medicaid long-term home health services
- Medicaid Hospice services
- PACE
- Aged & Disabled Adult (ADA) Waiver
- Project AIDS Care (PAC) Waiver
- Alzheimer’s Disease Waiver
- Assisted Living for the Elderly (ALE) Waiver
- Traumatic Brain Injury and Spinal Cord Injury (TBI/SCI) Waiver
- Channeling Waiver
- Comprehensive Adult Health Day Care (ADHC) Waiver
- Consumer Directed Care (CDC+) Waiver
- Frail Elder Project (FEP)
- Nursing Home Diversion Waiver
- Alzheimer’s Disease Initiative (ADI)
- Community Care for the Elderly (CCE)
- Home Care for the Elderly (HCE)
- Older American’s Act services (OAA)

The growth in HCBS participation mirrors the growth of the overall population in Palm Beach County. This is true, also, for Florida state-wide. The estimate for Palm Beach County is 7.7% annual growth for the HCBS population. This is identical with the estimated growth for total population in Palm Beach County. Florida state-wide growth is expected to be 6.7% annually.

<table>
<thead>
<tr>
<th>Table 23: HCBS Population Forecast (Aged and Disabled)</th>
</tr>
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<tbody>
<tr>
<td><strong>2000</strong></td>
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<tr>
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<tr>
<td>Palm Beach County</td>
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<tr>
<td>Florida</td>
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</tbody>
</table>

The pattern for the HCBS and the more general long-term care populations are similar. The expected increase in population among the aged receiving HCBS is slower than it is for the adult disabled population. Participation in HCBS among the aged in Palm Beach
County (6.8% growth annually) is expected to be greater than it is for Florida generally (4.3%).

### Table 24: HCBS Population Forecast (Aged)

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</tr>
</thead>
<tbody>
<tr>
<td>Palm Beach County</td>
<td>3,025</td>
<td>4,117</td>
<td>4,926</td>
<td>5,871</td>
<td>6,898</td>
<td>7,780</td>
<td>9,202</td>
</tr>
<tr>
<td>Florida</td>
<td>76,191</td>
<td>82,674</td>
<td>96,963</td>
<td>113,512</td>
<td>132,109</td>
<td>152,667</td>
<td>175,133</td>
</tr>
</tbody>
</table>

The ratio of aged to disabled adults in publicly-subsidized HCBS was similar in 2000 with 68.3% aged in Palm Beach County and 69.4% for Florida. By 2030, the percentages are expected to drop to 62.6% in Palm Beach County and 53.1% for Florida. As with long-term care generally, the difference between the Palm Beach County and Florida state-wide experiences is likely the result of differing demographic shifts.

**Community Needs Assessment**

The Healey Center serves a vulnerable population that has not been served by the commercial and not-for-profit SNFs in Palm Beach County. The unique character of the resident-mix at the Healey Center has demonstrated an existing community need. The question to be answered in this section of the report then becomes: “What is the expected change in community need for the Healey Center? In particular, will the facility need to grow in order to meet future demand and if so, by how many beds?”

A crude estimate of the expected resident count for 2030 was already presented: 363 residents. Not all residents at the Healey Center are long-term residents. Mortality is also a factor in bed supply. If the ratio of residents to beds remained similar between now and 2030, the expected annual resident count of 363 individuals would translate into a bed need of 186 beds. This is within the current licensed capacity of 198 beds.\(^{10}\)

It was also noted previously that approximately 125 beds are currently available for residents, with the remainder of the beds used for other purposes (such as offices and storage), unusable due to physical plant issues, or taken “off-line” for other reasons. This report cannot address the feasibility of bringing additional existing beds online. It can only note that the 125 beds currently in use at the facility cannot be expected to meet future demand in 2030.

**Refining the Forecast**

The crude estimate simply determines expected change in the general population and applies that to the current resident population at the Healey Center. More information is available than just expected change in the general population. The previous section of the report presented projections of the Medicaid population, the State-subsidized LTC

\(^{10}\) There were 244 residents and 125 beds for the most recent year of data from the Healey Center. The ratio of beds to residents (125 / 244) is 0.51. Multiplying the 2030 crude estimate of residents by that fraction (363 * 0.51) results in a crude need estimate of 186 beds.
population, and the State-subsidized HCBS population. This section of the report will use those estimates to refine the needs assessment.

The LTC population and the HCBS population have their own trajectories, distinct from what is expected to happen with the general population. The entire LTC and HCBS populations are unknown. Florida agencies do not collect population data on those populations. They do collect population data on the LTC and HCBS populations being served through public subsidy, either Medicaid or Florida GR. This leaves two groups largely out of the Florida administrative data. Individuals with long-term care insurance or the personal financial resources for private pay and individuals who are ineligible for public subsidy through Medicaid or Florida GR programs who are subsidized through county or municipal resources, such as the Edward J. Healey Rehabilitation and Nursing Center.

This report assumes that the future population growth for the excluded LTC and HCBS subpopulations will be similar to the trajectories for the subpopulations participating in Medicaid or Florida GR programs. If, for example, a smaller proportion of the population has long-term care insurance or the financial resources to afford long-term care, then the growth rates for the subpopulations participating in Medicaid or Florida GR programs would increase. Similarly, if affordable long-term care insurance becomes a widespread employee benefit, the expected growth in the Florida-subsidized LTC and HCBS populations would decrease in relative terms.

The annual population growth forecast for Palm Beach County through 2030 is 2.2%. The aged and disabled adult population in Florida-subsidized long-term care is forecast to grow at a faster rate: 4.7%. The LTC population includes HCBS services, long-term nursing home care, and hospice. The HCBS population is the population of most interest for refining estimates of future need for the Healey Center, since they are individuals that the State of Florida considers diverted from nursing home care. The HCBS population is composed of individuals being served in the community with a range of assistive services. If their fraction of the long-term care population changes substantially, so would estimates of future needs. Expected annual growth in the HCBS population is 7.7%.

The estimates of future growth in the LTC and HCBS populations are driven by recent Medicaid and Florida GR program claims experiences. In recent years, nursing home utilization has been largely flat and HCBS programs have expanded in Florida. The HCBS and non-HCBS subpopulations are not equal in size and have different growth rates. The expected growth rates for the aged and the disabled adults within the respective subpopulations also have different growth patterns. When these factors are considered,

\[11\] Both AHCA and DOEA consider Medicaid HCBS participants to be diverted from nursing home care because of the nursing home LOC requirements. Similar logic is applied to Florida GR program participants. This over-estimates the number of persons who would be likely to require or accept a nursing home placement. The fact that an individual meets nursing home LOC or has a risk-score sufficiently high to make a slot available does not mean that an individual will elect nursing home placement. Factors such as available caregiver, caregiver stress, social support networks, and the like also affect the decisions of individuals requiring assistance and their families.
the expected rate of annual growth in the non-HCBS portion of the aged and disabled adult LTC population is 1.9% for Palm Beach County. This is a slower rate of growth for Palm Beach County than the expected increase for the general population.

It is important to note that the disabled adult population has a faster expected growth rate. When the aged and the disabled adults are separately considered, the expected annual growth rates for the non-HCBS long-term care populations are 0.8% for the aged and 3.5% for the disabled adults.

The Healey Center resident population forecast appears in Table 25 below. Recall that the Healey Center has a much younger median age than other SNFs. The median is 54 years, which means that there are as many residents 54 year and under as there are older than 54 years. There are as many or more disabled adults as aged adults at the Healey Center. The faster growth rate among disabled adults has a substantial impact on the Healey Center resident population forecast. As a result, the refined estimate is larger than the crude estimate. 415 residents would translate into a future need of approximately 212 beds. According to this estimate, licensed capacity would need to expand by 17 beds (8.7%).

The refined estimate makes several important assumptions:

- There is a direct relationship between county population growth and county residents turning to the Healey Center for skilled nursing facility services;
- Factors impacting this growth will remain proportional in the future;
- There will be a constant trend for NF diversion efforts by Florida Medicaid;
- There will be no increased availability to Florida General Revenue HCBS alternatives;
- There will be no improvements in outcomes for chronic conditions like ischemic stroke; and
- There will be no improvement in disability-free life years.

The crude and refined estimates are consistent with a forecast of the fraction of the general population resident in a nursing home. The Florida-wide expectation is a smaller proportion of the population resident in a SNF (dropping from 1.3% to less than 1%). The prediction for Palm Beach County is a larger proportion of the population resident in a nursing home in 2030, increasing from 1.6% to 1.95%.
Table 26: Percentage of General Population in SNF

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Palm Beach County</td>
<td>1.62%</td>
<td>1.68%</td>
<td>1.71%</td>
<td>1.77%</td>
<td>1.83%</td>
<td>1.89%</td>
<td>1.95%</td>
</tr>
<tr>
<td>Florida</td>
<td>1.33%</td>
<td>1.27%</td>
<td>1.19%</td>
<td>1.12%</td>
<td>1.06%</td>
<td>0.99%</td>
<td>0.94%</td>
</tr>
</tbody>
</table>

The future growth in HCBS is uncertain. Not all nursing home residents are candidates for community care.

An alternative to skilled nursing care for some NF residents ready for discharge from a SNF (or as a means to divert persons from a SNF) is assisted living. However, Palm Beach County has experienced a recent overall downward trend in the number of ALF beds in contrast to the statewide trend.

Source: AHCA.

Figure 13: Assisted Living Facilities, Licensed Beds, Palm Beach County

Source: AHCA.

The trend for assisted living in Palm Beach County is different from the statewide trend. AHCA provided four years of licensure data on Florida ALFs. Licensed ALF beds in
Florida increased by 3.5% (2,593 beds) between 2005 and 2008. Licensed beds in Palm Beach County dropped by 112 beds at the same time, from 5,140 to 5,028. There was one less ALF in Palm Beach County by 2008 (down from 102 to 101).

**Conclusion**
The Edward J. Healey Health and Rehabilitation Center has a different case-mix than other Florida nursing homes. The Healey Center is unique even among SNFs operated by county or municipal governments.

The typical nursing home resident in the U.S. is a frail woman in her eighties or nineties. The typical Healey Center resident is male and in his fifties.

County-/city-owned SNFs are also more likely to accept resource-intensive residents than commercial and not-for-profit SNFs. The Healey Center is an extreme example, more likely to accept persons with quadriplegia, paraplegia, hemiplegia, and comatose residents than other nursing homes.

Current licensed capacity at the Healey Center is 198 beds. There were 244 residents served in 2006, with 125 beds available for patient use. The remaining bed space has been taken offline for various purposes.

ARIMA modeling was used to generate forecasts of the general population, nursing home population, Medicaid population, Florida-subsidized long-term care (LTC) population, and Florida-subsidized home and community-based services (HCBS) population. Multiple demographic crossings were used. The 2030 crude estimated Healey Center population (assuming the Palm Beach County Health Care District continued to serve a proportional fraction of the Palm Beach County population as it now does) is 363 residents requiring 186 beds. The crude estimate is based on trends in the general population. A more refined estimate incorporates information about the aged and disabled adult subpopulations in LTC and, more importantly, in HCBS. Stated differently, the refined estimate considers the trajectory of nursing home utilization and efforts at diversion from nursing home care. The 2030 refined estimate is 415 residents requiring 212 beds.

The crude estimate is more conservative. If all of the licensed beds were brought online, the expected need for beds could be met. However, the case-mix of the Healey Center residents is more resource intensive than the typical nursing home resident.

Because the Healey Center serves a much younger population than other nursing homes, and many of these residents were homeless before admission or had few if any resources, the residents are more likely to remain there for many years.

An adequate supply of beds will not ensure that the infrastructure at the Healey Center can meet the needs of an expanded resident population in a cost-effective manner. The
facility is more than eighty years old and was not designed for a large resident population with TBI/SCI aging in place and their special needs.

The refined estimate suggests that additional SNF capacity will be required to meet community needs in 2030 should the Health Care District continue to serve the same proportion of persons in Palm Beach County in need of SNF services as it does now. This estimate does not account for efforts that might be undertaken to fund alternative community-based settings or to divert persons seeking access to the Healey Center to other SNFs or settings.
The Health Care District Mission

Palm Beach County and the HCD provide a wide range of health care and social services. The HCD describes its mission as ensuring access to a comprehensive healthcare system for all Palm Beach County residents by providing lifesaving trauma services and health coverage for uninsured residents. The HCD operates or funds a range of health care and related programs:

- A children’s health care program employing over 200 school nurses. Palm Beach County is the largest school district in the nation to have a dedicated nurse in more than 170 public schools and serves as a model for other school health programs.

- Operation of the Healey Center for Palm Beach County residents who require long-term skilled nursing care.

- Operation of Glades General Hospital, a not-for-profit subsidiary of the Health Care District. Glades General Hospital is a 73-bed acute care hospital that provides a 24-hour physician staffed emergency room and a full-range of inpatient and out-patient services in western Palm Beach County. A new hospital is now under construction to replace the aging Glades General Hospital.

- Contracts with two hospitals to serve as Trauma Centers for Palm Beach County. St. Mary's Medical Center is the Trauma Center for the northern part of the county and Delray Medical Center is the Trauma Center for the southern part of the county.
  - The District owns and operates two state of the art aeromedical helicopters for trauma patient transports.
  - The HCD also contracts for acute inpatient rehabilitation services provided to trauma victims following their inpatient stay. Contractors are St. Mary’s Rehabilitation Hospital and Pinecrest Rehabilitation Hospital. Eleven percent of trauma patients are reported to need this level of care, with an average stay of 13 days.\(^{12}\)
  - Trauma patients who need extended rehabilitation and nursing care are served at the Healey Center.

- Operation of three health care coverage programs. (None of these programs include SNF services.)
  - Coordinated Care Program - A Managed Care Program for low-income Palm Beach County residents with incomes below 150% FPL. The program provides access to primary care, specialty care, emergency care, hospitalization and prescription drugs. There is no premium and no co-payment for services. There are three benefit options:

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\(^{12}\) Health Care District of Palm Beach County. Trauma Agency Annual Report, Calendar Year 2006. Exhibit B.
Healey Center Feasibility Study

Option 1: Full Services: Hospitalization, Primary Care, Dental, Prescription Drugs
Option 2: Clinic and Pharmacy: Primary Care and Prescription Drugs
Option 3: Pharmacy Only: Prescription Drugs

- Healthy Palm Beaches, Inc.
  - “Personal Health Plan” - A Medicaid HMO for Palm Beach County Medicaid recipients.
  - “Vita Health”, a shared cost, health coverage program for low-income residents who earn less than 300 percent of the Federal Poverty Level (FPL). Vita Health provides affordable, quality health coverage to residents who pay as little as $25 a month toward the premium. The remaining two-thirds of the monthly premium is covered by the Health Care District.

**Healey Center’s Role**

The Healey Center has been described by interviewees as an important community resource, one that should be continued at least at the level at which it currently operates. Providers that refer patients to the Healey Center describe it as a “charity care” facility. They clearly see the facility as the nursing home you send a patient to when no one else will admit them.

The Healey Center has traditionally served the uninsured and underinsured residents of Palm Beach County in need of SNF services, as well as residents with health care coverage who are not accepted for admission to other SNFs due to problem behaviors, specific care needs and other issues. Prior to 2007, the Healey Center served persons with serious behavior problems, including persons with existing drug abuse problems and persons with aggressive behaviors. While the HCD continues to admit persons with challenging or problem behaviors, they no longer admit persons actively using drugs or who have recently assaulted other persons. Problems with drug use, drug seeking behavior and sale of drugs at the facility along with incidents of aggression directed at other residents and/or staff prompted this change in admission policy. HCD staff believes this is the primary reason for a decline in resident days during 2007 (down 6% from the prior year) with a slightly greater decline anticipated for 2008.

Hospitals are the referral source for about 95% of residents at the Healey Center. St. Mary’s Hospital refers about 60% of residents. JFK Medical Center refers about 12% of residents.

**Healey Center Admissions Priorities**

The Healey Center provides priority admission to persons who enter the Palm Beach County trauma care system, are a resident of Palm Beach County and are a United States citizen. This includes patients with a payor source such as Medicaid, or persons who have...
been enrolled into the HCD Coordinated Care, Option 1 program for the uninsured. (Upon admission to Healey Center, Option 1 patients are no longer covered by Option 1.)

The Healey Center admits non-citizens with approval of the HCD, with non-citizen trauma victims generally having priority for admission over non-citizens who have not experienced trauma. Persons with a payor source like Medicaid or Medicare are always a priority for admission.

If a person is not a trauma care patient and has no payor source, the HCD must approve admission. Some of persons approved for admission who have no payor source are single, formerly homeless, non-elderly individuals who do meet the disability requirements for Medicaid.

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**Ella’s Story**

Ella (not her real name) is 59 years old and has lived at the Healey Center for 3 months. She came to the Healey Center after an injury to her knee. Ella broke her knee and then had a surgical repair at a hospital. When she was sent to the Healey Center to recuperate, she had twenty staples in her knee, was using a wheelchair and a brace.

Since coming to the Healey Center, she has had the staples removed, received physical therapy and no longer uses a wheelchair or walker. Ella walks around the facility and is able to do all of her own care.

Before her injury, Ella had been homeless a long time, living at a shelter. The social worker at the Healey Center has helped her apply for assistance and she will be evaluated by the Vocational Rehabilitation Program this month. She has an appointment with her doctor shortly to be medically cleared and then would be able to leave but has no place to go. She hopes some housing can be located soon.

Ella had some specific recommendations about the Healey Center:

- The location of the current facility is good – there is transportation nearby, stores, restaurants, a supermarket and a clinic.
- She thinks a lot of people need a place like the Healey Center to go to.

In general, the Healey Center does not admit persons with any type of criminal history, persons with serious mental illness, persons with MR/DD, and persons needing short-term IV antibiotic therapy. As noted previously, persons with serious problem behaviors are also no longer admitted.

The Healey Center has long accepted patients who are considered to be end-of-life patients. The HCD entered into a formal agreement with a local hospice provider during 2007 whereby the hospice provider provides hospice services at the facility and the Healey Center provides the basic SNF “board and care” to the patient. It is unclear at present whether this arrangement is of financial benefit to the Healey Center. Staff believe the program benefits residents who need end-of-life care, primarily because of the specialized skills provided by hospice staff, especially palliative care (pain relief).
Financing of the Healey Center
The Healey Center is financed primarily from three sources: Medicaid payment for SNF services, Medicaid Upper Payment Limit (UPL) payments, and County financing. Other sources such as Medicare and private funds finance a small fraction of the costs at the Healey Center.

Medicaid
Medicaid is the largest source of funding at the Healey Center accounting for 69% of resident days between October 1, 2006 and September 30, 2007.

Figure 15: Healey Center Resident Day Payor Sources 2006-2007

Source: Health Care District Staff.

Medicaid coverage has varied by year from a high of 76% of all resident days in 2002 – 2003 to between approximately 69% and 71% since that time.

Figure 16: Medicaid Coverage as a Percentage of All Resident Days

Source: Health Care District Staff.
The Florida Medicaid program reimburses SNFs a prospective per diem amount formulated using the state’s Medicaid Nursing Home Reimbursement Plan. The plan uses cost-based reimbursement subject to specified “ceilings” by cost category. The cost categories are:

- Operating – plant operation, laundry, administration, etc.
- Patient Care – nursing, dietary, activity, and social services staff, etc.
  - Direct Care
  - Indirect Care
- Property – taxes, insurance, depreciation, etc.

Most costs in these categories are subject to various “ceilings”, except that costs such as taxes and insurance are treated as “pass-through” costs (included in the per diem amount at 100% of cost). Each year a SNF submits their prior year cost report to the Agency for Health Care Administration, which uses the cost report to generate the rate for the coming year.

The Healey Center reported a cost of $346.12/day to the Medicaid program for 2007 (year ending September 30, 2007). This cost is substantially higher than the Medicaid per diem payment to the Healey Center for SFY 2007, which is revised twice annually: $196.20/day in July 2006 and $201.66/day in January 2007. The rate approved by the Medicaid program beginning July 2008 is $206.59/day or 60% of 2007 reported costs. In addition, Medicaid residents are required to contribute their income less a personal needs allowance ($35/month), toward the cost of their care. This averaged about $13/day in 2007.

The Nursing Home Upper Payment Limit (UPL) Payment

The per diem payment does not represent all Medicaid payments made to the Healey Center. The Healey Center, as a government-owned “safety-net” nursing home, qualifies for Medicaid UPL payments. The “UPL” is the estimated amount that would be paid to a provider if Medicaid days were reimbursed using Medicare reimbursement principles. The difference between the Medicaid paid amount and amount that could have been claimed if billed using Medicare reimbursement for the “average” patient day, represents the amount potentially available to the provider as a UPL payment, although the actual amount may be reduced depending on a state’s specific requirements for their UPL program. In order to access this additional funding in Florida, a county must send the state matching portion of the amount available to AHCA. AHCA then pulls down federal matching funds and sends the entire amount (the original amount submitted as match plus the federal portion) back to the county.

Each year the HCD sends the matching funds for the NF UPL to AHCA to pull down federal matching funds. AHCA calculates the amount available in FFP based on the number of Medicaid days at the Healey Center. In 2006 – 2007, the amount the HCD received from the NF UPL program in federal matching funds was $2,261,661. There were 29,198 “Medicaid days” in 2006-2007 – therefore, access to the NF UPL added another $75.60/day to the daily amount paid by Medicaid or a total of $277.26/day using the January 2007 Medicaid per diem rate ($201.66+$75.60). This is an approximate
amount, since NF rates change twice yearly, FFP is disbursed quarterly and the federal matching rate for the Florida Medicaid program is adjusted annually on October 1. The **total Medicaid shortfall** is reduced as a result of accessing the UPL payment but is still substantial: about **$56/day** ($346 minus the sum of $201.66+$75.60+$13).

Medicaid reimbursement rates that are lower than a facility’s reported cost are not unusual:

- A national study of Medicaid SNF reimbursement finds a projected average shortfall for 2007 of $13.15/day nationwide, with a Florida projected shortfall of $13.13/day.\(^\text{13}\)

- The Florida Agency for Health Care Administration (AHCA) reported that less than 5% of Florida nursing homes received 100% of their total cost under Medicaid in 2004.\(^\text{14}\)

- In Wisconsin, where 49 nursing homes are owned by counties, 36 of the 40 counties with nursing homes reported a funding shortfall in 2005. Both public and private nursing homes in Wisconsin report Medicaid reimbursement is not covering the cost of care.\(^\text{15}\)

The Healey Center’s high uncompensated cost per Medicaid day (almost $56/day) is not in our experience unusual for county-owned SNFs. For example, in 2005 Laguna Honda Hospital and Rehabilitation Center (LHH) in San Francisco, California received about $271 per patient day in state and federal funds through Medicaid SNF reimbursement. The total cost was nearly $397 per patient day and, after other revenues were collected, the cost to the general fund was $95 per patient day. In San Mateo County, California, the county-operated nursing home is expected to incur a loss of $80/Medicaid day in 2008 as a result of the shortfall in Medicaid funding.

Medicaid payment will continue to be inadequate, and likely will be increasingly so as Medicaid reimbursement falls or stalls and costs increase. One option the County may want to pursue in the future to prevent losses related to Medicaid reimbursement is to secure legislation directing the Florida Medicaid program to pay County-owned SNFs cost without imposition of ceilings, as is now permitted for “exempt” hospitals, (which includes county hospitals).

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Charity Care
Palm Beach County subsidizes care at the Healey Center, providing $9.1 million annually for operation and management of the facility and related uses. The $9.1 million is used to cover “charity care” as well as to offset the Medicaid shortfall.

Forty-three residents were reported to be receiving “charity care” in March 2008: 27 residents had previously applied for but were denied Medicaid coverage and 14 of these residents have a Medicaid application pending final determination. By July 2008, only three residents were in the “Medicaid pending” category and charity care residents had decreased significantly to thirty-two persons. HCD staff noted that Healey Center staff had been working aggressively to assist residents in gaining Medicaid eligibility and in helping illegal immigrants obtain documented status.

Table 27: Resident Payor Sources – July 2008

<table>
<thead>
<tr>
<th>Payor Sources</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charity</td>
<td>32</td>
<td>30%</td>
</tr>
<tr>
<td>Medicare</td>
<td>3</td>
<td>3%</td>
</tr>
<tr>
<td>Hospice (Medicaid)</td>
<td>4</td>
<td>4%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>63</td>
<td>59%</td>
</tr>
<tr>
<td>Medicaid pending</td>
<td>4</td>
<td>4%</td>
</tr>
<tr>
<td>Private</td>
<td>1</td>
<td>1%</td>
</tr>
</tbody>
</table>

Source: Edward J. Healey Health and Rehabilitation Center.

Medicare
Medicare covered days are a small fraction of all patient days at the Healey Center (just 1% October 2006 through September 30, 2007). Medicare coverage of SNF services is available for a Medicare eligible who spends at least three days in a hospital, who is subsequently discharged to a SNF and who requires skilled care (versus intermediate care). Coverage is limited to 100 days, with the first 20 days covered in full and the remaining days requiring a daily co-insurance payment from the resident. Nursing homes want to admit Medicare eligibles since Medicare payment is generally higher than Medicaid payment, and many of these residents will be short-stay residents admitted for rehabilitation and then discharged home.

Private Pay
Private pay patients (there is currently one such patient at the Healey Center) continue to use their personal funds to cover the cost of care at the Healey Center until they have “spent down” (exhausted) their personal assets. Prior to these funds being exhausted, the resident applies to Medicaid for continued coverage of services through the Medicaid program.

Long-Term Care and the County Mission
There is a lack of clarity and specificity regarding the mission of the Healey Center. However, there is a general agreement that the Healey Center is operated to ensure the
LTC needs of trauma patients and other Palm Beach County residents who are not served (for whatever reasons) in other SNFs are met.

The County has entered into an interlocal agreement with the HCD to operate the Healey Center until at least 2035. This agreement includes some specific terms that govern the HCD’s operation of the Healey Center, some of which are summarized below:

- It is in the best interests and for the welfare of the residents of Palm Beach County, Florida that the County pay annually a fixed amount to the District, in exchange for the District's agreement to manage and operate the "County Home" (the Healey Center);
- The terms of the interlocal agreement are for the health, benefit and welfare of the residents of Palm Beach county, Florida;
- The terms and provisions of the interlocal agreement shall result in cost savings and cost effectiveness in connection with the provision of health care services to the residents of Palm Beach county, Florida; and
- The Agreement is intended to be a long-term arrangement between the County and the District continuing for a term of at least forty years.

The interlocal agreement permits other uses of the annual subsidy provided for the operation and maintenance of the Healey Center, which are:

- Other District program costs
- Services related to the expansion, enhancement or provision of nursing home and long-term care services
- Non-acute care
- Rural health care
- Home health care
- Sub-acute care
- Rehabilitation care and other similar services

Since the interlocal agreement provides for these other uses, it appears that the County had an expanded view of the ways the HCD could meet the needs of persons served by the Healey Center (e.g., other long-term care services, home health, etc.) when the interlocal agreement was developed.

**Changes in Long-Term Care**

There have been important changes in the way publicly funded LTC services are delivered since the interlocal agreement was signed in 1995.
Home-Based Long-Term Care

The Americans with Disabilities Act, passed in 1990, and the Olmstead Supreme Court ruling issued in 1999, have contributed to a shift in the provision of LTC services funded by Medicaid, from institutional settings to community-based settings.

In 1996, 79% of Medicaid LTC expenditures were for institutional services (SNF and ICF/MR). By 2006, this amount had fallen to 61%. Medicaid funded alternatives to nursing home care are more readily available today than they were in 1995. In addition, federal initiatives have also provided access to more services and funds for home care services through programs such as the National Family Caregiver Support Program, administered by state units on aging. Overall, there is a clear preference for community-based LTC versus institutional LTC among most persons today.

States and counties have been the subject of recent litigation filed on behalf of NF residents who wish to be served in alternative community-based settings.

- The Florida Department of Elder Affairs and the Agency for Health Care Administration are named defendants in a lawsuit brought by seven Medicaid eligible adults who are currently residing, or have recently resided, in a nursing home. The individuals have alleged that their continued placement in a skilled nursing facility is a violation of the Americans With Disabilities Act (ADA), 42 U.S.C. sec. 12132, and sec. 504 of the Rehabilitation Act, 29 U.S. C. sec. 794(1). The lawsuit is pending before the United States District Court for the Northern District of Florida. [William Long, Charles Todd Lee, Rodney Peterson, John Boyd, Clayton L. Griffin, Margaret Washington, and Louise Seymour v. Holly Benson as Secretary of Florida Agency for Health Care Administration and Douglas Beach as Secretary of Department of Elder Affairs, Case No. 4:08cv26 RH/WCS.]17

- In San Francisco, a settlement agreement was recently announced in the Chambers lawsuit. The lawsuit is a civil rights class action filed to prevent unnecessary institutionalization of people with disabilities at Laguna Honda Hospital and Rehabilitation Center [Chambers et al. v. City and County of San Francisco]. Mark Chambers, lead plaintiff in the lawsuit, has lived in Laguna Honda Hospital since 1999. The settlement provides for assessment, referral and provision of subsidized housing, attendant and nursing care, case management, substance abuse treatment, mental health services, and assistance with meals to disabled San Franciscans. In addition, several hundred Medi-Cal Home and Community-Based Services waiver slots will be made available to eligible persons. The city/county will, over the next five years, secure and subsidize

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17 Legal Hold Information. Florida Department of Elder Affairs, Correspondence to Nursing Home Diversion Providers. June 24, 2008.
scattered-site, accessible, independent housing for approximately 500 people with disabilities and seniors who are eligible for community-based services.\(^{18}\)

There has also been a recent change in the Palm Beach County SNF “marketplace”. SNF occupancy rates have been declining in the County, resulting in the potential to “outsource” care to facilities with lower occupancy rates. (This shift is discussed in more detail in the section of this report entitled “Outsourcing of Care”.)

**Redesigned Nursing Homes**

There are also several initiatives underway nationally that seek to change the way nursing homes are designed and operated, emphasizing more home-like environments where residents have more control over their daily lives. In an effort to improve the quality of life for residents of nursing homes as well as to improve health outcomes and improve the work environment for staff, many nursing homes are undergoing cultural change. Their goal is to transform the nursing home into a setting that provides greater privacy, autonomy and comfort for residents.\(^{19}\) Culture change is frequently implemented as a resident-centered approach where:

- Care and all resident-related activities are chosen or directed by the resident;
- The living environment is designed to be a home rather than an institution;
- Close relationships exist between residents, family members, staff, and community;
- Work is organized to support and allow all staff to respond to residents' needs and desires;
- Management allows collaborative and group decision making; and
- Processes measures (measures designed to measure performance) are used for continuous quality improvement.

A recent survey by the Commonwealth Fund shows that 31% of the nursing homes surveyed are “culture change adopters”, 25% are culture change “strivers” and the remaining 43% are continuing with the more traditional, institutional nursing home model. The survey indicates that in facilities that incorporate some aspects of culture change, the more culture change initiatives that are underway, the greater the benefits in terms of staff retention, higher occupancy rates, better competitive position and improved operational costs.\(^{20}\)

Culture change can include changes to the physical plant (smaller, more homelike housing that features living spaces around a core central area), the introduction of pets,
plants and children into the nursing home environment and strengthened staff roles for the front-line workers. The facilities become less institutional and can be divided into “neighborhoods” or small “households”. Staff is permanently assigned to a particular group of residents as members of self-directed work teams. Rather than working in a single department, such as nursing, housekeeping, or food service, staff functions may be blended so that all staff members can help residents with their personal care, activities, and housekeeping. These changes refocus long-term care facilities as places that people can call home, where people live and also receive good care, rather than primarily as places that deliver care. Examples of cultural change efforts include the following:

The Green House™: The GreenHouse™ is a trademarked design for nursing homes that began in Mississippi in 2003. A Green House™ is designed to resemble a house rather than a traditional nursing home. Each house serves six to ten people and has private bedrooms and bathrooms configured around a common area. The Green Houses™ are clustered and the cluster becomes the “nursing home”. The houses are licensed and certified as SNFs. However, in keeping with the housing approach, residents control their own schedules. Additional Green Houses™ are being built across the country.

<table>
<thead>
<tr>
<th>State</th>
<th>Operating</th>
<th>Under Construction</th>
<th>In Development</th>
<th>Number of Elders Housed</th>
</tr>
</thead>
<tbody>
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<td>14</td>
<td>0</td>
<td>140</td>
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<td>0</td>
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<td>0</td>
<td>60</td>
</tr>
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<td>California</td>
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<td>Florida</td>
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<td>4</td>
<td>40</td>
</tr>
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<td>Georgia</td>
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<td>100</td>
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<tr>
<td>Kansas</td>
<td>6</td>
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<td>0</td>
<td>20</td>
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<tr>
<td>Wyoming</td>
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<td>0</td>
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<td>Total</td>
<td>41</td>
<td>22</td>
<td>105</td>
<td>1,849</td>
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</table>


A Green House Technical Assistance Project provides help to nursing homes adopting the model. The project is funded through a $10 million five-year grant from the Robert
Wood Johnson Foundation. The Green House model isn't less expensive than the institutional concept, but it has proven to be a financially feasible alternative. Factors like the state in which the nursing home is located, the money it receives through Medicaid reimbursements and the number of private-pay patients living there determine how much adopting the Green House model will cost. Analyzing that cost is a component of the technical assistance provided through grant funding.

The Jefferson County Nursing Home is a county-government owned 135-bed dually certified skilled nursing facility located in Dandridge, Tennessee, at the foothills to the Great Smoky Mountains. The facility will be expanding its capacity using Green Houses. With the addition of three Green Houses, the facility will grow to 160 beds.

The Eden Alternative began in upstate New York in 1992 and has spread to about 200 facilities around the world. This model advocates for more delegation of decision-making responsibility to the residents and their caregivers and includes pets, indoor plants and gardens and frequent visits by children into the nursing home environment.

Meadowlark Hills is a continuing care facility located in Manhattan, Kansas. 185 residents live in apartments and cottages, 40 residents in Assisted Living and 105 residents in Health Care Households. The Health Care Households replaced a traditional nursing home. Each Health Care Household houses 13 to 25 residents. Each household has its own entrance and doorbell with residents arranging most of their daily schedules. In order to sensitize the architects to the needs of the elders, the architectural firm hired to design the new model was required to admit one of their architects as a resident of the facility for 72 hours. Each household also has a multidisciplinary staff and leadership team. The CEO of Meadowlark Hills observes that staff turnover has dropped by more than 50 percent and clinical outcomes have improved since transforming to the “household” model.21

The changes in LTC and in nursing home models should be considered, along with financing considerations and projected need for LTC services, as the County and HCD answer some key questions that will influence the final decision regarding the future of the Healey Center. These include:

- Is the Healey Center a charity care facility that takes all persons needing SNF care who have no payor source?

- Should the Healey Center seek to achieve a specific payor mix in order to improve financial viability of the facility?

- Does the HCD (and County) intend to limit their contribution to the existing number of beds at the Healey Center or to the current amount of the County subsidy? How will projected future increased demand be met?

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21 Haran, Christine. Transforming Long-Term Care: GivingResidents a Place to Call “Home”. April 2, 2006. The Commonwealth Fund.
• Does the County/HCD mission include alternatives to NF LOC (like assisted living, housing with on-site supports) and if so, what would be the limits for alternatives or for total LTC services expenditures?

• Does the County and HCD want to transform the County-funded LTC services provided at the Healey Center from the more traditional nursing home to an alternative nursing home model and if so, how “transformative” should the change be?

We considered these questions when developing the options for models of care. See the section of this report entitled: “Possible Models of Care.”

**Mary’s Story**
Mary (not her real name) is 48 years old and has lived at the Healey Center for 1 ½ years. Mary is at the Healey Center as the result of a stroke - she spent 1 ½ months in a hospital after her stroke and came to Healey for additional therapy and help with her daily care. Prior to having a stroke, Mary lived at home and did lots of things around her home and community.

She has received physical therapy and was learning to get around using a walker. However, while living at the Healey Center she has had two more strokes, making it difficult for her to use a walker alone. She works with the staff at the Healey Center each day, who assist her with using a walker and help her with her daily care. Mary says she would like to leave the Healey Center but is not sure she can and not sure where she would go.
Outsourcing of Care
In order to address current trends in LTC, HMA assessed the potential for outsourcing of care to both other SNFs and to community-based placements and the advantages and challenges of outsourcing. There are two potential options for outsourcing of care: locate NFs willing to admit Healey Center residents (and in the future, persons referred by the HCD) and place residents in alternative community-based settings (such as ALFs or apartments with on-site supports).

Nursing Facility Availability
According to data from the federal centers for Medicare and Medicaid Services (CMS) there are fifty-six nursing facilities with 6,497 licensed beds in Palm Beach County. Not all of these beds are usable. For example, the Healey Center is identified in this dataset as having 198 beds, but as noted previously in this report, only 125 beds are available for use at present. There is no readily available data source that can be used to determine the number of available beds among all Palm Beach County NFs.

Palm Beach County NF occupancy has been declining recently and this trend appears likely to continue until the County reaches some baseline utilization rate or until SNFs begin taking actions to address the decline. This could include taking beds offline, closing units, closing facilities or converting units or facilities to alternative uses.

Figure 17: Palm Beach County SNF Occupancy Rates

Source: Health Care District of Palm Beach County, Treasure Coast Monthly SNF Report

In order to identify potential NFs for outsourcing we compiled a list of all Palm Beach County SNFs and then excluded SNFs that:

1. Do not accept Medicaid (CMS data);
2. Have an occupancy rate of 90% or higher (CMS data);
3. Have religious or ethnic limitations (CMS data, White Paper);
4. Are part of a continuing care retirement center (CCRC), including “upscale” SNFs (CMS data, Internet search);
5. Serve only short-term residents (take only “rehab” patients) – (Phone interview);
6. Have become inactive Medicaid providers since their last survey (AHCA data);
7. Were on the AHCA NF watch list as of July 31, 2008 (AHCA data);\(^{22}\) or
8. Had a Quality of care Score on their last survey as posted on the AHCA website of less than 3 stars (AHCA data). (The Healey Center has a 4-star quality of care rating.)\(^{23}\)

The full SNF list from CMS contained information for 56 facilities. These facilities had 6,497 certified beds with 5,450 beds occupied (1,047 vacancies). The vacancies are an estimate – not all certified beds can be occupied (like the Healey Center they may have been taken off-line or be unusable) and they represent a point in time count (the date of which varied based on each SNFs survey date).

After removing facilities that were in one or more categories above (items 1 through 8), there were 13 facilities remaining with 1,703 certified beds, of which 1,426 were occupied at the time of the survey leaving 297 unoccupied beds. We obtained June 2008 reported census from the HCD for each SNF and revised the count of available beds. Because of a drop in occupancy among =SNFs, there were now a reported 358 beds potentially available.

We contacted a sample of SNFs with 3-star or 4-star ratings. SNF administrators made a number of comments related to the Healey Center, including:

- “We don’t take County residents” (meaning residents funded by the county);
- “We serve mostly very old residents who are frail – we could not take younger residents with behavior problems”;
- “This is an upscale facility”; and
- “Healey is a valuable resource - needed in the community. They do a good job.”

The 3-star facilities reported interest in discussing contracting with the HCD and had significant bed availability. However, their lower quality of care rating is of concern and contracting with such facilities is not recommended.

\(^{22}\) The Watch List identifies nursing homes that are operating under bankruptcy protection or met the criteria for a conditional status during the past 30 months. A conditional status indicates that a facility did not meet, or correct upon follow-up, minimum standards at the time of an inspection. Immediate action is taken if a facility poses a threat to resident health or safety.

\(^{23}\) Star ratings are used as a way to compare one nursing home to other nursing homes in the region. For example, a 3-star rating means the nursing home ranked better than 41% to 60% of the facilities in its region on a specific measure. A 4-star score means the nursing home ranked better than 61-80% of nursing homes in the region. The Healey Center is compared to nursing homes in Region 9, which consists of Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie counties. Measures that are included in the scoring for Quality of Care include receiving appropriate treatment to prevent or heal pressure sores, providing adequate nutrition and fluids, etc. Nursing home ratings are posted at: [www.FloridaHealthFinder.gov](http://www.FloridaHealthFinder.gov)
If we limit the potential NFs to those on this list with a quality of care rating at least as high as that of the Healey Centers (4-star), there are six facilities with 753 licensed beds, and a potential 82 vacancies. However, three of these facilities when contacted reported no openings for long-term care clients or were not able to take patients with the types of needs common to Healey Center residents, reducing potentially available beds in the 4- or 5-star facilities to 50 beds.

Healey Center staff believe that 55% of residents require 24/7 care. This care would need to be provided in a SNF. This is about 62 residents (varying slightly depending on census). In addition, a portion of the 41 residents who require daily assistance and supervision, but less than 24/7 care, would also need to be served in a SNF.

**Barriers to Placement in Other SNFs**

Several SNFs expressed interest in serving Healey Center residents, but these SNFs had a quality of care rating below that of the Healey Center. Even if there were adequate numbers of beds in 4-star SNFs, significant barriers to outsourcing remain. While it is possible all of these SNFs would admit one or more Healey Center residents once they entered into an agreement with the HCD, there are a number of known and potential problems that create barriers to actual placement in these alternative SNFs.

- No SNF can guarantee access to a bed. June 2008 SNF occupancy in Palm Beach County was reported to be about 78%, the lowest occupancy rate in the last 18 months. Occupancy varies by facility, but bed availability is certainly greater than it has been in the past. Some providers in the nursing home industry believe the decline in occupancy is a “blip” and is not likely to continue. Factors that can affect nursing home occupancy include a changing economy and changes in third party payors.

- SNFs cannot hold beds open for HCD patients. They may be willing to sign a contract to provide priority access to the first available bed. There is no way to know at any point in time, how many and what types of beds will be available. If the HCD is incurring hospital costs for the patient (either because they are charity care patients or they have exceeded their annual 45-day Medicaid covered bed days in a hospital), these costs will quickly rise if SNF beds are not readily available.

- A SNF may intend to admit a Healey Center resident but when they review detailed information about the resident, they may determine they are not willing or able to do so. The most likely reasons a specific resident or HCD referred prospective resident might be declined are:
  - A history of problem behaviors that may pose a danger to other residents and to staff; and/or
  - Care needs in excess of what the SNF can accommodate, either due to the SNF’s staffing issues or due to the prospective resident’s special requirements.
• It may be difficult to move Healey Center residents to other SNFs, especially those residents who have been at the Healey Center for a long time or those with involved family members.
  o Residents may fear a move and may become anxious and distressed. There is some evidence (studies in the 1990s and before) that relocation of frail elders is associated with an increased risk of mortality. A more recent study finds an increased risk of falls following relocation with no other statistically significant outcomes. (Capezuti et al., October 2006.)
  o Long-term residents are likely to have formed close relationships with other residents and staff.
  o Families may find it difficult to travel to a different facility, especially if the facility is located far from the Healey Center and not accessible by public transportation.

**Placing Residents In Alternative Non-Nursing Home Settings**
In order to determine if outsourcing care to alternative community-based settings is an available option for some Healey Center residents, we used readily available data to estimate:

1) The number of residents who can be served in an alternative non-nursing home setting;
2) The amount of care that would be required and the cost of this care;
3) Additional costs that would be incurred by the HCD to provide access to this care; and
4) The overall cost-effectiveness of outsourcing care to alternative community-based settings.

**Alternative Community-Based Settings**
We asked the Healey Center staff to identify how many residents had needs that could be classified into one of the following groups:

• Requires 24/7 care
• Requires less than 24/7 care but does require some level of personal care and regular nursing care
• Could be served in an ALF
• Is independent

HMA also asked Healey Center staff to identify the number of residents in these categories who have specific circumstances that should be taken into account when developing cost estimates for “outsourcing” care. These are:

• Citizenship status – illegal non-citizen
• Access to funds – no access
• Medicaid status – ineligible or pending
- Disability status – does not meet disability requirements for public assistance (SSI/Medicaid)
- Problem behaviors – behaviors that would make admission to another SNF unlikely or that would require significant behavioral supports

Based on this information we were able to develop a table of projected needs and of circumstances we should take into consideration when projecting the feasibility of outsourcing care. (See Table 29.)

Table 29: Projected Setting and Considerations

<table>
<thead>
<tr>
<th>Category</th>
<th>Independent</th>
<th>Assisted Living</th>
<th>Limited Nursing/Home Health</th>
<th>24/7 Care</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Projected Setting</td>
<td>1</td>
<td>9</td>
<td>41</td>
<td>62</td>
<td>113</td>
</tr>
<tr>
<td>No Funds</td>
<td>1</td>
<td>4</td>
<td>14</td>
<td>20</td>
<td>39</td>
</tr>
<tr>
<td>Illegal</td>
<td>1</td>
<td>4</td>
<td>10</td>
<td>18</td>
<td>33</td>
</tr>
<tr>
<td>Do Not Meet Disability</td>
<td>5</td>
<td>3</td>
<td>N/A</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Pending Medicaid</td>
<td>1</td>
<td>2</td>
<td>2</td>
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<td>3</td>
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<tr>
<td>Problem Behaviors</td>
<td>1</td>
<td>1</td>
<td>9</td>
<td>17</td>
<td>28</td>
</tr>
</tbody>
</table>


Fifty-five percent of residents (or 62 of 113 residents) were identified as requiring 24/7 care. Forty-one residents (36%) require less than 24/7 care but varying amounts of personal care, nursing and other services. Nine residents were identified as being able to reside in an ALF, a community-based option that is not readily available for low-income residents as discussed previously. Complicating this placement option, four of the nine residents are illegal immigrants and so have no funds and no health insurance coverage. One resident was identified as independent – this resident is also an illegal immigrant who has no funds, no health insurance coverage and has problem behaviors.

Figure 18: Healey Center Resident Possible Alternative Setting

24 Alternative settings assume access to adequate support services and a suitable residential placement.
Problem behaviors are a complicating factor for placement in any alternative setting, including another SNF or community-based alternatives. A count of residents with problem behaviors by projected need/setting are displayed in Figure 19.

**Figure 19: Healey Center Residents with Problem Behaviors by Need Category**

<table>
<thead>
<tr>
<th>Need Category</th>
<th>Residents</th>
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<tbody>
<tr>
<td>Independent</td>
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<tr>
<td>Assisted Living</td>
<td>1</td>
</tr>
<tr>
<td>Limited Nursing/Home Health</td>
<td>1</td>
</tr>
<tr>
<td>24/7 Care</td>
<td>9</td>
</tr>
</tbody>
</table>

The Healey Center identified twenty-eight residents with problem behaviors. Problem behaviors include active drug use, drug seeking behaviors (including leaving the facility to obtain drugs), attempting to sell drugs, aggressive behaviors including attacking other residents or staff, and leaving the facility in a wheelchair and traveling in traffic the wrong way.

It is possible that a smaller, community-based setting would be a better alternative for some residents with problem behaviors, since greater independence may reduce frustration and the tendency to become agitated when confined or crowded. However, some residents would exhibit these behaviors in community-based settings or even increase these behaviors.

**Cost Scenarios**

We developed several scenarios to estimate the cost to provide care in alternative settings. In order to develop cost profiles we used service rates provided by the Florida BSCIP NF transition specialist for most services. For live-in supports and behavior services, we used the Medicaid Developmental Disabilities Waiver rate. Medical and other supply costs were either provided by the specialist or we obtained the typical cost charged by medical supply companies. We calculated a start-up cost that includes rent and utility deposits and supplies in non-ALF settings.

The BSCIP transition specialist has determined that an individual should pay no more than 1/3 of their income for rent, in order to have adequate funds to cover utilities and other expenses in non-ALF settings. In ALF settings, the person should retain at least the amount equivalent to the personal needs allowance required to be retained by NF.
residents ($35/month) and ALF residents receiving Optional State Supplementation (OSS) payments may retain $54/month.

We annualized the costs and calculated them as a daily amount in alternative settings in order to compare this cost to the cost to provide care at the Healey Center. We calculated costs for Medicaid and non-Medicaid eligible persons, assuming that persons with Medicaid would also be receiving SSI at the maximum benefit amount (currently $637/month), and, when in an ALF, would receive OSS payments and Medicaid assistive care services.

Medicaid assistive care services consist of:

- Health support;
- Assistance with activities of daily living (ADLs);
- Assistance with instrumental activities of daily living (IADLs); and
- Assistance with self-administration of medication.

Medicaid recipients must reside in an ALF, AFCH or RCF and:

- Be ambulatory, with or without assistance;
- Not exhibit chronic inappropriate behavior which disrupts the facility’s operations or is harmful to self or others;
- Be capable of taking his or her medication with assistance;
- Not have any stage 3 or 4 pressure sores; and
- Not require 24-hour nursing supervision.

For ALF costs, we calculated the cost for two different ALFs – a private ALF costing $3,000/month (the mid range was $2,700 in 2007) and an ALF operated by the HCD. A HCD-operated ALF is estimated to cost $3,570/month per person to operate based on a preliminary pro-forma. Appendix 3 includes the pro-forma for the HCD-operated ALF detailing the assumptions for the cost components.

ALFs cannot admit non-ambulatory persons, except those who can transfer with assistance and complete ADLs with assistance. Therefore, persons with quadriplegia would not be served in an ALF. Persons with paraplegia might be served depending on their specific capabilities.

We also calculated costs for on-site housing with and without access to federal rental subsidy vouchers available from the United States Department of Housing and Urban Development (HUD) to offset 2/3 of the cost of rent. The cost for HCD-operated housing appears similar to the average cost for private rentals ($1,214/month versus $1,200/month). However, the cost for HCD-operated housing includes some supports not generally available in private housing such as a full-time housing manager to meet the

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25 Housing vouchers are available to low-income families, the elderly and persons with disabilities. Vouchers are not an entitlement – a specified number are made available each year. The West Palm Beach Housing authority, which administers public housing and housing vouchers, has closed the housing waiting list. [http://www.wpbha.org/housing/waiting-closed.html](http://www.wpbha.org/housing/waiting-closed.html)
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needs of 20 tenants, a part-time activities director to assist residents in accessing community events or to arrange on-site opportunities, and access to a driver. A preliminary housing pro-forma is provided as Appendix 4.

We included two scenario variations that include access to a Medicaid HCBS waivers. The ability to access HCBS waivers and other sources of coverage would make each option more cost-effective for those persons who meet program eligibility requirements.

These cost comparisons are provided for illustrative purposes only. Actual costs will vary by person. If the person is uninsured (is not Medicaid eligible), the HCD will incur high medical costs for some of these persons. Many of these costs would be incurred irrespective of setting but will accrue to different programs (the Healey Center when residing in the SNF versus the Coordinated Care Program when residing in the community, for example). Nevertheless, the costs will ultimately be HCD and County costs.

The comparison costs are developed at the individual level in this section of the report and use the cost of care subsidized by the HCD at the Healey Center as the comparison cost, or $346/day for persons who are “charity care” and $56/day for Medicaid eligibles. Because savings could be substantial for charity care residents, we suggest the HCD consider the cost for alternative settings in the aggregate. In other words, residents with Medicaid who might cost more to serve in a HCD-operated ALF or housing unit should have access to this option when clinically appropriate and when total costs across all housing types are calculated. It is possible to achieve overall cost-effectiveness even though some individuals will be more costly to serve in an ALF or apartment, because others will cost much less. (This is the type of calculation used by the Florida Medicaid program to determine the cost-effectiveness of serving persons in a HCBS waiver versus nursing home.)

Summary of Scenarios

- **Scenario 1** - Three individuals with quadriplegia sharing a house and services: The cost for each individual if fully subsidized by the HCD (non-Medicaid, no income, no other payors) is cost-effective compared to the charity care cost at the Healey Center: $127/day compared to $346/day. For Medicaid eligibles, this option is more expensive than the HCD cost at the Healey Center: $179/day the first year and $120/day the second year and thereafter compared to $56/day.

  This option would be cost-effective if the individual were able to access services and/or funds through the BSCIP or TBI/SCI Waiver when slots are available and perhaps through some other funding sources.

- **Scenario 2a** - One Individual with quadriplegia and a live-in worker in a residence: The cost for this individual if fully subsidized by the HCD (non-Medicaid, no income, no other payors) is only cost-effective compared to the charity care cost at the Healey Center: $333/day the first year and $245/day thereafter compared to $346/day. For Medicaid eligibles, the cost exceeds the cost
incurred by the HCD for a Medicaid eligible residing at the Healey Center ($326/day the first year and $238/day thereafter compared to $56/day).

Medicaid eligibles would need to access substantial additional supports to make this cost-effective. This is possible through the BSCIP or TBI/SCI Waiver when slots are available and perhaps through some other funding sources.

- **Scenario 2b** - One Individual with quadriplegia and a Personal Care Attendant 24/7: This option is not cost-effective, with the lowest daily cost of $596/day compared to $346/day at the Healey Center if charity care and $589/day compared to $56/day if Medicaid eligible.

- **Scenario 3** - Three Individuals with Paraplegia Sharing a Residence: This is cost-effective for charity care residents ($117/day the first year and $85/day thereafter compared to $346/day) and close to cost-effective for Medicaid eligibles in the second year and thereafter ($78 compared to $56). Medicaid eligibles need only access a small amount of additional support to make this a cost-effective option.

- **Scenario 4** - Two individuals with TBI sharing a residence and services: The cost for each individual if fully subsidized by the HCD (non-Medicaid, no income, no other payors) is cost-effective compared to the charity care cost at the Healey Center: $102/day compared to $346/day.

For Medicaid eligibles, this option would be cost-effective if the individual were able to access services and supports to reduce the HCD cost. This is possible through the BSCIP or TBI/SCI Waiver when slots are available and perhaps through some other funding sources.

- **Scenarios 5a and 5b** - Assisted Living Scenarios: An ALF is a cost-effective alternative when compared to charity care costs at the Healey Center. Medicaid eligible residents who need limited supports cost more in an ALF (including a HCD-operated ALF) than at the Healey Center ($91/day compared to $56/day at a HCD-operated ALF). The more services a person needs, the less cost-effective the model becomes. However, there are several waivers that can fund services in an ALF including the ALE Waiver, TBI/SCI Waiver, and the NHD Waiver. It seems likely that Medicaid eligibles would be able to access some additional supports to reduce the cost.

- **Scenario 6** – HCD Apartment Scenarios: Apartments operated by the HCD could be a cost-effective option for Medicaid residents if they have access to HUD vouchers and an HCBS waiver. Charity care residents capable of living in independent housing with supports could do so cost-effectively even without a HUD Voucher or SSI compared to the cost incurred by the HCD for care at the Healey Center.

Table 30 provides a summary of theoretical community placement scenarios and the impact of a resident’s care needs, category of eligibility (charity care versus Medicaid) and access to other funding sources (such as HUD housing vouchers and Medicaid HCBS waiver services) on the cost of care per day. The cost savings to the HCD is greater for charity care residents than Medicaid residents because the cost incurred by the HCD for charity care residents is so high. (The HCD incurred costs of $346/day for residents...
covered through “charity care” and $56/day for residents covered by Medicaid in 2007.) There are ways to achieve cost-savings to the HCD for Medicaid residents residing in an ALF or housing but this requires accessing HCBS waivers.
### Table 30: Placement Scenarios and HCD Costs – Summary Table

<table>
<thead>
<tr>
<th>Charity Care Residents (Not Eligible for Medicaid/SSI or HUD Rental Vouchers)</th>
<th>A</th>
<th>B</th>
<th>C = B-A</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HCD 2007</strong> Healey Center Cost Per Day</td>
<td>HCD Scenario Cost Per Day</td>
<td>HCD Cost (Savings)/Day</td>
<td></td>
</tr>
<tr>
<td>Scenario 1: Individual with Quadriplegia Sharing a House and Services</td>
<td>$346</td>
<td>$127</td>
<td>($219)</td>
</tr>
<tr>
<td>Scenario 2a: Individual with Quadriplegia with Live-In Worker</td>
<td>$346</td>
<td>$245</td>
<td>($101)</td>
</tr>
<tr>
<td>Scenario 2b: Individual with Quadriplegia with 24/7 Personal Care Attendant</td>
<td>$346</td>
<td>$596</td>
<td>$250</td>
</tr>
<tr>
<td>Scenario 3: Individual with Paraplegia Sharing a Residence and Services</td>
<td>$346</td>
<td>$85</td>
<td>($261)</td>
</tr>
<tr>
<td>Scenario 4: Individual with TBI Sharing a Residence and Services</td>
<td>$346</td>
<td>$102</td>
<td>($244)</td>
</tr>
<tr>
<td>Scenario 5a: Individual with TBI at a Private ALF</td>
<td>$346</td>
<td>$155</td>
<td>($191)</td>
</tr>
<tr>
<td>Scenario 5b: Individual with some special Care Needs at HCD-Operated ALF</td>
<td>$346</td>
<td>$122</td>
<td>($224)</td>
</tr>
<tr>
<td>Scenario 7: Individual with Quadriplegia in a HCD Apartment</td>
<td>$346</td>
<td>$187</td>
<td>($159)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Residents with Medicaid</th>
<th>A</th>
<th>B</th>
<th>C = B-A</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HCD 2007</strong> Healey Center Cost/Day</td>
<td>HCD Scenario Cost/Day</td>
<td>Additional Cost (Savings)/Day</td>
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</tr>
<tr>
<td>Scenario 1: Individual with Quadriplegia Sharing a House and Services</td>
<td>$56</td>
<td>$120</td>
<td>$64</td>
</tr>
<tr>
<td>Scenario 2a: Individual with Quadriplegia with Live-In Worker</td>
<td>$56</td>
<td>$238</td>
<td>$182</td>
</tr>
<tr>
<td>Scenario 2b: Individual with Quadriplegia with 24/7 Personal Care Attendant</td>
<td>$56</td>
<td>$589</td>
<td>$533</td>
</tr>
<tr>
<td>Scenario 3: Individual with Paraplegia Sharing a Residence and Services</td>
<td>$56</td>
<td>$78</td>
<td>$22</td>
</tr>
<tr>
<td>Scenario 4: Individual with TBI Sharing a Residence and Services</td>
<td>$56</td>
<td>$95</td>
<td>$39</td>
</tr>
<tr>
<td>Scenario 5a: Individual with TBI at a Private ALF</td>
<td>$56</td>
<td>$124</td>
<td>$68</td>
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<tr>
<td>Scenario 5b: Individual with some special Care Needs at HCD-Operated ALF</td>
<td>$56</td>
<td>$91</td>
<td>$35</td>
</tr>
<tr>
<td>Scenano 5b with ALE Waiver</td>
<td>$56</td>
<td>$49</td>
<td>($7)</td>
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<tr>
<td>Scenario 6: Individual with Paraplegia in a HCD Apartment with HUD Rental Voucher &amp; SSI</td>
<td>$56</td>
<td>$72</td>
<td>$16</td>
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<tr>
<td>Scenario 7: Individual with Quadriplegia in a HCD Apartment with SSI and HUD Rental Voucher</td>
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<tr>
<td>Scenario 7 with TBI/SCI Waiver</td>
<td>$56</td>
<td>$42</td>
<td>($14)</td>
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**Scenario 1: Three Individuals with Quadriplegia Sharing a House and Services**

### Initial, One Time Expenditures

<table>
<thead>
<tr>
<th>Item</th>
<th>Each</th>
<th>Quantity</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power Chair</td>
<td>$10,000</td>
<td>3</td>
<td>$30,000</td>
</tr>
<tr>
<td>Cushion</td>
<td>$400</td>
<td>3</td>
<td>$1,200</td>
</tr>
<tr>
<td>Specialty Mattress</td>
<td>$3,500</td>
<td>3</td>
<td>$10,500</td>
</tr>
<tr>
<td>Hospital Bed</td>
<td>$725</td>
<td>3</td>
<td>$2,175</td>
</tr>
<tr>
<td>Hoyer Lift</td>
<td>$2,000</td>
<td>1</td>
<td>$2,000</td>
</tr>
<tr>
<td>Bathroom Modifications</td>
<td>$10,000</td>
<td>1</td>
<td>$10,000</td>
</tr>
<tr>
<td>Rolling Shower Chair</td>
<td>$1,500</td>
<td>3</td>
<td>$4,500</td>
</tr>
<tr>
<td>PERS installation</td>
<td>$30</td>
<td>3</td>
<td>$90</td>
</tr>
<tr>
<td>Household Items</td>
<td>$1,000</td>
<td>1</td>
<td>$1,000</td>
</tr>
<tr>
<td>Portable Ramp</td>
<td>$200</td>
<td>3</td>
<td>$600</td>
</tr>
<tr>
<td>Housing (Deposits)</td>
<td>$2,700</td>
<td>1</td>
<td>$2,700</td>
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<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td>$64,765</td>
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### On-Going Expenditures

<table>
<thead>
<tr>
<th>Service/Item</th>
<th>Rate</th>
<th>Unit</th>
<th>Monthly Units Per Individual</th>
<th># Individuals</th>
<th>Monthly Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing</td>
<td>$35</td>
<td>hour</td>
<td>32</td>
<td>3</td>
<td>$3,360</td>
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<tr>
<td>Personal Care</td>
<td>$20</td>
<td>hour</td>
<td>84</td>
<td>3</td>
<td>$5,040</td>
</tr>
<tr>
<td>Companion, Housekeeping</td>
<td>$12</td>
<td>hour</td>
<td>84</td>
<td>1</td>
<td>$1,008</td>
</tr>
<tr>
<td>Support Coordinator</td>
<td>$140</td>
<td>month</td>
<td>1</td>
<td>3</td>
<td>$420</td>
</tr>
<tr>
<td>PERS Maintenance</td>
<td>$30</td>
<td>month</td>
<td>1</td>
<td>3</td>
<td>$90</td>
</tr>
<tr>
<td>Supplies</td>
<td>$100</td>
<td>month</td>
<td>1</td>
<td>3</td>
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</tr>
<tr>
<td>Utilities</td>
<td>$200</td>
<td>month</td>
<td>1</td>
<td>1</td>
<td>$200</td>
</tr>
<tr>
<td>Housing Cost, no subsidy</td>
<td>$1,200</td>
<td>month</td>
<td>1</td>
<td>1</td>
<td>$1,200</td>
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<tr>
<td><strong>Total</strong></td>
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<td></td>
<td></td>
<td>$11,618</td>
</tr>
</tbody>
</table>

### Calculation of Per Diem Cost (Charity Care Resident)

- Initial, One Time Expenditures: $64,765
- On-Going Expenditures, annualized: $139,416
- Total Per Year for 3 Individuals: $204,181
- Cost Per Individual: $68,060

- Cost Per Diem, first year: $186
- Cost Per Diem, thereafter: $127

### Medicaid Resident with SSI (1/3 maximum $637 benefit or $212.33 month)

- Calculation of Per Diem Cost
- Initial, One Time Expenditures: $64,765
- On-Going Expenditures, annualized: $131,772
- Total Per Year for 3 Individuals: $196,537
- Cost Per Individual: $65,512

- Cost Per Diem, first year: $179
- Cost Per Diem, thereafter: $120
**Scenario 2a: One Individual with Quadriplegia with Live-in Worker.**

**Initial, One Time Expenditures**

<table>
<thead>
<tr>
<th>Item</th>
<th>Each</th>
<th>Quantity</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power Chair</td>
<td>$10,000</td>
<td>1</td>
<td>$10,000</td>
</tr>
<tr>
<td>Cushion</td>
<td>$400</td>
<td>1</td>
<td>$400</td>
</tr>
<tr>
<td>Specialty Mattress</td>
<td>$3,500</td>
<td>1</td>
<td>$3,500</td>
</tr>
<tr>
<td>Hospital Bed</td>
<td>$725</td>
<td>1</td>
<td>$725</td>
</tr>
<tr>
<td>Hoyer Lift</td>
<td>$2,000</td>
<td>1</td>
<td>$2,000</td>
</tr>
<tr>
<td>Bathroom Modifications</td>
<td>$10,000</td>
<td>1</td>
<td>$10,000</td>
</tr>
<tr>
<td>Rolling Shower Chair</td>
<td>$1,500</td>
<td>1</td>
<td>$1,500</td>
</tr>
<tr>
<td>Household Items</td>
<td>$1,000</td>
<td>1</td>
<td>$1,000</td>
</tr>
<tr>
<td>Portable Ramp</td>
<td>$200</td>
<td>1</td>
<td>$200</td>
</tr>
<tr>
<td>Housing (Deposits)</td>
<td>$2,700</td>
<td>1</td>
<td>$2,700</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
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**On-Going Expenditures**

<table>
<thead>
<tr>
<th>Service/Item</th>
<th>Rate</th>
<th>Unit</th>
<th>Monthly Units Per Individual</th>
<th># Individuals</th>
<th>Monthly Total</th>
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</thead>
<tbody>
<tr>
<td>Skilled Nursing</td>
<td>$35</td>
<td>hour</td>
<td>60</td>
<td>1</td>
<td>$2,100</td>
</tr>
<tr>
<td>In Home Supports (live-in)</td>
<td>$120</td>
<td>day</td>
<td>31</td>
<td>1</td>
<td>$3,720</td>
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<tr>
<td>Support Coordinator</td>
<td>$140</td>
<td>month</td>
<td>1</td>
<td>1</td>
<td>$140</td>
</tr>
<tr>
<td>Supplies</td>
<td>$100</td>
<td>month</td>
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<td>1</td>
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<tr>
<td>Utilities</td>
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<td>month</td>
<td>1</td>
<td>1</td>
<td>$200</td>
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<tr>
<td>Housing Cost, no subsidy</td>
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<td>1</td>
<td>1</td>
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<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$7,460</td>
</tr>
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</table>

**Calculation of Per diem Cost (Charity Care Resident)**

- Initial, One Time Expenditures: $32,025
- On-Going Expenditures, annualized: $89,520
- Total Per Year: $121,545
- Cost Per Diem, first year: $333
- Cost Per Diem, thereafter: $245

**Medicaid Resident with SSI (1/3 of maximum $637 benefit or $212.33 month)**

- Initial, One Time Expenditures: $32,025
- On-Going Expenditures, annualized: $86,972
- Total Per Year: $118,997
- Cost Per Diem, first year: $326
- Cost Per Diem, thereafter: $238
Scenario 2b: One Individual with Quadriplegia with 24/7 Personal Care Attendant.

### Initial, One Time Expenditures

<table>
<thead>
<tr>
<th>Item</th>
<th>Each</th>
<th>Quantity</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power Chair</td>
<td>$10,000</td>
<td>1</td>
<td>$10,000</td>
</tr>
<tr>
<td>Cushion</td>
<td>$400</td>
<td>1</td>
<td>$400</td>
</tr>
<tr>
<td>Specialty Mattress</td>
<td>$3,500</td>
<td>1</td>
<td>$3,500</td>
</tr>
<tr>
<td>Hospital Bed</td>
<td>$725</td>
<td>1</td>
<td>$725</td>
</tr>
<tr>
<td>Hoyer Lift</td>
<td>$2,000</td>
<td>1</td>
<td>$2,000</td>
</tr>
<tr>
<td>Bathroom Modifications</td>
<td>$10,000</td>
<td>1</td>
<td>$10,000</td>
</tr>
<tr>
<td>Rolling Shower Chair</td>
<td>$1,500</td>
<td>1</td>
<td>$1,500</td>
</tr>
<tr>
<td>Household Items</td>
<td>$1,000</td>
<td>1</td>
<td>$1,000</td>
</tr>
<tr>
<td>Portable Ramp</td>
<td>$200</td>
<td>1</td>
<td>$200</td>
</tr>
<tr>
<td>Housing (Deposits)</td>
<td>$2,700</td>
<td>1</td>
<td>$2,700</td>
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<tr>
<td><strong>Total</strong></td>
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<td></td>
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### On-Going Expenditures

<table>
<thead>
<tr>
<th>Service/Item</th>
<th>Rate</th>
<th>Unit</th>
<th>Monthly Units Per Individual</th>
<th># Individuals</th>
<th>Monthly Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing</td>
<td>$35</td>
<td>hour</td>
<td>60</td>
<td>1</td>
<td>$2,100</td>
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<tr>
<td>24/7 Personal Care</td>
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<td>hr</td>
<td>720</td>
<td>1</td>
<td>$14,400</td>
</tr>
<tr>
<td>Support Coordinator</td>
<td>$140</td>
<td>month</td>
<td>1</td>
<td>1</td>
<td>$140</td>
</tr>
<tr>
<td>Supplies</td>
<td>$100</td>
<td>month</td>
<td>1</td>
<td>1</td>
<td>$100</td>
</tr>
<tr>
<td>Utilities</td>
<td>$200</td>
<td>month</td>
<td>1</td>
<td>1</td>
<td>$200</td>
</tr>
<tr>
<td>Housing Cost, no subsidy</td>
<td>$1,200</td>
<td>month</td>
<td>1</td>
<td>1</td>
<td>$1,200</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>$18,140</strong></td>
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</tbody>
</table>

### Calculation of Per Diem Cost (Charity Care Resident)

- **Initial, One Time Expenditures** $32,025
- **On-Going Expenditures, annualized** $217,680
- **Total Per Year** $249,705

Cost Per Diem, first year: $684  
Cost Per Diem, thereafter: $596

### Medicaid Resident with SSI (1/3 of maximum $637 benefit or $212.33 month)

Calculation of Per Diem Cost

- **Initial, One Time Expenditures** $32,025
- **On-Going Expenditures, annualized** $215,132
- **Total Per Year** $247,157

Cost Per Diem, first year: $677  
Cost Per Diem, thereafter: $589
**Scenario 3: Three Individuals with Paraplegia Sharing a Residence and Services.**

### Initial, One Time Expenditures

<table>
<thead>
<tr>
<th>Item</th>
<th>Each</th>
<th>Quantity</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Chair</td>
<td>$2,500</td>
<td>3</td>
<td>$7,500</td>
</tr>
<tr>
<td>Cushion</td>
<td>$400</td>
<td>3</td>
<td>$1,200</td>
</tr>
<tr>
<td>Specialty Mattress</td>
<td>$3,500</td>
<td>3</td>
<td>$10,500</td>
</tr>
<tr>
<td>Hospital Bed</td>
<td>$725</td>
<td>3</td>
<td>$2,175</td>
</tr>
<tr>
<td>Home Modifications</td>
<td>$5,000</td>
<td>1</td>
<td>$5,000</td>
</tr>
<tr>
<td>Rolling Shower Chair</td>
<td>$1,500</td>
<td>3</td>
<td>$4,500</td>
</tr>
<tr>
<td>PERS installation</td>
<td>$30</td>
<td>3</td>
<td>$90</td>
</tr>
<tr>
<td>Household Items</td>
<td>$1,000</td>
<td>1</td>
<td>$1,000</td>
</tr>
<tr>
<td>Portable Ramp</td>
<td>$200</td>
<td>3</td>
<td>$600</td>
</tr>
<tr>
<td>Housing (Deposits)</td>
<td>$2,700</td>
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<td>$2,700</td>
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<td><strong>Total</strong></td>
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### On-Going Expenditures

<table>
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<th>Service/Item</th>
<th>Rate</th>
<th>Unit</th>
<th>Monthly Units Per Individual</th>
<th># Individuals</th>
<th>Monthly Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing</td>
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<td>3</td>
<td>$210</td>
</tr>
<tr>
<td>Home Health Aid</td>
<td>$20</td>
<td>hour</td>
<td>84</td>
<td>3</td>
<td>$5,040</td>
</tr>
<tr>
<td>Companion, Housekeeping</td>
<td>$12</td>
<td>hour</td>
<td>32</td>
<td>1</td>
<td>$384</td>
</tr>
<tr>
<td>Support Coordinator</td>
<td>$140</td>
<td>month</td>
<td>1</td>
<td>3</td>
<td>$420</td>
</tr>
<tr>
<td>Supplies</td>
<td>$100</td>
<td>month</td>
<td>1</td>
<td>3</td>
<td>$300</td>
</tr>
<tr>
<td>Utilities</td>
<td>$200</td>
<td>month</td>
<td>1</td>
<td>1</td>
<td>$200</td>
</tr>
<tr>
<td>Housing Cost, no subsidy</td>
<td>$1,200</td>
<td>month</td>
<td>1</td>
<td>1</td>
<td>$1,200</td>
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<td></td>
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</tr>
</tbody>
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### Calculation of Per Diem Cost (Charity Care Resident)

- Initial, One Time Expenditures: $35,265
- On-Going Expenditures, annualized: $93,048
- Total Per Year for 3 Individuals: $128,313
- Cost Per Individual: $42,771
- Cost Per Diem, first year: $117
- Cost Per Diem, thereafter: $85

### Medicaid Resident with SSI (1/3 maximum $637 benefit or $212.33 month)

- Calculation of Per Diem Cost
- Initial, One Time Expenditures: $35,265
- On-Going Expenditures, annualized: $85,404
- Total Per Year for 3 Individuals: $120,669
- Cost Per Individual: $40,223
- Cost Per Diem, first year: $110
- Cost Per Diem, thereafter: $78
Scenario 4: Two Individuals with TBI Sharing a Residence and Services.

### Initial, One Time Expenditures

<table>
<thead>
<tr>
<th>Item</th>
<th>Each</th>
<th>Quantity</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Household Items</td>
<td>$1,000</td>
<td>1</td>
<td>$1,000</td>
</tr>
<tr>
<td>PERS, installation</td>
<td>$30</td>
<td>2</td>
<td>$60</td>
</tr>
<tr>
<td>Housing (Deposits)</td>
<td>$2,700</td>
<td>1</td>
<td>$2,700</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>$3,760</strong></td>
</tr>
</tbody>
</table>

### On-Going Expenditures

<table>
<thead>
<tr>
<th>Service/Item</th>
<th>Rate</th>
<th>Unit</th>
<th>Monthly Units Per Individual</th>
<th># Individuals</th>
<th>Monthly Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supported Living Coach</td>
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<td>hour</td>
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<td>2</td>
<td>$400</td>
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<tr>
<td>In Home Supports</td>
<td>$101</td>
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<td>1</td>
<td>$3,131</td>
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<td>Support Coordinator</td>
<td>$140</td>
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<td>2</td>
<td>$280</td>
</tr>
<tr>
<td>Behavior Analysis/Planning</td>
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<td>2</td>
<td>$960</td>
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<tr>
<td>PERS, maintenance</td>
<td>$30</td>
<td>month</td>
<td>1</td>
<td>2</td>
<td>$60</td>
</tr>
<tr>
<td>Utilities</td>
<td>$200</td>
<td>month</td>
<td>1</td>
<td>1</td>
<td>$200</td>
</tr>
<tr>
<td>Housing Cost, no subsidy</td>
<td>$1,200</td>
<td>month</td>
<td>1</td>
<td>1</td>
<td>$1,200</td>
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<td><strong>Total</strong></td>
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<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

### Calculation of Per diem Cost (Charity Care Resident)

- Initial, One Time Expenditures: $3,760
- On-Going Expenditures, annualized: $74,772
- Total Per Year for 2 Individuals: $88,532
- Cost Per Individual: $44,266
- Cost Per Diem, first year: $108
- Cost Per Diem, thereafter: $102

### Medicaid Resident with SSI (1/3 maximum $637 benefit or $212.33 month)

- Calculation of Per Diem Cost
- Initial, One Time Expenditures: $3,760
- On-Going Expenditures, annualized: $67,128
- Total Per Year for 3 Individuals: $70,888
- Cost Per Individual: $23,629
- Cost Per Diem, first year: $101
- Cost Per Diem, thereafter: $95
### Scenario 5a: One Individual with TBI at a Private ALF

**On-Going Expenditures**

<table>
<thead>
<tr>
<th>Service/Item</th>
<th>Rate</th>
<th>Unit</th>
<th>Monthly Units Per Individual</th>
<th>Monthly Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support Coordinator</td>
<td>$140</td>
<td>month</td>
<td>1</td>
<td>$140</td>
</tr>
<tr>
<td>Home Health Aide (Personal Care)</td>
<td>$20</td>
<td>hour</td>
<td>60</td>
<td>$1,200</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>$35</td>
<td>hour</td>
<td>4</td>
<td>$140</td>
</tr>
<tr>
<td>Behavior Analysis/Planning</td>
<td>$60</td>
<td>hour</td>
<td>4</td>
<td>$240</td>
</tr>
<tr>
<td>Housing Cost, without subsidy (rent = $100/day)</td>
<td>$3,000</td>
<td>month</td>
<td>1</td>
<td>$3,000</td>
</tr>
</tbody>
</table>

**Calculation of Per Diem Cost (Charity Care Resident)**

- On-Going Expenditures, annualized: $56,640
- Cost per diem: $155

### Medicaid Resident with SSI ($637/month maximum benefit less $54 PNA or $583/month)

- Calculation of Per diem Cost
- On-Going Expenditures, annualized: $49,644
- OSS Payment ($78.40/month): $941
- Assistive care payment ($9.28/day): $3,387
- Cost per diem: $124

### Scenario 5b: One Individual with Some Special Care Needs at HCD-Operated ALF

**On-Going Expenditures**

<table>
<thead>
<tr>
<th>Service/Item</th>
<th>Rate</th>
<th>Unit</th>
<th>Monthly Units Per Individual</th>
<th># Individuals</th>
<th>Monthly Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support Coordinator</td>
<td>$140</td>
<td>month</td>
<td>1</td>
<td>1</td>
<td>$140</td>
</tr>
<tr>
<td>Housing Cost, without subsidy (rent = $119/day)</td>
<td>$3,570</td>
<td>month</td>
<td>1</td>
<td>1</td>
<td>$3,570</td>
</tr>
</tbody>
</table>

**No income (Charity Care Resident)**

- Calculation of Per Diem Cost
- On-Going Expenditures, annualized: $44,520
- Cost per diem: $122

**Medicaid Resident With SSI ($637/month maximum benefit less $54 PNA or $583/month)**

- Calculation of Per diem Cost
- On-Going Expenditures, annualized: $37,524
- OSS Payment ($78.40/month): $941
- Assistive care payment ($9.28/day): $3,387
- Cost per diem: $91
- With ALE Waiver ($1,556/month)*: $49

*Excludes assistive care which cannot be provided to all ALE Waiver enrollees*
**Scenario 6: HCD Housing Scenarios**

**Individual with Paraplegia In a HCD Apartment (Medicaid Resident)**

### Initial, One Time Expenditures

<table>
<thead>
<tr>
<th>Service/Item</th>
<th>Each</th>
<th>Quantity</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manual Chair</td>
<td>$2,500</td>
<td>1</td>
<td>$2,500</td>
</tr>
<tr>
<td>Cushion</td>
<td>$400</td>
<td>1</td>
<td>$400</td>
</tr>
<tr>
<td>Specialty Mattress</td>
<td>$3,500</td>
<td>1</td>
<td>$3,500</td>
</tr>
<tr>
<td>Hospital Bed</td>
<td>$725</td>
<td>1</td>
<td>$725</td>
</tr>
<tr>
<td>Rolling Shower Chair</td>
<td>$1,500</td>
<td>1</td>
<td>$1,500</td>
</tr>
<tr>
<td>Household Items</td>
<td>$1,000</td>
<td>1</td>
<td>$1,000</td>
</tr>
<tr>
<td>Housing (Deposits)</td>
<td>$0</td>
<td>1</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>$9,625</strong></td>
</tr>
</tbody>
</table>

### On-Going Expenditures

<table>
<thead>
<tr>
<th>Service/Item</th>
<th>Rate</th>
<th>Unit</th>
<th>Monthly Units Per Individual</th>
<th># Individuals</th>
<th>Monthly Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing</td>
<td>$35</td>
<td>hour 2</td>
<td>1</td>
<td>1</td>
<td>$70</td>
</tr>
<tr>
<td>Home Health Aid</td>
<td>$20</td>
<td>hour 84</td>
<td>1</td>
<td>1</td>
<td>$1,680</td>
</tr>
<tr>
<td>Support Coordinator</td>
<td>$140</td>
<td>month 1</td>
<td>1</td>
<td>1</td>
<td>$140</td>
</tr>
<tr>
<td>Supplies</td>
<td>$100</td>
<td>month 1</td>
<td>1</td>
<td>1</td>
<td>$100</td>
</tr>
<tr>
<td>Utilities</td>
<td>$200</td>
<td>month 1</td>
<td>1</td>
<td>1</td>
<td>$200</td>
</tr>
<tr>
<td>Housing Cost</td>
<td>$1,202</td>
<td>month 1</td>
<td>1</td>
<td>1</td>
<td>$1,202</td>
</tr>
<tr>
<td>SSI and HUD Voucher</td>
<td>($1,202)</td>
<td>month 1</td>
<td>1</td>
<td>1</td>
<td>($1,202)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$2,190</td>
</tr>
</tbody>
</table>

### Calculation of Per Diem Cost

- Initial, One Time Expenditures: $9,625
- On-Going Expenditures, annualized: $26,274
- Cost Per Individual: $35,904
- Cost Per Diem, first year: $98
- Cost Per Diem, thereafter: $72
### Individual with Quadriplegia in a HCD Apartment

#### Initial, One Time Expenditures

<table>
<thead>
<tr>
<th>One Time Expenditures</th>
<th>Each</th>
<th>Quantity</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power Chair</td>
<td>$10,000</td>
<td>1</td>
<td>$10,000</td>
</tr>
<tr>
<td>Cushion</td>
<td>$400</td>
<td>1</td>
<td>$400</td>
</tr>
<tr>
<td>Specialty Mattress</td>
<td>$3,500</td>
<td>1</td>
<td>$3,500</td>
</tr>
<tr>
<td>Hospital Bed</td>
<td>$725</td>
<td>1</td>
<td>$725</td>
</tr>
<tr>
<td>Hoyer Lift</td>
<td>$2,000</td>
<td>1</td>
<td>$2,000</td>
</tr>
<tr>
<td>Rolling Shower Chair</td>
<td>$1,500</td>
<td>1</td>
<td>$1,500</td>
</tr>
<tr>
<td>Household Items</td>
<td>$1,000</td>
<td>1</td>
<td>$1,000</td>
</tr>
<tr>
<td>Housing (Deposits)</td>
<td>$0</td>
<td>1</td>
<td>$2,700</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>$21,825</strong></td>
</tr>
</tbody>
</table>

#### On-Going Expenditures

<table>
<thead>
<tr>
<th>On-Going Expenditures</th>
<th>Rate</th>
<th>Unit</th>
<th>Monthly Units Per Individual</th>
<th># Individuals</th>
<th>Monthly Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing</td>
<td>$35 hour</td>
<td>32</td>
<td>1</td>
<td>1</td>
<td>$1,120</td>
</tr>
<tr>
<td>Personal Care</td>
<td>$20 hour</td>
<td>84</td>
<td>1</td>
<td>1</td>
<td>$1,680</td>
</tr>
<tr>
<td>Companion, Housekeeping</td>
<td>$12 hour</td>
<td>84</td>
<td>1</td>
<td>1</td>
<td>$1,008</td>
</tr>
<tr>
<td>Support Coordinator</td>
<td>$140 month</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>$140</td>
</tr>
<tr>
<td>PERS Maintenance</td>
<td>$30 month</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>$30</td>
</tr>
<tr>
<td>Supplies</td>
<td>$100 month</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>$300</td>
</tr>
<tr>
<td>Utilities</td>
<td>$200 month</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>$200</td>
</tr>
<tr>
<td>Housing Cost</td>
<td>$1,202 month</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>$1,202</td>
</tr>
<tr>
<td>SSI and HUD Voucher</td>
<td>($1,202) month</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>($1,202)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>$4,478</strong></td>
</tr>
</tbody>
</table>

#### Calculation of Per Diem Cost with SSI/HUD Voucher (Medicaid Resident)

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial, One Time Expenditures</td>
<td>$21,825</td>
<td></td>
<td></td>
</tr>
<tr>
<td>On-Going Expenditures, annualized</td>
<td>$53,736</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Per Year</td>
<td>$75,561</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost Per Diem, first year</td>
<td>$207</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost Per Diem, thereafter</td>
<td>$147</td>
<td></td>
<td></td>
</tr>
<tr>
<td>With TBI/SCI Waiver</td>
<td>$42</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Charity Care Resident: Without SSI and HUD Voucher

<table>
<thead>
<tr>
<th>Calculation of Per diem Cost</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial, One Time Expenditures</td>
<td>$21,825</td>
<td></td>
<td></td>
</tr>
<tr>
<td>On-Going Expenditures, annualized</td>
<td>$68,160</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Per Year</td>
<td>$89,985</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost Per Diem, first year</td>
<td>$247</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost Per Diem, thereafter</td>
<td>$187</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
It appears possible that a portion of the residents at the Healey Center could be served in community-based settings, even those with significant medical needs. Transition to the community assumes, for the majority of people at the Healey Center, access to rental housing and this is something that does not appear to be readily available in Palm Beach County. Even when housing is available, there is a long waiting list of people seeking access to this housing. Therefore, unless the HCD develops housing (apartments, ALF beds, etc.), transition is not likely to occur. Access to home care services is also problematic. Even if the HCD funds the cost of home care services, finding home care workers and ensuring they show up to work, providing back-up, oversight and monitoring are all costly and labor intensive endeavors. If the HCD utilized HCD employees, home care would be more readily available.

Some persons may be able to access various programs to pay for a portion of the cost of care (but it is unlikely any resident at the Healey Center would access enough assistance to cover the full cost of care in the community). These programs include several Medicaid HCBS waiver programs. The various programs each have their own eligibility requirements. Illegal immigrants will be unable to access any of these programs. Potential programs and funding streams, depending on age, income, legal status, diagnosis and disability include:

- A/DA Waiver
- ALF Waiver
- TBI/SCI Waiver
- NHD Waiver
- BSCIP
- Meals on Wheels
- Other senior services (Older Americans Act and/or state funded)
- HUD Housing Vouchers

Because there are many issues that affect the feasibility of outsourcing care to the community, the range of issues regarding access to community-based care are discussed below.

**Cost-Effectiveness of Alternative Community-Based Care**

Cost-effectiveness of community-based care is an important consideration for the Health Care District. Anyone can be served in an alternative community-based setting given access to sufficient resources. However, the cost of community-based care for some people will far exceed the cost of NF services depending on the mix of their care needs and the level of resources available. Factors that can reduce costs to the county include:

- Access to unpaid caregivers (family, friends);
- Access to funding sources other than the county, such as Medicaid HCBS waiver funding, Older American Act funding and state GR funding;
- Access to affordable residential/housing options; and
- Ability to share resources (housing and care).
We have been told that access to unpaid care for persons at the Healey Center is very limited, either because families have very limited financial resources and are unavailable 24/7 or because residents no longer have involved family members or are far from family. Access to other funding streams has also been limited.

The Community Needs Assessment portion of this report compared the penetration rates for state-subsidized HCBS statewide and for Palm Beach County. HCBS utilization has been increasing quite steadily since 1999. However, the penetration rate in Palm Beach County was approaching 70% of the aged and disabled population in 2005 while statewide penetration was approaching 80%. There are a number of possible explanations for Palm Beach County’s lower penetration rate:

- Need for HCBS among the aged and disabled population might be lower in Palm Beach County than across the state;
- Funding decisions may have been made at the regional or local level that have resulted in less access to HCBS;
- Persons in need of HCBS are not being readily identified in Palm Beach County and linked with these options; and/or
- There are a shortage of residential options for persons who could access HCBS.

**Jean’s Story**

Jean (not her real name) is 59 years old and has lived at the Healey Center for 5 years. Jean came to the Healey Center after suffering a stroke that impacted her left side, weakening this side of her body. Prior to her stroke, Jean was very busy working two jobs. She was married and raised three sons who are now in college.

After her stroke Jean was admitted to a hospital – she is not sure how long she was there but had a feeding tube inserted prior to being discharged to the Healey Center. Since coming to the Healey Center, her feeding tube has been removed and she has received physical therapy. She is able to walk with a walker (although she still uses a wheelchair much of the time to get around), comb her hair, brush her teeth, and feed herself. She participates in activities at the facility including trips to stores in the community. Jean would like to live somewhere else – she would like to go home to an apartment but needs someone who can help her in a new place.

Jean does not think it matters whether the Healey Center is repaired/refurbished or a new facility is built. She does feel that more programs (activities) should be available in the evenings and on weekends.

**Lack of Affordable Housing Options**

Experience at the Healey Center (and this is a common experience among county-funded SNFs) suggest that for the population the Center serves, access to HCBS has been limited in part by a lack of access to suitable housing or other residential options for a waiver enrollee. Housing cannot be funded by HCBS waivers – enrollees must either use personal funds such as SSI or access funding from other sources, like rent subsidies. Lack of access to housing for Healey Center residents occurs for several reasons.
Thirty-nine residents are reported to have no income or funds to use to pay rent and other expenses. Most of the residents who have no income are illegal immigrants who cannot receive SSI or other government benefits (33 residents). The remainder of the residents with no income do not qualify for SSI because they do not meet the Social Security Administration’s (SSA’s) disability criteria. Palm Beach County has a greater need for housing options for persons with disabilities and for elders than are currently available. Frail elders and adults with disabilities who do not own their own home or have access to a family or shared home must locate affordable housing in order to leave a nursing home.

Susan’s Story
Susan (not her real name) is 52 years old and has lived at the Healey Center for the past three years. Before coming to the Healey Center, Susan worked as an assistant manager at a local bank. She is at the Healey Center as a result of an injury: she fell off some stairs hitting her head and suffered nerve damage. Susan spent 3 months at a local hospital recovering from her injury but is now unable to walk and needs assistance with some of her daily care.

Susan uses a wheelchair and initially received physical therapy and other types of therapy at the Healey Center but was “not making progress” in therapy (an assessment Susan does not agree with) and no longer receives scheduled therapy. Susan receives Medicare and Medicaid. Medicare coverage started two years after she began receiving Supplemental Security Disability Income – income available to a person who becomes disabled and who worked prior to disability.

Susan would like to leave the Healey Center and get a roommate who could share an apartment. She will need help with her daily care and special equipment in order to move and hopes this will happen soon. She has a person who might be able to share an apartment with her – they currently reside in an assisted living facility. Susan thinks the Healey Center should be renovated rather than building a new nursing home.

Types of housing options most commonly used to house seniors and persons with disabilities are:

- **“Shelter Plus Care”**, a federally subsidized program that provides rental assistance for hard-to-serve homeless persons with disabilities in connection with supportive services funded from sources outside the program. In order to qualify for this program, a person must meet federal definitions of “homelessness” and “disability”. Palm Beach County Community Services staff report it can be difficult to document homelessness and disability. The Palm Beach County Shelter Plus Care Programs are reported to maintain an average of six persons on the waiting list for 6-9 months.

- Rental housing is reported to be expensive in Palm Beach County and exceeds the income levels of very low-income residents. There is a waiting list for **HUD subsidized housing** that is now closed. The West Palm Beach Housing Authority is not taking applications for **HUD Housing Vouchers** or Public Housing.

- The **Single Room Occupancy (SRO)** program makes federal funds available to public housing agencies (PHAs) for rehabilitation of residential properties that,
when rehabilitation is completed, will contain multiple single room dwelling units. Once the SRO units are completed, PHAs make Section 8 rental assistance payments to participating owners (i.e., landlords) on behalf of homeless individuals who rent the rehabilitated dwellings. The rental assistance payments cover the difference between a portion of the tenant's income (normally 30%) and the unit's rent, which must be within the fair market rent (FMR) established by HUD. Rental assistance for SRO units is provided for a period of 10 years. Palm Beach County does not have an SRO program.

Counties and states that have successfully transitioned persons from SNFs generally find it necessary to undertake housing development and to seek special access to HUD Section 8 vouchers for tenant use. These housing initiatives are expensive and take many years to develop. They often rely on access to existing housing stock or buildings (like older hotels) that can be rehabilitated and transformed into accessible apartments for frail elders and persons with disabilities. New construction is reportedly substantially more expensive in many instances than rehabilitation of existing buildings. San Francisco is one city/county that has undertaken substantial development of housing options for elders and persons with disabilities. Presentation Senior Community is one example of a successful development.

San Francisco Presentation Senior Housing
- 90 units
- New housing constructed on formerly vacant lot within city of San Francisco
- 60 units targeted to frail elders
- On-site adult day care
- On-site security
- Meals available for all residents
- Efficiency apartments
- 10 year development from beginning to completion and full occupancy (1991-2001)
- Cost: $16,394,812
- Funds: HUD Capital Advance (48%), County funds (48%), fund raising, contributions

Palm Beach County has 101 licensed Assisted Living Facilities (ALFs) with 5,028 beds. ALFs are an attractive option that persons with LTC needs sometimes choose when they no longer can remain at home safely without 24/7 oversight and access to hands-on assistance but do not require SNF services. However, cost and supply are two factors that tend to make ALFs unavailable to low-income persons. Licensed ALF beds in Palm Beach County dropped by 112 beds between 2005 and 2008. Even when ALF beds are available, affordable ALF beds are reported to be limited.

Prices for ALFs vary considerably. The ALF “base rate” generally includes room and board along with care management and supervision, assistance with activities of daily living, housekeeping and laundry, medication management, recreational activities, security, transportation and two or more meals a day. ALFs charge additional fees for extra care and special services, such as Alzheimer’s Disease care, additional personal care, meal delivery or extra transportation. Some ALFs are part of a continuing care retirement community. These communities generally charge a large, one time up-front
fee plus a monthly fee in exchange for care provided in any of the three settings a resident needs while residing at the facility; independent with access to onsite services, assisted living and nursing home care. The United States average base rate for private pay residents was $2,969/month in 2007 (or $35,628 annually). Base rates in Florida for three metropolitan areas are provided in Table 31.26

<table>
<thead>
<tr>
<th>Area</th>
<th>Low Base Rate</th>
<th>High Base Rate</th>
<th>Average Base Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jacksonville</td>
<td>$1,600</td>
<td>$3,750</td>
<td>$2,480</td>
</tr>
<tr>
<td>Orlando</td>
<td>$2,000</td>
<td>$4,025</td>
<td>$2,776</td>
</tr>
<tr>
<td>Miami</td>
<td>$2,000</td>
<td>$3,375</td>
<td>$2,718</td>
</tr>
</tbody>
</table>


It is unlikely Healey Center residents could afford care at most ALFs without a county subsidy and enrollment into the Medicaid Assisted Living for the Elderly (ALE) Waiver or the Nursing Home Diversion (NHD) Waiver. (The maximum SSI payment to an individual in 2008 is $637/month). The county subsidy would cover the difference between the cost of room and board, state supplemental payments and the individual’s contribution and the waiver would cover the services provided in the ALF plus case management and, when needed, incontinence supplies.

ALE Waiver reimbursement is $28/day for “assisted living”, plus case management reimbursed at $100/month provided by a non-ALF case manager and incontinence supplies of $125/month. Medicaid recipients not enrolled in the ALE Waiver may be eligible for assistive care services in an ALF. Assistive care provides a small fee ($9.28/day) to ALF providers for the “care” component of room and board. The assistive care fee may also be paid to eligible providers who are residential treatment facilities or adult family care homes. ALE Waiver services are limited to licensed ALFs. Not all recipients may receive both assistive care services and ALE Waiver services, with coverage varying by income.

NHD Waiver providers may provide care to enrollees 65 years of age or older residing in ALFs. The amount of payment to the ALF is determined by the NHD Waiver provider, who receives a PMPM payment for a full range of services provided to enrollees. NHD Waiver providers generally “subsidize” the cost of ALF room and board in order to prevent the need for admission to a nursing home. The NHD Waiver provider is at full risk for SNF care. There are ten NHD Waiver providers who include Palm Beach County in their program.

Lack of Access to HCBS Waiver Programs
Access to HCBS is limited because the four HCBS waiver programs most likely to be used by Healey Center residents have enrollment limits.

• The Aged and Disabled Adult (A/DA) Waiver and Assisted Living for the Elderly (ALE) Waiver was closed to enrollment for the past year but will likely be reopened in the near future. However, enrollment is limited by appropriation and so will continue to be subject to periods where enrollment could stall again.

• The Nursing Home Diversion (NHD) Waiver was recently expanded (as it has been each year) with funding to provide care for an estimated additional 4,000 persons. However, because enrollment into this program was stopped during 2007 and the waiting list for this program grew to 6,000 persons, the new “slots” will likely be filled before the end of the year (if not sooner). This program is limited to persons 65 years of age or older.

• The Traumatic Brain Injury and Spinal Cord Injury (TBI/SCI) Waiver is continuing to grow. However, slots are limited and current enrollment is just over 300 persons statewide.

Access to care at home is critical for persons transitioned from nursing homes. Sheila (not her real name) believes she would not have needed to go to the Healey Center if she had received access to home care services. Sheila’s story is provided below.

Sheila’s Story
Sheila (not her real name) is 57 years old. She has been at the Healey Center for almost a year. Sheila is at the Healey Center as a result of a stroke.

Prior to her stroke, Sheila did telephone work and raised two daughters with her husband. Her daughters are now grown and she has grandchildren. After her stroke she was admitted to a hospital and then sent home. She needed help with her care at home and her husband found this difficult since he left the home to work each day. After being at home briefly, Sheila was sent to the Healey Center for therapy and for the assistance she needed each day.

Sheila reports improving at the Healey Center as a result of her therapy – she can now bathe herself, feed and dress herself. She gets around with a wheeled walker and says she is still improving her ability to do things for herself. She very much wants to go home and says her husband is “ready for me to come home”. She hopes this will happen soon and thinks maybe if she had been able to get services at home before, she might not have needed to come to the Healey Center. She will need some amount of home help when she goes home.

Sheila says a new facility would be nice but the existing building is OK.

Legal Status
Another barrier to movement to the community is legal status of non-citizens. Non-citizens are classified as either “qualified” or “non-qualified” in regard to Medicaid eligibility. Qualified non-citizens are those who enter the country legally. Qualified citizens who entered the United States before August 22, 1996 may receive full Medicaid benefits. Qualified non-citizens who entered after this date must wait five (5) years before receiving all but emergency Medicaid benefits, except for refugees and asylees and some Cuban, Haitian and Amerasian immigrants. Illegal immigrants are “non-qualified”, non-citizens and are eligible only for emergency services.
Eligibility for SSI is also impacted by legal status. SSI is available to “qualified aliens” who are persons receiving SSI as of August 22, 1996 and who continue to meet SSI eligibility requirements or who were residing in the United States as of August 22, 1996 and who subsequently became disabled. Special groups who may receive SSI include non-citizens who are very elderly and may have trouble producing documentation and alien members of the United States armed forces who are honorably discharged. Aliens who were lawfully admitted to work and who complete at least 40 qualifying quarters of work may also qualify for SSI (if they meet other SSI requirements regarding disability and income).

Some Healey Center residents who are non-citizens entered the United States after August 22, 1996 and have not been in the United States for five years. Others are illegal aliens. They are ineligible for Medicaid if they leave the facility. Medicare is also unavailable to non-citizens until they have resided in the United States for 5 years continuously. Michael is a non-citizen who has not yet been in the United States for five years. Michael has extensive care needs due to a spinal cord injury. Michael’s story is provided below.

**Michael’s Story**

Michael (not his real name) is 24 years old and has lived at the Healey Center for four years. Michael is at the Healey Center following a car accident. He is from Jamaica and was visiting the United States when he was injured. He was attending school in Jamaica and every six months came to the United States (where he has relatives living). At the time of the accident he was an expectant father (his daughter will turn four soon.) The car accident resulted in a spinal cord injury – his injury is at C4-C5 (meaning the 4th and 5th cervical vertebrae where whiplash typically occurs). Michael has weakness in his arms and little control of his body from this point down. Michael needs help with his daily care and transferring in and out of his wheelchair and bed. He is able to control his wheelchair with an adapted hand control and the use of an arm splint.

Michael has no alternatives at present to the Healey Center – there are no health facilities in Jamaica that provide the care he needs unless a person can pay for the full cost of this care (something he cannot do). He does not have the documents he needs to qualify for any other options for care in the United States. Michael says he “loves it at Healey”. The activities at the Healey Center are primarily suited for residents older than him, but he stays busy listening to music and has a computer. He also uses the facility computer to access the Internet. Michael is able to visit with family members who live in the area. He talks with his daughter by phone and receives photographs.

Michael had some specific recommendations about the Healey Center:

- There should not be any 4-person rooms.
- Privacy is important – a “hard” partition/sliding wall in shared rooms would provide for this (rather than the existing curtains).
- Each resident needs their own closet located by their bed.
- Bigger rooms are needed to accommodate electric wheelchairs.
- A private shower would be good.
- Things that help residents learn skills for independence would also be good (like a transitional living unit or cooking facilities, etc.).
Residents at the Healey Center tend to have longer stays than residents of “typical” nursing homes.

**Table 32: SNF Residents Length of Stay**

<table>
<thead>
<tr>
<th>Length of Stay</th>
<th>Number of Healey Center Residents</th>
<th>% of Healey Center Residents</th>
<th>County-/City-Owned</th>
<th>Palm Beach County</th>
<th>Florida</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1 year</td>
<td>35</td>
<td>29%</td>
<td>63.55%</td>
<td>81.47%</td>
<td>80.21%</td>
</tr>
<tr>
<td>1 - 5 years</td>
<td>51</td>
<td>42%</td>
<td>27.42%</td>
<td>16.40%</td>
<td>17.16%</td>
</tr>
<tr>
<td>5 - 10 years</td>
<td>25</td>
<td>21%</td>
<td>6.91%</td>
<td>1.86%</td>
<td>2.26%</td>
</tr>
<tr>
<td>More than 10 years</td>
<td>10</td>
<td>8%</td>
<td>2.12%</td>
<td>0.27%</td>
<td>0.37%</td>
</tr>
</tbody>
</table>

*Source: MDS II, CMS and Edward J. Healey Health and Rehabilitation Center*

Length of stay directly impacts transition from a nursing home. Nursing home residents with short lengths of stay are less likely to face several barriers to discharge that residents with long lengths of stay face:

- **Loss of housing**: Residents who lived at home prior to entering a nursing home and who are discharged quickly are less likely to lose their home due to inability to maintain the home, make mortgage payments or pay rent. The longer a resident stays in the nursing home the more at risk they are of losing access to their prior housing. While we are told a significant number of Healey Center residents were homeless prior to admission, some residents have homes or housing they could return to but that is at-risk the longer they remain in the facility.

- **“Institutionalization”**: The longer a person remains in a nursing home the more likely they are to become acclimated to the institutional setting. For people who live in nursing homes for a long time, the staff and other long-term residents become “family” to them. The possibility of leaving the nursing home, whether to go to a different nursing home or to a community-based setting, can be very stressful and frightening to the resident. Concerns about safety and loneliness may be primary issues for the resident in this situation. This is not to say transition is not possible for long-stay residents. Long-stay nursing home residents can transition successfully, but a primary factor in the success of the resident in a new setting is their desire to move to the new setting. Absent this desire, success will be challenging.

- **Complexity of care**: While there is not always a direct relationship between a resident’s care needs and length of stay (some residents with complex care needs are discharged home with home care), a portion of residents at the Healey Center are reported to be at the facility because no other SNF will serve them due to their behaviors. Reported problem behaviors include: drug use, attempts to distribute or sell drugs, leaving the facility without notifying staff, riding down the street in a wheelchair the wrong way (head on, into traffic), physical altercations with other residents, and property destruction. In addition, some residents require 24/7 assistance and daily nursing care.
Some Healey Center residents could be served cost-effectively in alternative settings, but such settings are not readily available. While we do not believe outsourcing of care to community-based settings is feasible for most Healey Center residents, we do believe that the HCD could provide care in a more desirable manner and in an overall cost-effective way by developing “community” capacity as part of the array of options available through the Healey Center. This could include on-site assisted living residences and on-site efficiency apartments. These options are presented in the sections entitled “Possible Models of Care” and “Recommendations”.
The Healey Center Facility

Healey Center is reported to provide good or excellent care by Healey Center staff, Health Care District staff, community based organization (CBO) interviewees, and by discharge planners interviewed at two local hospitals. One interviewee noted that while “basic care” is good, some practices are “behind the times”, including rehabilitation services.

The facility is, in our opinion, in poor condition, although clean. Staff of the Healey Center concurred that the facility is in very poor condition. The overall atmosphere is cheerful, helped substantially by the well maintained gardens and lawn around the facility. However, the facility design is very outdated.

Staff report that over the last decade minimal repairs have been made to the facility. In fact, the staff of the Center has devised an innovative way to deal with roof leaks. (See Figure 20.) They have modified a video surveillance plastic enclosure to enable the collection of rainwater from a leaky roof through the enclosure, to a pipe and down into a collection bucket.

Figure 20: Healey Center - Facility "Rain Adaptation"

There are reportedly several of these “innovations” installed in the Center.
A new chiller was installed several years ago, but staff report no consideration was given to replacing old, leaky windows. There is no air conditioning in the hallways, the northeast section is built on wooden tresses, and there is little insulation in this section of the facility. The staff who were interviewed felt that they have been able to adequately address the maintenance of the mechanical equipment such as refrigeration, but that they have not been able to maintain the ceilings, windows, roof (physical structure).

Resident rooms are cramped and the overall layout is not efficient in terms of staff “steps” and problematic for some residents who find it difficult to travel (by foot or wheelchair) to various wings for activities, therapies and dining (rather than having these areas centrally located or multiple areas located on each unit).

The nursing stations are especially problematic, located on one side of the hallway and not allowing for line of sight supervision. We observed a tendency for nursing staff to congregate in the nursing stations (not an uncommon situation in health care facilities). In fact, NFs and hospitals are increasingly using “mobile” work stations and electronic medical records to facilitate contact between staff and residents, using a nursing station or even simply a nursing desk, for the few activities that require a separate and/or quiet area.

Mold was apparent to several of us on the HMA team during our site visits (primarily the smell of mold), and the facility is reported to have ongoing problems with leaks.

**Suggestions for a Refurbished or “New” Healey Center**

We received many suggestions from staff and residents during our site visits for changes in physical plant design at the Healey Center or for a “new” Healey Center. Frequently mentioned, desired features were:

- Single story design (this was universally endorsed by staff and residents)
- Private and semi-private rooms (staff and residents) - no more than 2 residents to a room (residents)
- Private or semi-private bathrooms (staff and residents) that are wheelchair accessible – however, some staff raised concerns about safety if showers are located in resident rooms
- Larger more spacious and easily navigated resident rooms (residents)
- Closets for each resident next to their beds rather than clustered together on a single wall like the current facility, and more closet space (residents)
- Partitions in each resident room that provide privacy – something more solid like the partition used in the activity room (not a curtain as used currently) (residents)
- Smaller sized, but greater number of and more accessible, family-style dining rooms – this was suggested by staff, but a significant number of residents attending the resident council meeting felt two central dining areas were preferable. One dining room would accommodate residents who require assistance with meals and one for residents who can eat independently. This preference appeared to be related to a desire among the residents present at the meeting for socialization with larger number of residents at mealtime. Some residents said they did not have a preference.
- Improved ramps – the current ramp is too steep (residents)
- Wheelchair push button access ("Push to Open" Push-Buttons with ADA Symbol) for doors throughout facility. Existing doors are reported by residents to be very difficult for residents in wheelchairs to open (residents)
- A walking path – the walking path has been reportedly cut-off by the new security fencing (residents)
- A chapel is needed – one that will be suitable for people of various faiths (residents)
- More PT areas and equipment (residents)
- A gymnasium – “We need more than range of motion, for after we are discharged from PT.” (residents)
- A swimming pool (residents)
- Cooking facilities and other areas and equipment for residents who want to maintain or learn independent living skills (staff and residents)
- A microwave in each resident room (residents)
- A room for computers equipped with a variety of computers to meet special needs – voice activated, adaptive controls, etc. (residents)

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**Dean’s Story**

Dean (not his real name) is 47 years old and has lived at the Healey Center since 1983. In 1980 he broke his neck and was paralyzed – his mother cared for him at home, but she died three years later. Dean says he could have stayed with his Dad but he did not want to be a burden to him. He was admitted to the Healey Center directly from his home.

Dean worked for 20 years while living at the Healey Center, traveling to his work each day. After the three hurricanes, facilities at his job were destroyed and people were laid off. He was among those who lost their jobs. He is not working presently but in the past has found work through the newspaper classified advertisements.

Dean has an amazing setup of electronic equipment in his room including a Ham radio and computer that he and his father assembled. He does this in a room that houses four people – the lack of space is a challenge but Dean’s father made him a cabinet system to house his equipment.

Dean stays busy with his radio and computer activities. He does not attend activities as much as he initially did – “they get old after a while”.

Dean is concerned that any changes to the Healey Center or a new facility not result in units where patients are grouped by intensity of their care needs. He believes if residents who need a lot of hands-on assistance are placed in one unit, and residents who require less care or who might be transitioning out of the Healey Center are placed in separate units, the nurses aides will not be evenly distributed. Fewer aides will want to work on the “hard” units and more will favor the lighter care or transitional units. He notes the facility has survived a lot – it has weathered hurricanes for example - so the building has its advantages. He also feels that separate closets by each bed are needed.
• Air conditioning that provides even cooling and also cools hallways – current window units are reported to make the resident near the window too cold, resident furthest from window too warm. (residents)
• A private place to meet with family and friends – a lounge area (residents)
• An arts and crafts room with a “dirty” area, where ceramics and other items can be worked on and left for finishing (residents)
• A library – staff report they have a good supply of books, including large print and audio books, but no place to shelve them and to make them readily available for resident use (residents)
• Telephones for resident use (residents)
• An in-facility store to purchase small toiletries etc. (residents)
• A new call system (residents)
• An outdoor BBQ area with seating and grills, a place where residents can enjoy cook outs and socializing (residents)
• A couch in the resident’s rooms (the resident stated they knew this might be too costly) (residents)
• An internet or other hook-up with camera that would allow residents to see and speak with families who cannot visit (for families able to access compatible equipment) (residents)
• More office space (staff)
• A phone system that is easy to call out on, that includes caller ID and allows quick access to messages (reportedly the recent phone system is a problem) (staff)
• More storage space (staff and residents)
• More meeting space
• More exam rooms for physician use (staff)
• “Multi-use” rooms or offices (staff)
• Some extra large rooms with extra large beds and lifts for bariatric patients (staff)
• Special unit design for “elopers” and wanderers (dementia design guidelines etc. - staff)
• A transitional living unit (ALF or other level) – along with training kitchen, training bathroom etc. (staff and residents) Most of the residents attending the resident council meeting liked the idea of an ALF unit or building at the Healey Center

Less frequently mentioned or practice-specific recommendations included:
• Locked medications in each patient room except for persons with a substance abuse history (nursing staff)
• Wet room (PT staff)
• In-room O2 (staff)
• Activities and therapy adjacent or closely located (staff)
• Horticultural area (staff and residents)
• Centrally-located kitchen (dietary)
• Laundry capabilities (staff and residents), a washing machine on each unit so residents who want to can launder their own clothes (residents)
• Isolation rooms/negative pressure rooms (staff)
• Adequate parking (plant operations, housekeeping/facilities)
• Workshop detached from main building, with covered access to main building (staff)
• Secure but accessible office for resident accounts (staff)
• On-site child care (staff)
• Open nursing stations and line of sight (nursing staff)
• A holding space as a “morgue” – a cooler of some type (residents who are deceased are often left in their rooms for hours awaiting pick-up. This is very disturbing to other residents).
• Adult day health care capacity (staff), however some staff indicated they believe there is an existing and large supply of ADHC in the community
• Posturepedic mattress (one resident)

Other considerations raised during meetings included:
• A desire for electronic medical records capability – “we are ready!” (staff)
• Stay at same location (or in same neighborhood) (staff), most residents attending the resident council meeting stated they feel the existing location of the facility is best. Reasons cited included access to transportation and stores, meets the needs of the surrounding neighborhood
• Many residents noted the historic importance of the Healey Center
• A resident raised a concern about pests or animals outside such as squirrels and raccoons that create a nuisance
• The general community awareness about the Healey Center is reported to be almost non-existent (staff and external interviewees). The Healey Center is generally not a facility that family members or patients ask to go to. In most instances, it is believed they are not familiar with the facility. A referral from a hospital to the Healey Center generally occurs when there is no other NF available or willing to accept the patient. Most of the time, this means the patient is a “charity care” patient and has no payor source for NF care such as Medicaid or Medicare, or is “Medicaid pending”, or has care needs that other NFs determine they cannot meet.
• There are opportunities for greater connections with community based organizations (CBO interviewees)

**Additional Healey Center Service Lines Suggested by Interviewees**

Some possible additional service lines were suggested by interviewees.

**Assisted Living or Other Lower Levels of Care**

The Healey Center staff identified residents who could be served in an ALF or alternative setting (at least ten residents). Even though there are reported to be vacant ALF beds in Palm Beach County, ALF operators generally don’t admit anyone with a criminal record or with a mental illness, (which some of the residents at the Healey Center have). ALFs with limited mental health licenses are reportedly generally full.

A CBO assessed about 20 Healey Center residents several years ago to determine if they could be served at lower levels of care. They found that many could have been discharged but community resources were either not available or not adequate as currently configured and/or funded to meet the residents’ community-based LTC needs.

We believe that inclusion of an ALF is desirable. The cost models provided earlier in the report demonstrate this could be a cost-effective option but this depends on the extent of a person’s care needs, their access to other payor sources and the cost incurred by the HCD for the person if residing in the SNF ($346/day for “charity care” residents and $56/day for Medicaid covered residents).

**Adult Day Care**

It has previously been suggested that adult day care could be provided at the Healey Center as one method to increase the array of services and funding for the facility. It is difficult to operate adult day care centers in Florida and achieve profitability. County salaries and benefits, which tend to be higher than the private sector, make this an even less feasible option. One potential benefit of adult day care at the Healey Center (and this would only be applicable if a new facility is constructed), would be as a way to attract potential future SNF residents to the Healey Center who have a payor source. However, unless these prospective residents would come to the SNF in the future for Medicare rehabilitative services or were private pay residents, there would be limited benefit (since the HCD is subsidizing the cost of care for Medicaid residents).

We believe inclusion of an adult day care center at the Healey Center is a dubious proposition and do not recommend inclusion of adult day care services.

**A unit for ventilator dependent patients (probably a sub-acute unit)**

Some hospitals in Palm Beach County have numerous patients who are ventilator dependent and who cannot be discharged due to lack of alternative placements, thus resulting in costly and non-covered expenditures for the hospitals. The Health Care District hospital on the other hand has only one patient in this situation and rarely has more than one. Such a unit would likely need to be a “sub-acute” unit (with related special staffing and program requirements).
The inclusion of a unit for ventilator dependent patients at the Healey Center is not recommended. There is no special payment in Florida for SNFs that provide care to patients who are ventilator dependent. Providers generally develop these units when they operate a hospital that has multiple patients awaiting discharge from the hospital but who cannot be discharged due to their dependency on a ventilator. Hospitals in this situation may find it cost-effective to pay a supplement to SNFs to accept their ventilator patients who would otherwise be incurring large uncompensated care expenses in the hospital. The HCD reports only occasionally having a patient who is ventilator dependent awaiting discharge. In addition, Kindred healthcare recently opened a long-term acute care (LTAC) hospital in Riviera Beach. Kindred specialties include ventilator care and weaning.

**A unit for persons with challenging behaviors**

One interviewee stated they believe the Health Care District should develop a unit for persons who meet NF LOC and who have behavioral health issues and challenging behaviors and who are generally not admitted at present due to safety concerns in the existing facility.

We recommend the HCD consider this option if a new construction is approved. Such a unit would be feasible if designed to meet the special needs of these residents, much like units in SNFs that are designed to meet the special needs of persons with Alzheimer’s Disease. While Florida does not offer a special payment for serving persons with challenging behaviors, it is likely the County is incurring costs in other programs when such persons cannot find appropriate SNF placements.

**Medical respite beds**

Medical respite beds were suggested by some interviewees. Medical respite generally consists of short-term residential care designed to provide residents time to recuperate while being able to access hospitality, medical and supportive services. Medical respite programs are focused on homeless persons who have a medical injury/illness and may also have mental illness or substance abuse issues. The service is typically utilized when a person is discharged from the hospital and needs a period of recovery, does not need another “level of care” such as nursing facility care, and would otherwise be homeless. There are reported to be instances in Palm Beach County of persons being discharged from a hospital directly to the Department of Health wearing a hospital gown and with an IV pole who have nowhere to go and whose needs are above those that can be met at a shelter. Medical respite would help prevent these types of situations.

Some interviewees believe there is an even greater need for this service option now that the Healey Center is no longer admitting patients in need of short-term IV antibiotic therapy.

Inclusion of medical respite beds at the Healey Center is not recommended. Medical respite beds would be utilized by homeless persons in need of short-term medical care below the level of care provided in a SNF. Even if the Healey Center becomes a SNF/ALF and housing mix, placement of these persons in the ALF or housing units would be disruptive to the residents in what is essentially their home.
**Outpatient dialysis (probably a subacute unit)**

There is a reported shortage of outpatient dialysis beds, especially for patients with Medicaid coverage. This is not reported to be a problem for the HCD hospital and so is not recommended as a service option at the Healey Center.

**Short-term rehabilitative services**

This type of unit would provide an intensive level of rehabilitative services for persons during the critical initial period of recovery from a stroke, traumatic brain injury, spinal cord injury, surgery or other conditions.

Expansion of the Healey Center service lines to include rehabilitation services such as those provided at Pinecrest Hospital, even if a new facility is built, is not feasible. Pinecrest Hospital is a specialty hospital licensed under hospital regulations.

However, enhancement of rehabilitation services at the Healey Center that would potentially attract more “rehab” patients during their Medicare period of coverage is feasible and can be included in the master facility design plan should the Board authorize Phase II of this project.

Medicare reimbursement for skilled nursing home services uses the Skilled Nursing Facility (SNF) Prospective Payment System (PPS). The SNF PPS uses Resource Utilization Groups (RUGs) to help determine a daily payment rate. The RUGs reflect a resident’s severity of illness and the kind of services that a person requires. Each RUG is assigned a case-mix weight and an associated payment. For residents who require special care or rehabilitation, Medicare payment is generally higher than Medicaid payment and, for some types of care (including rehabilitative care), exceeds the cost of care at the Healey Center. The ability to attract rehabilitation patients by enhancing rehabilitation services (with a new facility and with additional training of staff for both providing and billing therapy) could improve finances at the Healey Center.

If the Healey Center were a new facility with a state of the art rehabilitation department, and since the Healey Center has a higher quality of care rating than most facilities that take a large number of Medicaid recipients, we believe that it is feasible to attract more dually-eligible persons to a new facility and increase revenue. In addition, the ability to provide outpatient rehabilitation at the Healey Center is another area of potential revenue growth. Again, this capability is dependent on the construction of a new facility if it is to be “attractive” enough to draw persons to the Center. While private SNFs have in the past pursued and attracted most Medicare patients for rehab services, the HCD could target the two hospitals who refer the most patients to the Healey Center (St. Mary’s and JFK) and seek to persuade them to refer rehab patients to the Healey Center. In addition, the ability to provide outpatient rehabilitation at the Healey Center is another area of potential revenue growth. Again, this capability is dependent on the construction of a new facility if it is to be “attractive” enough to draw persons to the Center.

**Healey Center Cost Issues**

At the time of our first site visit, Healey Center and HCD staff reported a number of cost issues related to the Healey Center of special concern. Some of these issues have since...
been resolved or are improving. We note the current status of each issue following the status of the issue as reported in January 2008.

- Payor source has been a big financial problem for the Healey Center, with a decline in Medicaid eligible residents in more recent years. The Healey Center reports they have worked on significantly improving the payor profile of the facility and have significantly increased the count of Medicaid-eligible residents. This includes helping non-citizens become eligible for Medicaid after five years of United States residency and helping undocumented immigrants to become documented.

- Prescribed drug costs were reportedly to have been very high by January 2008. Several cost cutting measures have now been put in place. These include maximizing the use of Medicare drug benefits, use of a formulary and substitution of prescribed medications when medically indicated. Prescribed drug prices are much lower this fiscal year due to these changes. The HCD is also considering use of the in-house HCD pharmacy to do some of the dispensing for the nursing home.

- Dietary costs were also reportedly high and reportedly more than the average NF cost in January 2008. Healey Center staff believe this is at least in part related to greater caloric needs of predominantly non-elderly residents. Dietary costs have undergone some reductions recently. The cost of raw food was higher 18 months ago compared to today (August 2008). Changes were made that included limiting food choices and eliminating certain expensive choice items (such as Gatorade). This has reduced dietary costs. HCD staff report average meal costs remain higher than the typical SNF due to the stated reasons of higher caloric need of a younger, male population who are quite active.

- There has also been reported over staffing in dietary. Dietary staffing has been reduced over the last two years and use of agency staff in dietary has been eliminated.

- Outsourcing of laundry has been problematic. The HCD has used multiple vendors in the past few years and have had issues with them all. The current vendor was awarded a contract on the basis of a low bid. The Healey Center has staffing capacity to do laundry in-house.

- Agency staffing is expensive and has been a cost overrun in nursing. By August 2008, HCD staff reported agency staffing had been greatly reduced from prior year use.

- Hospice services were added at the Healey Center in 2007. The HCD believes hospice services are a necessary part of the services the Healey Center offers. The services are contracted out, with Hospice of PBC paying the Healey Center the Hospice Medicaid/Medicare rate. If the Healey Center continues to have excess beds and Hospice of PBC has inpatient needs, there might be an opportunity for additional arrangements. However, Hospice of PBC is struggling and last month laid off sixty staff.
The Healey Center had not billed Medicare for at least a year when HMA visited in January 2008, and therefore lost their Medicare provider number. The Medicare number has been restored and as of August 2008, Medicare billing is up to date.

**Healey Center Renovation**

Renovating the existing Healey Center physical plant to keep it operational as a Skilled Nursing Facility is always an option. However, we do not believe it is financially the best investment of HCD/County funds. In addition, there are significant safety and efficiency issues that cannot be resolved adequately by renovating the facility. Renovation was previously determined to cost upwards of 60-70% of the cost for new construction and some portions of the facility are believed to be unsuitable for renovation (i.e. would not meet existing building code requirements for a NF). Problems with renovation include the immediate costs to bring the facility up to compliance with essential fire and safety codes, the ongoing costs associated with maintaining such an old building, the inefficiencies of operating a SNF in this building and the general poor physical environment, which is not suited to the needs of residents. In addition, there are significant safety and efficiency issues that cannot be resolved adequately by refurbishing the facility.

The Florida Building Code allows for a great deal of grandfathering of existing conditions, but this is permitted only as long as no remodeling work is undertaken. The Code requires that once remodeling begins, anything that is touched or modified must be upgraded/replaced in order meet to current code minimums. This is not a problem for minor redecorating, but it is a major problem for electrical or mechanical system upgrades.

Improvements to the existing mechanical system can be completed in a slightly more piece meal fashion, although the code requires that improvements made to an area must be accompanied by making the entire “smoke compartment” compliant with current standards.

Because the facility is so old and the configuration so poor, areas would need to be completely gutted and then completely retrofitted and redesigned. The redesign would be less than ideal, since you would be working within the constraints of the existing structure. After complete gutting and renewal of everything within the gutted area (estimated to cost $18.1M), the facility would still be functionally obsolete and lacking in appeal. The following estimate is based upon a virtual gutting of the existing interior construction, using the exterior walls and roof where possible. This includes replacing all the windows with hurricane rated assemblies, installing all new mechanical, plumbing and electrical systems and some exterior upgrades to improve the appearance. (See Table 33.) An inflation factor and contingency fee have been applied and are conservatively estimated at 5% and 15%, respectively.
Table 33: Estimated Cost to Renovate the Healey Center

<table>
<thead>
<tr>
<th>Task</th>
<th>Estimated Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site development, for accel / decel lane</td>
<td>$50,000</td>
</tr>
<tr>
<td>Landscaping improvements</td>
<td>$75,000</td>
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<tr>
<td>Interior demolition of 87,000 sq ft</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Interior rebuild @ $100 per sq ft</td>
<td>$8,700,000</td>
</tr>
<tr>
<td>Exterior facelift</td>
<td>$2,000,000</td>
</tr>
<tr>
<td>Architectural and engineering fees</td>
<td>$900,000</td>
</tr>
<tr>
<td>New furniture and furnishings</td>
<td>$950,000</td>
</tr>
<tr>
<td>Kitchen equipment all replaced</td>
<td>$150,000</td>
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<tr>
<td>Interior designer</td>
<td>$50,000</td>
</tr>
<tr>
<td>20% premium for phasing</td>
<td>$2,140,000</td>
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<tr>
<td>Inflation for 1 year at 5%</td>
<td>$535,000</td>
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<tr>
<td>Contingency at 15%</td>
<td>$1,605,000</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>$18,155,000</strong></td>
</tr>
</tbody>
</table>

The following are specific areas of concern.

1. Most of the facility does not have central air conditioning and is dependent on in-room air conditioning units. The air conditioning units require almost constant maintenance to keep them functioning (and they are inadequate). A new central air conditioning system is required. We estimate the current cost to install a system in a 87,000 square foot existing and operating facility to be approximately $1.75 million.

2. The plumbing in portions of the building is well over 50 years old, and it can be expected that the fixtures and both water supply lines and drain lines will continue to deteriorate causing significant maintenance problems. The water lines can be replaced overhead but replacing drain lines under the slab could be devastating to ongoing operations. We estimate that the current cost to replace the water lines overhead and all fixtures would be approximately $600,000. This does not address the cost or problems associated with replacement of the underground drainage piping. The cost for this cannot be reasonably estimated since the entire floor and subfloor would need to be torn up and replaced throughout the facility. This would pose a significant safety concern in addition to expense.

3. The electrical system is functioning, but the wiring and electrical panels do not meet current code requirements for a new facility. Most of the items that are deficient deal with safety issues. For example, a fire hazard exists without a redundant grounding system and panels with proper fault protection. The system can be left alone, but once any significant remodeling is undertaken, the affected portions of the electrical system must be brought up to today’s standards as per the building code requirements. We estimate the cost to upgrade all the branch wiring and panel gear would be in excess of $1.2 million and up to $2 million.

4. Fire Protection Sprinkler system: As you are probably aware, the State of Florida has mandated that all existing nursing homes have a complete automatic sprinkler
system. We understand that this expense is already being undertaken. However, this is yet another example of renovation costs that are going to continue to grow with the existing facility since refurbishing the facility will make changes to the new system no matter how efficiently one tries to plan the current fire sprinkler upgrade. It is likely to be completed before refurbishment of the Healey Center would be underway, if selected as the desired option.

5. The roofing is a problem that has required ongoing maintenance. The estimate to replace the entire roofing system is in excess of $400,000.

A major remodeling could be undertaken with huge expense and at the conclusion you would still have a 40 year old building with a design layout that is functionally outdated. The public perception of these improvements as a remodeling project would be negligible as compared to a replacement facility that could gain prominence as a progressive facility with modern design and technology.

There are multiple advantages to building a new facility. Briefly, a few of these are:

- Reduced energy bills due to better insulation and more efficient operating equipment.
- Lower water bills with the use of water savings fixtures.
- Lower cost of hot water through the use of energy efficient equipment and recycling potential.
- Lower cost of staff due to better design layout for effective daily operation of the facility.
- Reduced maintenance costs without the burden of constant upkeep of old systems. (For example, the existing facility is utilizing 8 FTEs for plant operations (ongoing maintenance). A new SNF would require fewer FTEs.
- Increased protection from hurricane and other weather-related problems.
- Increase in positive public perception of a new structure.

**Healey Center Replacement**

We believe the Healey Center meets a critical need in the County and should be replaced with a new facility. Ideally, the Healey Center should include SNF, ALF and housing options.

O’Keefe Associates is proposing a preliminary conceptual design for a new SNF that is based upon a modified pod design. This design seeks to develop a cost-effective arrangement that incorporates Greenhouse principles but that is not as costly as a Greenhouse to build or operate. The design uses two semi-pods each with 15 beds, most resident rooms being semi-private rooms, with 1 or 2 private rooms for residents with special needs. The two semi-pods would share a nursing station.

The design would also use one, 3-story and one, 2-story SNF building attached to a 1-story administrative building. The multi-story design is the most feasible approach because pod design requires more space. A single story pod design would be excessively
long and rambling, making it difficult to navigate. A single story pod design could not be constructed on the existing site due to space requirements. It could, however, be built on the Jai Alai site.

Each room has exterior windows and the overall layout is more spacious than a traditional facility. Each area would also have a lanai to incorporate the “outdoors” for residents who are less inclined or able to go outside by exiting the first floor. The pod design is a much more progressive design than traditional double loaded corridors like the existing facility. AHCA is emphasizing ‘culture change’ in nursing homes and encouraging new designs that depart from the traditional institutional setting.

The design plan for a model that includes an ALF and housing, locates the ALF as a distinct part within one of the SNF buildings. The housing is proposed in a single building separate from the SNF and ALF.

The pod design will provide a far better living and working environment. It will also be more homelike for those residents who are unable, for whatever reasons, to transition to an ALF or housing. The 3-story design could be constructed at the existing location without disturbing the residents of the Healey Center.

We acknowledge that some residents and staff have a stated preference for a one-story design. We believe that if they were familiar with the benefits of the pod design, they would be amenable to a 2 and 3-story new facility. It would truly be an outstanding, progressive facility, in which the County, HCD, staff and residents could take great pride. The inclusion of an ALF section and on-site housing would be an added enhancement.

O’Keefe Architects estimate a new Healey Center that is built using advanced NF design concepts, that is fully ADA compliant and that would include a state of the art rehabilitation department, can be constructed for between $22 and $31.8 million. This amount includes a one year inflation factor of 5% and a 15% contingency rate. The cost varies by configuration and size, $31.8 million being the cost for a larger SNF/ALF/housing combination with a total capacity of 212 beds.

A cost breakdown for three models (a 120-bed SNF/ALF, a 140-bed SNF/ALF/housing combination and a 212 SNF/ALF/housing combination) is provided in Appendix 1. Appendix 2 provides schematics for each model. Attachment II provides the specifications for the construction.

Items included in this amount are:

- Site work
- Soil Borings
- Surveys
- Level I environmental report
- Landscaping
- Landscape Architect
- Civil Engineering
- Architectural work
• Interior Designer
• Kitchen equipment
• Furnishings
• Building Construction

Items not included are:
• Land
• Financing costs
• Legal fees
• Impact fees
• Insurance
• Start up costs

A Certificate of Need (CON) is not required from the State for a replacement facility constructed at the same location as the facility it is replacing.

Multiple Sites
One issue raised in the previous feasibility study was whether or not the HCD should operate two or three smaller nursing homes in different locations within Palm Beach County, one being located in the southern end of the County in addition to the more northerly location of the existing facility. We cannot identify a compelling reason that a second site is required in the Southern part of the County. While the area of the county where the Healey Center is located has more NF beds in nursing homes that have at least a 3-star rating, that accept Medicaid patients and that have an occupancy rate below 90%, than other areas of the County, the number of beds in the northern and southern ends of the County are similar. There is no demonstrated need for additional NF beds in the western part of the county.

Operating Costs – Multiple Nursing Homes versus Single Nursing Home
The requirements for nursing home management do not vary by size. This means that if you build two or three separate nursing homes, you will increase and in some instances double or triple (respectively) your costs in certain areas. Location of a second “Healey” facility at either the northern or southern ends of the County would double the management costs because of excessive travel time between facilities. If multi-site nursing homes are located within a reasonable travel time from each other, management requirements would include the following:

• Nursing Home Administrator - an administrator will be required at each facility/location.
• A Director of Nursing will also be required for each facility/location.
• A social services, activities and therapy director at each location would be recommended unless each site were small (less than 60 beds, for example).
- Plant management – While there is no specific requirement to have plant
  management at all sites there will need to be someone responsible at each site for
  the physical plant, leading to something less than a tripling of costs.

- Dietary staffing – This will be higher. How much higher will depend on if each
  facility has its own food preparation or whether you utilize a centralized kitchen
  and transport food. This needs to be carefully analyzed in terms of costs and
  quality.

- Ancillary service providers – Multiple facilities/locations could have minimal
  increased costs as the therapists can move from location to location depending on
  need. Based on resident groupings (residents admitted primarily for rehabilitative
  care at one location) this cost could be further reduced.

- Regulatory compliance functions should be centralized, so there would be no
  additional cost. In addition, since most compliance citations are reported as gross
  violations per facility and not violations per bed, overall quality scores might rise
  since there should be fewer non-compliance findings in a smaller facility relative
  to a larger facility.

- The facilities would use a single business office and finance function, leading to
  no additional costs between models for this cost center.

The largest cost center in any nursing home (and to some extent, the primary factor that
affects resident satisfaction and quality of care), is the ratio of direct care staff (including
nurses) to residents. Staffing levels are not impacted by having a single large facility or
three smaller facilities (assuming the smaller facilities reach a minimal scale).

Costs for utilities and other services would generally be higher, since some services are
priced by site or facility or incur a base cost that does not vary by size of facility.

Operation of multi-site nursing homes in Palm Beach County that are located within
different and distinct parts of the County would result in a loss of efficiencies that might
otherwise be available in smaller counties. Because of the size of the County and time
required to travel from one end of the County to another, suggestions for location of
another “Healey” site in the far northern or southern parts of the County would require a
complete duplication of functions and is not recommended.

The HCD would also incur higher construction costs by losing some efficiencies during
construction. For example, the construction of two 106-bed SNFs costs about $1.4
million more than a single 212-bed SNF.
### Table 34: Estimated Costs for Two 106-bed SNFs versus One 212 bed SNF

<table>
<thead>
<tr>
<th>Detail</th>
<th>106 Beds</th>
<th>212 beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site Development</td>
<td>$400,000</td>
<td>$500,000</td>
</tr>
<tr>
<td>Soil Borings</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Survey</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Level 1 Environmental report</td>
<td>$6,000</td>
<td>$6,000</td>
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<tr>
<td>Civil Engineering</td>
<td>$40,000</td>
<td>$50,000</td>
</tr>
<tr>
<td>Landscape Architect</td>
<td>$6,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>Landscaping and lawn sprinkler system</td>
<td>$75,000</td>
<td>$100,000</td>
</tr>
<tr>
<td>Kitchen designer</td>
<td>$9,000</td>
<td>$9,000</td>
</tr>
<tr>
<td>Kitchen equipment</td>
<td>$150,000</td>
<td>$150,000</td>
</tr>
<tr>
<td>Interior designer</td>
<td>$35,000</td>
<td>$35,000</td>
</tr>
<tr>
<td>Furnishings and movable equipment</td>
<td>$600,000</td>
<td>$1,150,000</td>
</tr>
<tr>
<td>Architectural and Building Engineering</td>
<td>$565,000</td>
<td>$1,090,000</td>
</tr>
<tr>
<td><strong>Construction</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SNF 57,000 sq ft/110,000 sq ft x $180 sq ft</td>
<td>$10,260,000</td>
<td>$19,800,000</td>
</tr>
<tr>
<td>Demolition of half of existing facility</td>
<td>$750,000</td>
<td>$1,500,000</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td>$12,966,000</td>
<td>$24,406,000</td>
</tr>
<tr>
<td><strong>2-106 bed SNFs</strong></td>
<td></td>
<td>$25,812,000</td>
</tr>
<tr>
<td><strong>Difference in cost for 2-106 bed SNFs and 1 - 212 bed SNF</strong></td>
<td></td>
<td><strong>$1,406,000</strong>*</td>
</tr>
</tbody>
</table>

*Excluding contingency fee and inflation factor*

The increased cost does not include the cost required for two sites compared to a single site. Unless the County owns a suitable site in a different part of the County, additional funds will be required to purchase property. The cost to purchase and develop a 2-acre parcel of land would likely be about $2 million.

There are no nursing homes for sale in Palm Beach County at present, another method that might otherwise be used to secure a second facility.
Possible Models of Care

We developed three possible “models of care” that could be used to meet the LTC needs of persons now served at the Healey Center and those who will turn to the HCD in the future:

- Payor models: Where the HCD contracts for services but no longer provides services directly.
- Provider models: Where the HCD provides services directly.
- Mixed payor/provider models: Where the HCD contracts for some services and provides some services.

Payor Models

The HCD could seek to outsource care to other SNFs, and close the Healey Center. The County would become a payor, contracting with other SNFs to serve existing residents of the Healey Center and persons in the future referred by the HCD for SNF services. The HCD could also include other levels of care or settings under this scenario (such as assisted living and public housing with wrap around supports).

Advantages to a Payor Model

- There appears to be a good supply of SNF beds now: SNF occupancy rates in Palm Beach County have generally been declining. If the decline continues or occupancy remains below 90% on average county-wide, the HCD may have more leverage to contract for SNF services than was thought possible in the past. However, excess capacity generally exists in facilities rated as having a quality of care of 3-stars or less. (The Healey Center is rated as a 4-star facility for quality of care.)
- The County could potentially sell the bed licenses at the Healey Center (198 in all) to another SNF provider.
- The County could use the land where the Healey Center is now located for another purpose or could sell the property.

Concerns with a Payor Model

Counties that operate nursing homes often debate whether they should be a “provider” of services or a “payor” of services. Some counties convert from providers to payors of NF services when:

- There are large numbers of vacant beds in community NFs and their residents are primarily covered by Medicare or Medicaid;
- They serve a more “traditional type” of nursing home resident;
- They have serious problems with quality of care; and
- They are losing large amounts of money operating the facility.
Furthermore, some counties have experienced significant problems after divesting themselves of the county-owned nursing home. In Eau Claire County Wisconsin, the Chair of the County Human Services Board reported a range of adverse outcomes and problems resulting from sale of their facility, concluding: “The impact of the decision to sell the county nursing home has significantly escalated our county cost and more importantly denied the appropriate level of care to the individuals for whom we are responsible”.27

While limiting the county role to a payor appears reasonable to some, and in some circumstances would be sensible, there are many reasons Palm Beach County is likely to find this difficult:

- There are an inadequate number of SNF beds available in NFs rated at the same level or higher for quality of care as the Healey Center (at least a 4 star rating).
- The HCD may be unable to find sufficient number of SNFs willing and/or able to serve all Healey Center residents, even with lowered overall SNF occupancy rates and even when considering SNFs with a quality of care rating lower than the Healey Center.
- Even if adequate numbers of SNF beds are located, SNF providers are likely to charge a “premium” to accept some Healey Center residents.
  - Some Healey Center residents have serious behavior problems. SNFs located in states where Medicaid pays enhanced rates to serve patients with behavioral problems may be reimbursed between $300 and $600 a day for care on behavioral units or TBI units. Unfortunately, the Florida Medicaid program does not make enhanced or supplemental payments for these types of units. The HCD would absorb any additional payments for both charity care and Medicaid residents with significant behavioral problems.
  - Even if the HCD contracted with SNFs to serve all residents, the HCD would retain some costs for:
    - Referral assessment and screenings
    - Case management
    - Quality of care oversight
- Some residents have care needs that some SNFs do not meet, such as having a new tracheostomy or requiring oxygen. The supply of SNF beds for these residents is, therefore, reduced.
- There is a limited supply, and recently a decline in the supply, of ALF beds.
- There is extremely limited to no access to subsidized housing and/or Section 8 housing vouchers. In addition, wrap around services funded by Medicaid are not readily available.

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• There is no assurance of access to contracted SNF beds even with executed contracts. SNFs can refuse referrals on the basis of “not being able to meet needs” or because “problem behaviors or history place other residents at risk”, and so on.
• Some SNFs may attempt to charge the HCD increasing supplements or high per diems once a resident is admitted as a result of special care needs the SNF provider did not adequately anticipate. This could also occur in ALFs.
• The HCD has experience as a “payor” for inpatient hospital services for the trauma care system. This year the HCD reports being asked to increase rates they pay for inpatient services by 100%. The HCD has limited leverage in this type of situation.
• SNF and ALF providers are not likely to sign a contract that includes specific rates for more than a 2-year period.
• It is easier to limit expenditures by the HCD when there is a “building” (a limited number of beds at the Healey Center). The HCD will have to manage a waiting list for “slots” more rigorously than for “beds.”

While “outsourcing” of care to community nursing homes appears reasonable for a small number of residents and can be part of a future solution to meeting the increased need for SNF services, we do not believe full outsourcing is possible or desirable.

**Provider Models**
The provider models assume the HCD will continue to operate a SNF. There are several possible options for the provider model. These are:

- Refurbish the Healey Center
- Build a new Healey Center
  - SNF beds only
  - SNF beds and alternative levels and types of care such as assisted living, subacute care, short-term rehabilitation services, and/or adult day care

**Refurbish the Healey Center – Advantages**
- Less costly in the near-term than new construction.

**Refurbish the Healey Center – Concerns**
- Over the long-term, this option is not a good use of HCD or County funds.
- The current design is not conducive to high quality of care. It is inefficient and does not meet the needs of a younger resident population.
- There is very limited ability to change the physical structure without major demolition and reconstruction, which would be very expensive and disruptive.
- Retrofitting of the facility to meet safety standards does not provide for the best outcome – there is little to no ability to build in redundancies that are desirable in a facility that houses so many non-ambulatory residents.
- The old facility has limited appeal – the ability to attract private pay patients is severely constrained.
Build a New Healey Center – Advantages

- Provides the opportunity to design the facility using today’s standards and innovations and to maximize efficiencies.
- Improves the overall attractiveness of the facility, which might result in an ability to attract residents who have a more desirable payor source. Design of a new facility will be critical in terms of attracting potential private pay residents. The ability to attract more Medicaid residents especially dually-eligible residents with Medicare is the most likely benefit from a new facility.
- Provides the opportunity to more readily include additional levels or types of care (if cost-effective to do so). These can include assisted living, a state of the art rehabilitation unit, and a special care unit, for example.

Build a New Healey Center – Concerns

- Expensive up-front costs. (However, the HCD has accumulated reserve funds more than adequate to fund the construction of a new facility.)

Mixed Payor/Provider Model

The HCD would serve a smaller number of persons than the projected “need” (212 beds by 2030), while placing some persons in need of SNF services who in the past would have been placed at the Healey Center in other SNFs in Palm Beach County. The HCD will still need to determine if refurbishment or construction of a new facility is the best option: the advantages and concerns related to these choices were discussed previously. In addition, concerns regarding contracting with other SNFs (described previously) would still be an issue, especially if the population of persons turning to the HCD for LTC services grows faster than projected or if SNF bed occupancy begins to rise and “contracted” beds are less readily available or both. Alternatives to SNFs, including ALFs and housing, are not readily available in Palm Beach County for low-income persons.

Mixed Payor/Provider Model – Advantages

- Leverages existing capacity in other SNFs, enabling the HCD to operate a smaller SNF than might otherwise be needed.
- Limits the HCD liability to a smaller number of beds (although it may be difficult to limit expenditures for “outsourcing” to other nursing homes).
- There is no assurance of access to non-HCD SNF beds or to other outsource options such as private ALFs.

Mixed Payor/Provider Model – Concerns

- The acuity of residents at the Healey Center under this scenario is likely to increase with no increase in payment available. There is no additional Medicaid payment available to serve a specialty population (other than the existing supplemental payment for persons with HIV/AIDS and medically fragile children served in SNFs). While special rates or supplemental payments are made available through Medicaid in other states (New York and New Jersey, for example), there is little prospect for such payments in Florida in the near term.
• The HCD may find it difficult to limit expenditures for “outsourcing” to other nursing homes, depending on the needs of persons who might be placed in another nursing home.

**Continuum of Care Model**
Under this scenario, the HCD would expand their role to include becoming a provider of community-based LTC services including assisted living, “housing” and potentially home health, HCBS (Medicaid waiver and county-funded) and managed acute/LTC services as well as continuing to provide SNF services.

**Continuum of Care Model – Advantages**
The primary advantage to this option is the ability of the HCD to serve persons in alternative settings when cost-effective to do so and to operate these settings in a manner that maximizes successful community placement. If an ALF and housing is part of the “Healey Center” continuum, the resident maintains ties to the Healey Center. This makes transition from the SNF easier and also makes a continuum available when residents in “Healey” housing or the ALF decline and need either temporary or permanent placement at the Healey Center SNF.

Under the most comprehensive option, a managed acute/LTC option, the Healey Center would control the full range of services (physician, inpatient hospital, NF and community-based services), and this could include Medicaid and Medicare services. The target population for the expanded continuum could be all persons in need of LTC services in Palm Beach County, which could be advantageous to the HCD. A full analysis would be required to determine if the expanded continuum of care is financially viable. Specific advantages to expanding the continuum of care include:

• The HCD would have the ability to provide LTC services in a setting chosen by the individual when cost-effective to do so and residents are more likely to succeed in these alternative settings rather than in scattered housing units or private ALFs.

• Under a fully capitated comprehensive acute/LTC model, the HCD would control all services and be able to potentially generate cost-savings through chronic care management, disease management, timely access to acute and specialty services, and substitution of less costly services in a homelike setting. The HCD has experience operating a Medicaid managed care plan and experience operating the Healey Center – expansion to community-based LTC services and managed LTC services would build on this existing expertise.

**Continuum of Care Model – Concerns**
• The continuum of care model is a much more attractive option than a SNF. Access to the alternatives settings would need to be carefully managed to ensure only those persons truly at risk of otherwise entering the Healey Center SNF would access the on-site alternatives.
• The continuum of care model that includes ALF and/or housing will also require careful financial management. The alternative settings are only cost-effective for some persons in some groups. There is greater flexibility to use these options if the HCD measures cost-effectiveness in the “aggregate”.

Summary
• The Healey Center served 244 persons during 2006. Using 2006 as the base year for the purposes of projections, we determined that by 2030 the Healey Center would serve 415 residents and require 212 beds to do so. This projection assumes that factors such as access to alternatives to nursing home care and disability status will not change proportionally from what exists today.

• The Healey Center is not big enough to meet future projected need.
  o The Healey Center currently has 198 licensed beds, 134 operational beds and an additional 30 beds that could be brought back online (164 beds). 34 of the 198 beds have previously been determined unusable.

• The need for SNF beds at the Healey Center can be reduced through the use of a mix of alternatives, including placement at other SNFs, access to ALF beds and access to housing with supports.
  o Outsourcing of SNF care might be feasible to offset some of the future demand for SNF services provided by the HCD, but is problematic. There is no way to ensure access to an adequate number of contracted SNF beds, to ensure contracted rates will be “affordable” and to ensure quality of care is adequate. At present, there are an inadequate number of SNF beds in facilities with a quality of care rating equivalent to or higher than that of the Healey Center.
  o Outsourcing of care to alternative community-based options such as ALFs and housing with supports is not feasible unless the HCD/County develops ALF beds and provide access to housing. In addition, access to HUD vouchers to offset the cost of HCD housing would be needed to ensure the housing model is cost-effective. Even with access to these resources, some persons will continue to require SNF services either as a result of health care needs, safety issues and/or the cost of care (community-based versus SNF).

• The HCD covers the cost of care for “charity patients” (persons with no other payor source) at a cost of $346/day in 2007. Thirty percent of residents in July 2008 were not covered by Medicaid or any other payor source, but were instead “charity care” covered. The HCD also subsidizes the cost of care for Medicaid residents. Medicaid reimbursement in 2007 was $201.66/day. In addition, Medicaid residents are required to contribute their income less a personal needs allowance, toward the cost of care. This averaged about $13/day in 2007. The HCD receives approximately $75.60/day in UPL funds from Medicaid for a total Medicaid reimbursement of $277.26 using the January 2007 Medicaid per diem
The overall Medicaid shortfall was about $56/day in 2007 ($346 minus the sum of $201.66+$75.60+$13). About 69% of all resident days at the Healey Center were reimbursed by Medicaid for the year ending September 30, 2007.

- The HCD has a reserve fund of $52 million comprised of money not spent in the past 13 years of operations from the annual $9.1 million allocation from the County.

- No matter which option is selected in regard to the Healey Center, the HCD does not have adequate funds to cover the cost of charity care or to offset the Medicaid losses in the future even if operating the Healey Center at the current census levels and with the current resident mix and payor sources. Since the County contribution is fixed, and despite access to a reserve amount, eventually costs will exceed the amount available through the County subsidy. NF inflation is projected to continue at 3% annually. In addition, the Medicaid “gap” changes each time the per diem is reset (twice yearly), and the UPL payment fluctuates based on Medicaid days.

- Construction of new health care facilities is always a costly endeavor. It may appear that refurbishment of a facility is more cost-effective. However, in facilities of an advanced age, refurbishment is costly (estimated at 18.1 million) and it is not possible to achieve the desired layout within the existing shell. There are opportunity costs associated with operation of an outdated facility. These include inability to improve efficiencies in multiple areas such as staffing, medical records and patient care to name a few. Even after a complete renovation, the facility would still be lacking in efficiency and appeal.

- A mixed-use facility is viewed as desirable by some residents and staff and is consistent with nationwide trends for provision of LTC services.

- Enhancement of rehabilitation services at the Healey Center is feasible and can be included in the master facility design plan should the Board authorize Phase II of this project. If the Healey Center were a new facility with a state of the art rehabilitation department (and since the Healey Center has a higher quality of care rating than most facilities that take large number of Medicaid recipients), we believe that it is feasible to attract more dually-eligible persons to a new facility and increase revenue. In addition, the ability to provide outpatient rehabilitation at the Healey Center is another area of potential revenue growth. Again, this capability is dependent on the construction of a new facility if it is to be “attractive” enough to draw persons to the Center.

- For reasons discussed previously we do not recommend inclusion of: adult day care, medical respite, outpatient dialysis, or a ventilator dependent unit.

**Recommendations**

The recommended models of care are those determined to be consistent with the County and HCD mission in regard to the Healey Center based on the interlocal agreement and statements of HCD and county interviewees. The models of care are also, to the
maximum extent feasible, consistent with the stated desires of the residents of the Healey Center and staff of the Healey Center. They are provided in order of preference.

We developed the following guiding principles:

- The County is committed to meeting the LTC needs of Palm Beach County residents by operating the Healey Center.
- Since the Healey Center was originally built as the “County Home”, and county homes traditionally serve low-income persons with no other options for care, the Healey Center is designed to serve residents whose needs cannot be met elsewhere.
- The HCD may provide other services to expand, enhance or provide nursing home care and long-term care services.

Expansion must take into account available resources, including the available sites for location of a facility or facilities and the amount of funding (both reserve and anticipated revenue).

Alternatives to SNF services must be cost-effective.

Desired enhancements include: a more homelike environment in which to receive LTC services (whether at the Healey Center or an alternative setting); a facility that incorporates to the maximum extent feasible the most advanced nursing home design features; an upgraded rehabilitation capability; and access to alternative levels of care or settings for persons who would otherwise have received skilled nursing facility services at the Healey Center.

For these reasons we recommend that no matter which model is selected, should a new facility be constructed, it be constructed using a modified pod design as explained previously. We estimate a new facility with three types of care (SNF, ALF and housing) and 212 beds could be constructed for about $31.8 million at the existing site. A smaller facility with 100 SNF beds and 20 ALF beds could be constructed for about $22 million.

- We believe inclusion of at least an on-site ALF (and ideally housing) is highly desirable. This option can be cost-effective but will require careful management. Healey Center staff or HCD social workers will need to provide enhanced case management services in order to pursue and secure access to HCBS waivers. The staff of the Florida BSCIP has offered their assistance to the HCD. They are willing to come to the Healey Center, to conduct assessments of persons with TBI or SCI, to work with the residents and staff to develop a community-based care plan and to provide access to BSCIP program funding and TBI/SCI Waiver slots to support transition and residency in alternative community-based settings. The HCD will also need to work with local and state agencies to pursue improved access to HCBS waivers such as the A/DA and ALE Waivers.
- If a new facility is constructed, we recommend including a special unit for persons with challenging behaviors who are not currently served at the Healey Center but who meet NF LOC.
• Should the Commission determine 198 SNF beds are not required for the future, excess SNF bed licenses at the Healey Center can be sold. It is likely excess licenses could be sold for $15,000/bed.

Below are the three recommended models. Following the models is a high-level financial analysis for each model that estimates revenue and expenses using the modeling described in the scenarios and assuming current Medicaid and charity care costs. (See Tables 35 through 38.)

**Recommended Model 1 (Mixed Provider/Payor Model)**

Build a new but smaller “Healey Center” that includes a SNF and a distinct part ALF that in total meet a portion of the projected future need and use outsourcing to meet any future additional LTC service need or set a limit on SNF/ALF beds at a size smaller than projected future need.

- The SNF – 100 beds. Retain additional SNF bed licenses in the event the HCD determines that the ALF is not feasible and/or the need for SNF beds is so great, conversion of the ALF is needed and/or construction of an additional wing is needed. The facility would be designed to allow for future addition of an additional 30-bed pod (comprised of two 15-bed semi-pods). The HCD may request continuation of “licenses” from AHCA annually. However, the request is limited to the number of beds physically available for conversion at the time of the request. Therefore, only 20 SNF licenses could be retained (for conversion of the 20 ALF beds) unless an exception was granted by the State.

- The ALF – 20 beds. A SNF may include an ALF as long as the ALF is a “distinct part.” Staff from the SNF may work at the ALF as long as they are not assigned to both parts simultaneously – staff may not float between facilities. The nursing home administrator may administer the ALF but in this case there must be an ALF manager. The ALF should be constructed compliant with NF regulations to allow conversion to SNF licensure in the event this becomes necessary in the future.

- Use private SNFs, ALFs and housing whenever feasible to meet additional need or set a limit on need to be met by the HCD of a fixed number of beds.

**Recommended Model 2 (Provider Model)**

Build a new “Healey Center” that includes a SNF, a distinct part ALF and on-site efficiency apartments (non-licensed) that in total meet a portion of projected future need.

- The SNF – 100 beds. Retain additional SNF bed licenses in the event the HCD determines that the ALF is not feasible and/or the need for SNF beds is so great, conversion of the ALF is needed and/or construction of an additional wing is needed. The facility would be designed to allow for future addition of an additional 30-bed pod (comprised of two 15-bed semi-pods). The HCD may request continuation of “licenses” from AHCA annually. However, the request is limited to the number of beds physically available for conversion at the time of
the request. Therefore, only 20 SNF licenses could be retained (for conversion of the 20 ALF beds) unless an exception was granted by the State.

- The ALF – 20 beds. A SNF may include an ALF as long as the ALF is a “distinct part.” Staff from the SNF may work at the ALF as long as they are not assigned to both parts simultaneously – staff may not float between facilities. The nursing home administrator may administer the ALF but in this case there must be an ALF manager. The ALF should be constructed compliant with NF regulations to allow conversion to SNF licensure in the event this becomes necessary in the future.

- Efficiency apartments – 20. The housing should be compliant with HUD housing requirements to ensure that residents may access HUD Section 8 vouchers should they be available. HUD financing might be available to construct the housing although the financing is complex and reportedly very difficult to access. The HCD reports there have been about 20 residents each year who could have been served in housing but who remain at the SNF due to lack of access to resources in the community.

**Recommended Model 3 (Provider Model)**

Build a new “Healey Center” that includes a SNF, a distinct part ALF and housing that in total meet the projected future need.

- The SNF – 172 beds.

- The ALF – 20 beds. A SNF may include an ALF as long as the ALF is a “distinct part”. Staff from the SNF may work at the ALF as long as they are not assigned to both parts simultaneously – staff may not float between facilities. The nursing home administrator may administer the ALF but in this case there must be an ALF manager. The ALF should be constructed compliant with NF regulations to allow conversion to SNF licensure in the event this becomes necessary in the future. However, only 6 additional SNF bed licenses would be available for future conversion – potential conversion of all 20 ALF beds to SNF beds would require a new CON for the balance of the beds (14) to be converted.

- Efficiency apartments – 20 beds. The housing should be compliant with HUD housing requirements to ensure that residents may access HUD Section 8 vouchers should they be available. HUD financing might be available to construct the housing although the financing is complex and reportedly very difficult to access. The HCD reports there have been about 20 residents each year who could have been served in housing but who remain at the SNF due to lack of access to resources in the community.
Table 35: Per Diem Revenues and Expenditures by Setting

<table>
<thead>
<tr>
<th></th>
<th>ALF Medicaid</th>
<th>ALF Charity Care</th>
<th>SNF Medicaid</th>
<th>SNF Charity Care</th>
<th>APT Medicaid</th>
<th>APT Charity Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OSS</td>
<td>$2.61</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>ALE Waiver</td>
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</tr>
<tr>
<td>SSI</td>
<td>$13.00</td>
<td>$13.00</td>
<td>$13.00</td>
<td></td>
<td>$13.22</td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$277.00</td>
<td></td>
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<td>HUD Voucher</td>
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<td></td>
<td>$26.84</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>$105.00</td>
<td></td>
</tr>
<tr>
<td>Total Revenue</td>
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<td>$0.00</td>
<td>$290.00</td>
<td>$0.00</td>
<td>$145.07</td>
<td>$0.00</td>
</tr>
<tr>
<td><strong>Expenditures</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$122 per day</td>
<td>$122.00</td>
<td>$122.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$346 per day</td>
<td></td>
<td>$346.00</td>
<td>$346.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$212 per day</td>
<td></td>
<td></td>
<td></td>
<td>$187.00</td>
<td>$212.00</td>
<td></td>
</tr>
<tr>
<td>Total Expenditures</td>
<td>$122.00</td>
<td>$122.00</td>
<td>$346.00</td>
<td>$346.00</td>
<td>$187.00</td>
<td>$212.00</td>
</tr>
<tr>
<td><strong>Net (Shortfall)</strong></td>
<td>($54.42)</td>
<td>($122.00)</td>
<td>($56.00)</td>
<td>($346.00)</td>
<td>($41.93)</td>
<td>($212.00)</td>
</tr>
</tbody>
</table>

Note: The model proposes 92% occupancy in a SNF (higher than current occupancy) and 100% occupancy in the ALF. If occupancy were lower, the model results in a lower overall cost to the HCD because every bed day, whether Medicaid or charity care, incurs a loss paid for by the HCD. Because the model is simplistic, it does not reflect variable cost changes that would occur with changes in occupancy or size. (These types of changes will be taken into account for the detailed financial projections to be completed during Phase II of this project.)
Table 36: Model 1 Revenues and Expenditures – 100 Bed SNF and 20-Bed ALF versus 120-Bed SNF

<table>
<thead>
<tr>
<th></th>
<th>ALF</th>
<th>SNF</th>
<th>TOTAL</th>
<th>Annualized</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OSS</td>
<td>$26.13</td>
<td>$261.30</td>
<td>$94,068.00</td>
<td></td>
</tr>
<tr>
<td>ALE Waiver</td>
<td>$518.67</td>
<td>$518.67</td>
<td>$186,720.00</td>
<td></td>
</tr>
<tr>
<td>SSI</td>
<td>$130.00</td>
<td>$801.32</td>
<td>$931.32</td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td></td>
<td>$17,074.28</td>
<td>$17,074.28</td>
<td>$6,146,740.80</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>$674.80</td>
<td>$17,875.60</td>
<td>$18,550.40</td>
<td>$6,678,144.00</td>
</tr>
<tr>
<td><strong>Expenditures</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$122 per day</td>
<td>$2,440.00</td>
<td>$2,440.00</td>
<td>$878,400.00</td>
<td></td>
</tr>
<tr>
<td>$346 per day</td>
<td></td>
<td>$31,832.00</td>
<td>$31,832.00</td>
<td>$11,459,520.00</td>
</tr>
<tr>
<td>Total Expenditures</td>
<td>$2,440.00</td>
<td>$31,832.00</td>
<td>$34,272.00</td>
<td>$12,337,920.00</td>
</tr>
<tr>
<td><strong>Net (Shortfall)</strong></td>
<td>($1,765.20)</td>
<td>($13,956.40)</td>
<td>($15,721.60)</td>
<td>($5,659,776.00)</td>
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</tbody>
</table>

Comparison: 120 Bed SNF (92% Occupancy, 2/3 Medicaid)

<table>
<thead>
<tr>
<th></th>
<th>Per Day</th>
<th>Annualized</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
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</tr>
<tr>
<td>SSI</td>
<td>$961.58</td>
<td>$346,170.24</td>
</tr>
<tr>
<td>Medicaid</td>
<td>$20,489.14</td>
<td>$7,376,088.96</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>$21,450.72</td>
<td>$7,722,259.20</td>
</tr>
<tr>
<td><strong>Expenditures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$346 per day</td>
<td>$38,198.40</td>
<td>$13,751,424.00</td>
</tr>
<tr>
<td>Total Expenditures</td>
<td>$38,198.40</td>
<td>$13,751,424.00</td>
</tr>
<tr>
<td><strong>Net (Shortfall)</strong></td>
<td>($16,747.68)</td>
<td>($6,029,164.80)</td>
</tr>
</tbody>
</table>

Note: 120 Beds = 100 Bed SNF (92% Occupancy – 2/3 Medicaid), 20 Bed ALF (100% Occupancy – 50% Medicaid)
### Table 37: Model 2 – 140 Beds (100 Bed SNF, 20 Bed ALF and 20 Apartments)

<table>
<thead>
<tr>
<th></th>
<th>ALF</th>
<th>SNF</th>
<th>APT</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenues and Expenditures Per Day</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OSS</td>
<td>$26.13</td>
<td>$26.13</td>
<td></td>
<td>$9,408.00</td>
</tr>
<tr>
<td>ALE Waiver</td>
<td>$518.67</td>
<td>$518.67</td>
<td></td>
<td>$186,720.00</td>
</tr>
<tr>
<td>SSI</td>
<td>$130.00</td>
<td>$801.32</td>
<td>$132.22</td>
<td>$1,063.54</td>
</tr>
<tr>
<td>Medicaid</td>
<td>$17,074.28</td>
<td>$17,074.28</td>
<td></td>
<td>$6,146,740.80</td>
</tr>
<tr>
<td>HUD Voucher</td>
<td>$268.45</td>
<td></td>
<td>$268.45</td>
<td>$96,640.80</td>
</tr>
<tr>
<td>TBI Waiver</td>
<td></td>
<td>$1,050.00</td>
<td>$1,050.00</td>
<td>$378,000.00</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>$674.80</td>
<td>$17,875.60</td>
<td>$1,450.67</td>
<td>$20,001.07</td>
</tr>
<tr>
<td><strong>Expenditures</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$122 per day</td>
<td>$2,440.00</td>
<td></td>
<td>$2,440.00</td>
<td>$878,400.00</td>
</tr>
<tr>
<td>$346 per day</td>
<td>$31,832.00</td>
<td></td>
<td>$31,832.00</td>
<td>$11,459,520.00</td>
</tr>
<tr>
<td>$212 per day</td>
<td>$3,740.00</td>
<td></td>
<td>$3,740.00</td>
<td>$1,346,400.00</td>
</tr>
<tr>
<td>Total Expenditures</td>
<td>$2,440.00</td>
<td>$31,832.00</td>
<td>$3,740.00</td>
<td>$38,012.00</td>
</tr>
<tr>
<td><strong>Net (Shortfall)</strong></td>
<td>($1,765.20)</td>
<td>($13,956.40)</td>
<td>($2,289.33)</td>
<td>($18,010.93)</td>
</tr>
</tbody>
</table>

Note: 100 Bed SNF (92% Occupancy – 2/3 Medicaid), 20 Bed ALF (100% Occupancy – 50% Medicaid), 20 Apartments (50% Medicaid)

### Comparison: 140 Bed SNF (92% Occupancy, 2/3 Medicaid)

<table>
<thead>
<tr>
<th></th>
<th>Per Day</th>
<th>Annualized</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSI</td>
<td>$1,121.85</td>
<td>$403,865.28</td>
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<tr>
<td>Medicaid</td>
<td>$23,903.99</td>
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</tr>
<tr>
<td>Total Revenue</td>
<td>$25,025.84</td>
<td>$9,009,302.40</td>
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<tr>
<td><strong>Expenditures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$346 per day</td>
<td>$44,564.80</td>
<td>$16,043,328.00</td>
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<tr>
<td>Total Expenditures</td>
<td>$44,564.80</td>
<td>$16,043,328.00</td>
</tr>
<tr>
<td><strong>Net (Shortfall)</strong></td>
<td>($19,538.96)</td>
<td>($7,034,025.60)</td>
</tr>
</tbody>
</table>

Healey Center Feasibility Study

Health Management Associates 128 October 9, 2008
Table 38: Model 3 - 212 Beds (172 Bed SNF, 20 Bed ALF and 20 Apartments)

<table>
<thead>
<tr>
<th>Revenues and Expenditures Per Day</th>
<th>ALF</th>
<th>SNF</th>
<th>APT</th>
<th>TOTAL</th>
<th>Annualized</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OSS</td>
<td>$26.13</td>
<td>$26.13</td>
<td></td>
<td>$9,408.00</td>
<td></td>
</tr>
<tr>
<td>ALE Waiver</td>
<td>$518.67</td>
<td>$518.67</td>
<td></td>
<td>$186,720.00</td>
<td></td>
</tr>
<tr>
<td>SSI</td>
<td>$130.00</td>
<td>$1,378.27</td>
<td>$132.22</td>
<td>$1,640.49</td>
<td>$590,576.54</td>
</tr>
<tr>
<td>Medicaid</td>
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</tr>
<tr>
<td>HUD Voucher</td>
<td></td>
<td>$268.45</td>
<td></td>
<td>$96,640.80</td>
<td></td>
</tr>
<tr>
<td>TBI Waiver</td>
<td>$1,050.00</td>
<td></td>
<td>$1,050.00</td>
<td>$378,000.00</td>
<td></td>
</tr>
<tr>
<td>Total Revenue</td>
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<td>$1,450.67</td>
<td>$32,871.50</td>
<td>$11,833,739.52</td>
</tr>
<tr>
<td><strong>Expenditures</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$122 per day</td>
<td>$2,440.00</td>
<td></td>
<td></td>
<td>$2,440.00</td>
<td>$878,400.00</td>
</tr>
<tr>
<td>$346 per day</td>
<td></td>
<td>$54,751.04</td>
<td></td>
<td>$54,751.04</td>
<td>$19,710,374.40</td>
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<tr>
<td>$212 per day</td>
<td></td>
<td></td>
<td>$3,740.00</td>
<td>$3,740.00</td>
<td>$1,346,400.00</td>
</tr>
<tr>
<td>Total Expenditures</td>
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<td>$3,740.00</td>
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</tr>
<tr>
<td>Net (Shortfall)</td>
<td>($1,765.20)</td>
<td>($24,005.01)</td>
<td>($2,289.33)</td>
<td>($28,059.54)</td>
<td>($10,101,434.88)</td>
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</tbody>
</table>

Note: 172 Bed SNF (92% Occupancy – 2/3 Medicaid), 20 Bed ALF (100% Occupancy – 50% Medicaid), 20 Apartments (50% Medicaid)

Comparison: 212 Bed SNF (92% Occupancy, 2/3 Medicaid)

<table>
<thead>
<tr>
<th>Revenue</th>
<th>Per Day</th>
<th>Annualized</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSI</td>
<td>$1,698.80</td>
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</tr>
<tr>
<td>Medicaid</td>
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<tr>
<td>Total Revenue</td>
<td>$37,896.27</td>
<td>$13,642,657.92</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Expenditures</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$346 per day</td>
<td>$67,483.84</td>
<td>$24,294,182.40</td>
</tr>
<tr>
<td>Total Expenditures</td>
<td>$67,483.84</td>
<td>$24,294,182.40</td>
</tr>
<tr>
<td>Net (Shortfall)</td>
<td>($29,587.57)</td>
<td>($10,651,524.48)</td>
</tr>
</tbody>
</table>
**Additiona Recommendations**

- Consider seeking legislation to require full cost-based reimbursement of county-owned SNFs through the Medicaid program consistent with Medicaid reimbursement of “exempt” hospitals (including county and rural hospitals).

- Consider the possibility of developing a Medicaid HCBS waiver for county residents residing in or at imminent risk of entering the Healey Center, where the HCD would contribute funds to pull down FFP. HMA is assisting a county in California with development of this type of waiver at present.

- No matter what decision is made in regard to the future of the Healey Center, we suggest that Healey Center and/or HCD social workers undertake more intensive efforts to place residents with TBI/SCI in the community by working with the BSCIP.

- Explore the possibility of becoming a managed integrated acute/LTC provider both through Medicaid and Medicare. This would require a model similar to the proposed Senior Care program that includes non-elderly adults who are dually eligible (have Medicare and Medicaid coverage).
### Appendix 1: Cost Estimate for Healey Center Models

**Model 1: 120 Beds (100 Beds SNF, 20 bed ALF)**

<table>
<thead>
<tr>
<th>Item</th>
<th>Estimated Cost</th>
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<td>Site Development</td>
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</tr>
<tr>
<td>Soil Borings</td>
<td>$5,000</td>
</tr>
<tr>
<td>Survey</td>
<td>$5,000</td>
</tr>
<tr>
<td>Level 1 Environmental report</td>
<td>$6,000</td>
</tr>
<tr>
<td>Civil Engineering</td>
<td>$50,000</td>
</tr>
<tr>
<td>Landscape Architect</td>
<td>$6,000</td>
</tr>
<tr>
<td>Landscaping and lawn sprinkler system</td>
<td>$100,000</td>
</tr>
<tr>
<td>Kitchen designer</td>
<td>$9,000</td>
</tr>
<tr>
<td>Kitchen equipment</td>
<td>$150,000</td>
</tr>
<tr>
<td>Interior designer</td>
<td>$35,000</td>
</tr>
<tr>
<td>Furnishings and movable equipment</td>
<td>$700,000</td>
</tr>
<tr>
<td>Architectural and Building Engineering</td>
<td>$800,000</td>
</tr>
<tr>
<td><strong>Construction</strong></td>
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</tr>
<tr>
<td>Nursing and ALF 80,800 sq ft x $180 sq ft</td>
<td>$14,544,000</td>
</tr>
<tr>
<td>Demolition of existing building</td>
<td>$1,500,000</td>
</tr>
<tr>
<td><strong>SUBTOTAL</strong></td>
<td>$18,410,000</td>
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<tr>
<td>Contingency factor at 15%</td>
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<tr>
<td>Inflation x 1 year at 5%</td>
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<tr>
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**Model 2: 140 Beds (100 bed SNF, 20 bed ALF, 20 Apartments)**

<table>
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<th>Item</th>
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<tr>
<td>Site Development</td>
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</tr>
<tr>
<td>Soil Borings</td>
<td>$5,000</td>
</tr>
<tr>
<td>Survey</td>
<td>$5,000</td>
</tr>
<tr>
<td>Level 1 Environmental report</td>
<td>$6,000</td>
</tr>
<tr>
<td>Civil Engineering</td>
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</tr>
<tr>
<td>Landscape Architect</td>
<td>$6,000</td>
</tr>
<tr>
<td>Landscaping and lawn sprinkler system</td>
<td>$100,000</td>
</tr>
<tr>
<td>Kitchen designer</td>
<td>$9,000</td>
</tr>
<tr>
<td>Kitchen equipment</td>
<td>$150,000</td>
</tr>
<tr>
<td>Interior designer</td>
<td>$35,000</td>
</tr>
<tr>
<td>Furnishings and movable equipment</td>
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<tr>
<td>Architectural and Building Engineering</td>
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<tr>
<td><strong>Construction</strong></td>
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</tr>
<tr>
<td>Residential units 17,500 sq ft x $125 sq ft</td>
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</tr>
<tr>
<td>Nursing and ALF 80,800 sq ft x $180 sq ft</td>
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<tr>
<td>Demolition of existing facility</td>
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<td><strong>SUBTOTAL</strong></td>
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<tr>
<td>Contingency factor at 15%</td>
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<td><strong>TOTAL</strong></td>
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## Model 3: 212 Beds Total (172 bed SNF, 20 ALF, 20 Apartments)

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<tr>
<td>Soil Borings</td>
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<tr>
<td>Survey</td>
</tr>
<tr>
<td>Level 1 Environmental report</td>
</tr>
<tr>
<td>Civil Engineering</td>
</tr>
<tr>
<td>Landscape Architect</td>
</tr>
<tr>
<td>Landscaping and lawn sprinkler system</td>
</tr>
<tr>
<td>Kitchen designer</td>
</tr>
<tr>
<td>Kitchen equipment</td>
</tr>
<tr>
<td>Interior designer</td>
</tr>
<tr>
<td>Furnishings and movable equipment</td>
</tr>
<tr>
<td>Architectural and Building Engineering</td>
</tr>
<tr>
<td><strong>Construction</strong></td>
</tr>
<tr>
<td>Residential units 17,500 sq ft x $125 sq ft</td>
</tr>
<tr>
<td>Nursing and ALF 110,000 sq ft x $180 sq ft</td>
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<tr>
<td>Demolition of existing facility</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
</tr>
<tr>
<td>Contingency factor at 15%</td>
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<tr>
<td>Inflation x 1 year at 5%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
</tr>
</tbody>
</table>

Prepared by O’Keefe Architects, inc.
Appendix 2: Schematics for Models 1, 2 and 3. Prepared by O'Keefe Architects, inc.
## Appendix 3: ALF Cost Model

### Healey Center ALF Model Personnel Assumptions

<table>
<thead>
<tr>
<th>Number of Units</th>
<th>20</th>
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<tbody>
<tr>
<td>Number of Second Occupants</td>
<td>0</td>
</tr>
<tr>
<td>Total Number of Occupants</td>
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</table>

### POSITION TITLE | PAY SCALE | # FTEs | PER MONTH |
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<tr>
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<tbody>
<tr>
<td>Administrator</td>
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<td>Housing Manager</td>
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<td>Receptionist</td>
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<td>0.25</td>
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<td>Activities Director</td>
<td>19.23 Per Hour</td>
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<td>Van Driver</td>
<td>14.31 Per Hour</td>
<td>0.50</td>
<td>1,239.98</td>
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<td>RN or LVN/LPN</td>
<td>28.24 Per Hour</td>
<td>0.50</td>
<td>2,447.60</td>
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<tr>
<td>Nurse On-Call</td>
<td>- Per Month</td>
<td>-</td>
<td>-</td>
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<td>Resident Assistants</td>
<td>17.08 Per Hour</td>
<td>6.33</td>
<td>18,741.27</td>
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<td>Lead Cook/Food Service Director</td>
<td>25.09 Per Hour</td>
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<tr>
<td>Cook(s)</td>
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<td>2,479.97</td>
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<tr>
<td>Dietary Aide</td>
<td>14.31 Per Hour</td>
<td>1.00</td>
<td>2,479.97</td>
</tr>
<tr>
<td>Server</td>
<td>14.31 Per Hour</td>
<td>1.00</td>
<td>2,479.97</td>
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<tr>
<td>Housekeeper</td>
<td>14.31 Per Hour</td>
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<td>Maintenance Person</td>
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<tr>
<td>Other Project-Specific Personnel</td>
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<td>Total Labor Costs</td>
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<td>44,787.53</td>
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</table>

Percent of labor costs allocated to benefits, workers compensation insurance, overtime/holiday pay and payroll taxes: 37.4% 16,750.54

TOTAL PERSONNEL COSTS: 61,538.07
## Healey Center ALF Model Expense Assumptions

| Number of Units | 20 |
| Number of Second Occupants | 0 |
| Total Number of Occupants | 20 |

<table>
<thead>
<tr>
<th>DESCRIPTION OF EXPENSE</th>
<th>EXPENSE</th>
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<th>COST FACTOR</th>
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<td>Telephone</td>
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<td>Pagers/Cellular Phones</td>
<td>Fixed Per Project</td>
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<td>$60</td>
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<td>Automobile (mileage)</td>
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<td>Administrative Advertising</td>
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<td>$160</td>
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<tr>
<td>Dues/Memberships</td>
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<td>$4.00</td>
<td>$80</td>
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<tr>
<td>Education/Training</td>
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<td>$80</td>
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<td>Audit Expense</td>
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<td>$500</td>
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<td>Certification Fee (per unit)</td>
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<td>$60</td>
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</table>

| **DIETARY/KITCHEN** |         |      |             |       |
| Raw Food | Variable Per Occ./Per Day | $4.50 | $2,736 |
| Kitchen Supplies | Variable Per Occupant | $7.00 | $140 |
| Smallwares and Minor Equipment | Variable Per Occupant | $4.00 | $80 |
| Dietary Consultant | Variable Per Occupant | $2.00 | $40 |

| **RESIDENT CARE** |         |      |             |       |
| Care Supplies | Variable Per Occupant | $10.00 | $200 |
| Pharmacy | Variable Per Occupant | $3.00 | $60 |
| Activity Supplies and Entertainment | Variable Per Occupant | $4.50 | $90 |
| Laundry | Variable Per Occupant | $150 |
| Housekeeping Supplies | Variable Per Occupant | $12.00 | $240 |

<p>| <strong>MAINTENANCE</strong> |         |      |             |       |
| Repair Expense | Fixed Per Unit | $11.00 | $220 |</p>
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<th>Per Project</th>
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<tbody>
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<td>$0</td>
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<td>Lead Cook/Food Services Director</td>
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<td>Dietary Aide</td>
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<td><strong>Housekeeping/Maintenance</strong></td>
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<td><strong>Benefits, Taxes, etc.</strong></td>
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### Healey Center
#### ALF Model
#### Expense

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### Healey Center
#### ALF Model
#### Summary

**EXPENSES:**

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## Appendix 4: Housing Cost Model

### Personnel Assumptions

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### Personnel Costs

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Percent of labor costs allocated to benefits, workers compensation insurance, overtime/holiday pay and payroll taxes: 37.4% 4,070.76

**TOTAL PERSONNEL COSTS**: 14,955.14
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<td>Cable TV</td>
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<td>15.00</td>
<td>300.00</td>
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<td>Sewer</td>
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<td>10.00</td>
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<td>Trash Removal</td>
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<td>Professional Liability Insurance</td>
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<td>PROPERTY COSTS</td>
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<td></td>
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<tr>
<td>Property Taxes</td>
<td>Fixed</td>
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<td></td>
</tr>
<tr>
<td>Repair and Replacement Reserve</td>
<td>Fixed</td>
<td>25.00</td>
<td>500.00</td>
<td></td>
</tr>
</tbody>
</table>

| Healey Center                   |              |            |               |
| Housing Model                   |              |            |               |
| Expense Assumptions             |              |            |               |
| Number of Units                 |              | 20         |               |
| Number of Second Occupants      |              | 0          |               |
| Total Number of Occupants       |              | 20         |               |
| PERSONNEL EXPENSES:             |              |            |               |
| ADMINISTRATION                  |              |            |               |
| Administrator                   |              | -          |               |
| Housing Manager                 |              | -          |               |
| Receptionist                    |              | 50,648.00  |               |
| ACTIVITIES                      |              |            |               |
| Activities Director             |              | 19,995.56  |               |
| Van Driver                      |              | 14,879.80  |               |
| CARE STAFF                      |              |            |               |
| Registered Nurse                |              | -          |               |
| Nurse On-Call                   |              | -          |               |
| Resident Assistants             |              | -          |               |
| DIETARY/KITCHEN                 |              |            |               |
| Lead Cook/Food Services Director |              | -          |               |
| Cook                            |              | -          |               |
| Dietary Aide                    |              | -          |               |
| Server                          |              | -          |               |
| HOUSEKEEPING/MAINTENANCE.       |              |            |               |
| Housekeeping                    |              | 29,759.60  |               |
| TOTAL PERSONNEL COSTS           |              | 15,329.60  |               |
| BENEFITS, TAXES, ETC.           |              | 48,849.10  |               |

Health Management Associates 145 October 9, 2008
<table>
<thead>
<tr>
<th>Category</th>
<th>Expenses</th>
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<td>TOTAL STAFFING EXP.</td>
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<td>ADMINISTRATIVE EXPENSES</td>
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<td>Automobile (mileage)</td>
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<td>DIETARY/KITCHEN</td>
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<td>Kitchen Supplies</td>
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<tr>
<td>Smallwares and Minor Equipment</td>
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<tr>
<td>Dietary Consultant</td>
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<td>RESIDENT CARE</td>
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<tr>
<td>Care Supplies</td>
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<tr>
<td>Pharmacy</td>
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<td>Activity Supplies and Entertainment</td>
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<td>VAN EXPENSES</td>
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<td>Vehicle Maintenance</td>
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<td>MARKETING</td>
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<td>Advertising</td>
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<tr>
<td>Referral Agency Fees</td>
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<td>Printing</td>
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<td>OTHER COSTS</td>
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<td>TOTAL SERVICE EXPENSES</td>
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## Healey Center Feasibility Study

### Expense Assumptions

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<tr>
<th>PROPERTY EXPENSES</th>
<th>Annual Total</th>
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<tr>
<td>Maintenance Personnel</td>
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<td>Grounds Contract</td>
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<td>Pest Control</td>
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<td>Alarm Monitoring</td>
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<td>Miscellaneous Maintenance</td>
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<table>
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<tr>
<th>UTILITIES</th>
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<tbody>
<tr>
<td>Electricity</td>
<td>10,800.00</td>
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<td>Gas</td>
<td>6,480.00</td>
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<tr>
<td>Water</td>
<td>2,400.00</td>
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<tr>
<td>Cable TV</td>
<td>3,600.00</td>
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<tr>
<td>Sewer</td>
<td>2,400.00</td>
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<tr>
<td>Trash Removal</td>
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<table>
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<th>PROPERTY COSTS</th>
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<tr>
<td>Management Fee (Property)</td>
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<tr>
<td>PROPERTY MANAGER</td>
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<tr>
<td>Benefits for Property Manager</td>
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### Total Annual Project Expenses

<table>
<thead>
<tr>
<th>TOTAL REAL ESTATE EXP.</th>
<th>68,282.87</th>
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### Annual Total

<table>
<thead>
<tr>
<th>EXPENSES:</th>
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<tbody>
<tr>
<td>TOTAL SERVICE EXPENSES</td>
<td>227,221.67</td>
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<tr>
<td>TOTAL REAL ESTATE EXPENSES</td>
<td>68,282.87</td>
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</table>

| TOTAL PROJECT EXPENSES | 295,504.54 |
| (AVE. PROJECT EXP. PER OCC.) | 14,775.23 |
| PER PATIENT DAY | 40.48 |
## Appendix 5 - Acronyms

### Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAA</td>
<td>Area Agencies on Aging – The local AAA is the AAA of Palm Beach/Treasure Coast.</td>
</tr>
<tr>
<td>ADA</td>
<td>Americans with Disabilities Act</td>
</tr>
<tr>
<td>ADL</td>
<td>Activities of Daily Living</td>
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<tr>
<td>A/DA Waiver</td>
<td>Aged and Adult Disabled Waiver</td>
</tr>
<tr>
<td>AHCA</td>
<td>Agency for Health Care Administration</td>
</tr>
<tr>
<td>ALE Waiver</td>
<td>Assisted Living for the Elderly Waiver</td>
</tr>
<tr>
<td>ALF</td>
<td>Assisted Living Facility</td>
</tr>
<tr>
<td>ARIMA</td>
<td>Auto-Regressive Integrated Moving Average</td>
</tr>
<tr>
<td>BSCIP</td>
<td>Brain and Spinal Cord Injury Program</td>
</tr>
<tr>
<td>CBO</td>
<td>Community Based Organizations</td>
</tr>
<tr>
<td>CCE</td>
<td>Community Care for the Elderly</td>
</tr>
<tr>
<td>CDC Waiver</td>
<td>Consumer Directed Care Waiver</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicaid and Medicare Services</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
</tr>
<tr>
<td>CON</td>
<td>Certificate of Need</td>
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<tr>
<td>DD</td>
<td>Developmental Disabilities.</td>
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<tr>
<td>DHHS</td>
<td>Department of Health and Human Services</td>
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<tr>
<td>DOEA</td>
<td>Department of Elder Affairs:</td>
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<tr>
<td>DOH</td>
<td>Department of Health</td>
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<tr>
<td>DD Waiver</td>
<td>The Developmental Disabilities Waiver</td>
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<tr>
<td>FFP</td>
<td>Federal Financial Participation</td>
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<td>FFS</td>
<td>Fee for service</td>
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### Acronyms

<table>
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<th>Description</th>
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<tr>
<td>FFY</td>
<td>Federal Fiscal Year: October 1 through September 31 each year.</td>
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<tr>
<td>FPL</td>
<td>Federal Poverty Level</td>
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<tr>
<td>FS</td>
<td>Florida Statutes</td>
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<tr>
<td>FTE</td>
<td>Full Time Equivalent (AKA Full Time Position)</td>
</tr>
<tr>
<td>GR</td>
<td>General Revenue (State funds)</td>
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<tr>
<td>HCBS</td>
<td>Home and Community-Based Services (such as personal care and respite services)</td>
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<tr>
<td>HCBS Waiver</td>
<td>HCBS funded through a Medicaid “waiver” – such as the TBI/SCI Waiver</td>
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<tr>
<td>HCD</td>
<td>Health Care District of Palm Beach County</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>HMA</td>
<td>Health Management Associates</td>
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<tr>
<td>HMO</td>
<td>Health Maintenance Organization</td>
</tr>
<tr>
<td>HUD</td>
<td>United States Department of Housing and Urban Development</td>
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<tr>
<td>ICF/MR</td>
<td>Intermediate Care Facility for the Mentally Retarded</td>
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<tr>
<td>IV</td>
<td>Intravenous</td>
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<tr>
<td>LOC</td>
<td>Level of Care</td>
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<tr>
<td>LOS</td>
<td>Length of Stay</td>
</tr>
<tr>
<td>LTC</td>
<td>Long-Term Care</td>
</tr>
<tr>
<td>MDS</td>
<td>Minimum Data Set (Data required to be collected by all SNFs describing resident demographics, diagnoses and care needs.)</td>
</tr>
<tr>
<td>MI</td>
<td>Mental Illness</td>
</tr>
<tr>
<td>MMIS</td>
<td>Medicaid Management Information System</td>
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<tr>
<td>MR</td>
<td>Mental Retardation</td>
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<tr>
<td>MR/DD</td>
<td>Mental Retardation/Developmental Disabilities</td>
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<tr>
<td>NCHS</td>
<td>National Center for Health Statistics</td>
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</table>
### Acronyms

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<th>Acronym</th>
<th>Description</th>
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<tr>
<td>NF</td>
<td>Nursing Facility</td>
</tr>
<tr>
<td>NHD Waiver</td>
<td>Nursing Home Diversion Waiver</td>
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<tr>
<td>OSS</td>
<td>Optional State Supplementation</td>
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<tr>
<td>PAC Waiver</td>
<td>Project AIDS Care Waiver</td>
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<tr>
<td>PACE</td>
<td>Program of All-inclusive Care for the Elderly</td>
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<tr>
<td>PHAs</td>
<td>Public Housing Agencies</td>
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<td>PMPM</td>
<td>Per Member, Per Month</td>
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<td>QA</td>
<td>Quality Assurance</td>
</tr>
<tr>
<td>RFP</td>
<td>Request for Proposals</td>
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<tr>
<td>SCI</td>
<td>Spinal Cord Injury</td>
</tr>
<tr>
<td>SFY</td>
<td>State Fiscal Year (In Florida, July 1 through June 30 each year)</td>
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<td>SNF</td>
<td>Skilled Nursing Facility</td>
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<td>Supplemental Security Income</td>
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<td>Traumatic Brain Injury</td>
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<td>Traumatic Brain Injury/Spinal Cord Injury Waiver</td>
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<td>Upper Payment Limit</td>
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<td>University of South Florida</td>
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