CliftonLarsonAllen

32nd Edition of the Skilled Nursing Facility Cost Comparison Report: More Data and More Insight

Based on 2016 Data

WEALTH ADVISORY | OUTSOURCING | AUDIT, TAX, AND CONSULTING

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The proliferation of technology and data are fundamentally changing the skilled nursing facility (SNF) industry. Providing high quality service no longer guarantees success. Instead, SNFs must demonstrate outcomes, quality metrics, and cost efficiency.

As this data-rich industry evolves, we see some unintended negative consequences of this abundance of data. In working with more than 2,100 senior living providers throughout the country, we have noted that SNFs either don't have the data necessary to make decisions, or they have adequate data but lack the understanding to interpret it. In extreme cases, SNFs are paralyzed by the overabundance of information available. Regardless of the underlying circumstances, skilled nursing organizations frequently struggle to transform data into action that improves performance.

CliftonLarsonAllen (CLA) wants to help skilled nursing organizations use data in a way that drives informed decisions that will positively impact their success. Given the robust data sets available and the technological advances that we have developed, we now have a database that houses the financial and quality metrics of all 15,000+ Medicare certified SNFs in the United States. Through the creation of a number of algorithms applied to this data, we now have more than 800 million data points to inform the industry on trends impacting SNFs and the characteristics of organizations that are top performers in terms of profitability and quality.

Users of benchmark information often want deeper levels of detail than the data can provide. One deeper level of insight we are often asked about relates to the performance of proprietary SNFs — both privately held and publicly traded — in comparison to nonprofit SNFs. The overall assumption in the industry is that proprietary and nonprofit SNFs, in general, have different capital structures, staffing patterns, operating metric expectations, and administrative oversight. SNFs are interested in understanding how those differences impact metrics. While this is merely one of several factors influencing overall performance, we explore this in our interactive webpage that will allow readers to explore proprietary and nonprofit performance within a geographical region.

While benchmarking is a great first step, SNFs often need more. Through a close inspection of a SNF's data and the data of others, a professional with experience in identifying themes can bring this information to life.

A discussion about how a SNF's performance lines up with others in the region with similar characteristics can make the difference between interesting information and a level of analysis that truly drives decisions that will enhance performance.

In response to this need, CLA created a resource called CLA Clarity. It pairs the data we have acquired and our industry experience to deliver unmatched insights that can help you better understand your business and specific areas that you can focus on to improve performance.

> At CLA, our promise is to know you and help you.

Through deep analysis of our database, we have learned that high-performing SNFs have a core set of shared characteristics. By understanding the characteristics of these top performers and comparing your metrics to this subset of SNFs, you can focus your energy on aspects of your operations that can provide the largest economic impact. By focusing on performance in these areas, your organization can create its own pathway to improved performance.

The health care world is fundamentally changing, and we are only at the beginning of the evolution. The regulatory and reimbursement environment will continue to strain the industry, but there are a number of opportunities for innovative SNF providers. By embracing big data, SNFs can demonstrate their value to referral sources in a meaningful way. And by continuously improving outcomes, SNFs can position themselves to provide critical services in a sustainable, profitable manner.

At CLA, our promise is to know you and help you.

We hope you find this *32nd Edition of the Skilled Nursing Facility Cost Comparison* full of useful insights, and we welcome the opportunity to work closer with you to provide the analysis and understanding you need to find your path to improved performance.

Macro trends

As we organized and analyzed the 2016 data, an overarching narrative emerged related to operating difficulties. Hospital behavior is changing, resulting in fewer hospitalizations and thereby fewer skilled nursing admissions. Substitutions of care are driving a larger percentage of hospital discharges towards other sites of service, including home health. Hospitals and Medicare Advantage plans are expecting shorter lengths of stay. Together, these trends are reducing occupancy and profitability nationwide. In addition, workforce shortages and elevated regulatory scrutiny is making it more expensive to operate in the SNF industry. In short, the operating environment for SNFs is difficult, and a growing number of SNFs are approaching insolvency.

CLA believes that, as health reform takes shape and referral sources narrow their post-acute network, there will be a larger standard deviation in the financial results of high performing SNFs and their low performing counterparts. Referral sources will continue to guide a greater percentage of their referrals to high quality, low cost providers with a proven track record of producing good outcomes for their residents. The 2016 data in this report supports this perspective. The current year data shows that the variation in performance is growing wider, with low performing SNFs experiencing substantially lower year-over-year performance metrics when compared to their high performing counterparts. We anticipate this trend to continue as one and two star quality facilities are starved for referrals.

Together, these trends point to the importance of continuous performance improvement. As we look into the future, high performers will continue to attract referrals, which will in turn produce better financial results. Less successful providers will have more substantial struggles from one year to the next, which may ultimately result in the sale or closure of facilities. All providers will have to continue to improve performance — status quo performance will not suffice.

Uses of this publication

The primary purpose of this publication is to provide financial ratio and cost comparison data to CLA's skilled nursing facility clients. In addition, it can assist decision makers in understanding and meeting their responsibilities to residents, assessing their facility operations in comparison to specific benchmarks, and promoting a better understanding of the long-term care field to external viewers, including investors, legislators, and the general public.

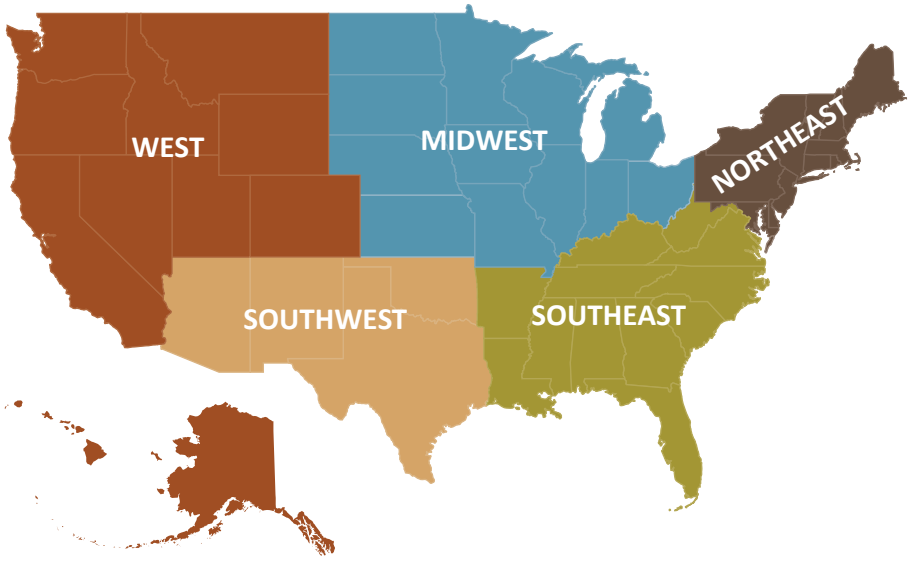
The ratio and cost analyses published in this report can be used on an ongoing basis by decision makers to assist in strategic planning, internal budgeting, and to define, track, and measure financial and operating goals.

> In short, the operating environments for SNFs is difficult, and many SNFs are approaching insolvency.

We organized this document into two sections. Section I presents various ratio analyses depicting the financial and operating condition of the nursing facilities included in their respective geographic region, including the Midwest, Northeast, Southeast, Southwest, and West.

Ratio analyses in Section I are organized into three categories: financial statement indicators, operating indicators, and staffing indicators. Included with each of these ratio analyses is a brief definition of the ratio and a concise commentary on what the results appear to indicate.

Section II presents cost analyses tables, which include a variety of data related to skilled nursing facility cost. The presentation of the per diem cost comparisons and compensated hours analyses is based on each geography and ranked by percentile.



Ratio and cost analyses

Measuring your financial results against industry data is a critical step in the pursuit of operational excellence. Although no two SNFs are exactly alike, this data can spark conversations and further exploration as you seek to understand how your data compares to peer averages, and how you can improve your performance. However, there are limitations to ratio and cost analyses. No ratio or cost comparison should be used alone to assess the financial condition of an organization. Variances from benchmarks should be prioritized, investigated, and reviewed.

Percentile rankings

This publication provides a variety of benchmarks with financial ratios and cost analyses. Each facility's data was ranked numerically and stratified into percentiles. The 75th percentile represents the value at which 75 percent of values are below and 25 percent of values are above. The converse is true of the 25th percentile. The 50th percentile represents the median of the population.

The percentiles are not a judgement of good or bad, but rather they provide a context through which an organization may understand how it performs compared to similar organizations. Also, the higher percentile is not always better. For example, an organization would like to be in the 75th percentile for days cash-on-hand because higher cash balances are desirable, but they would also seek to be in the 25th percentile for days revenue in accounts receivable because lower levels of accounts receivable are preferable.

Financial statement indicators

Valuable insights into a facility's financial condition and operational performance can be gained through analysis of key financial statement indicators.

$$\text{Current Ratio} = \frac{\text{Current Assets}}{\text{Current Liabilities}}$$

Current ratio

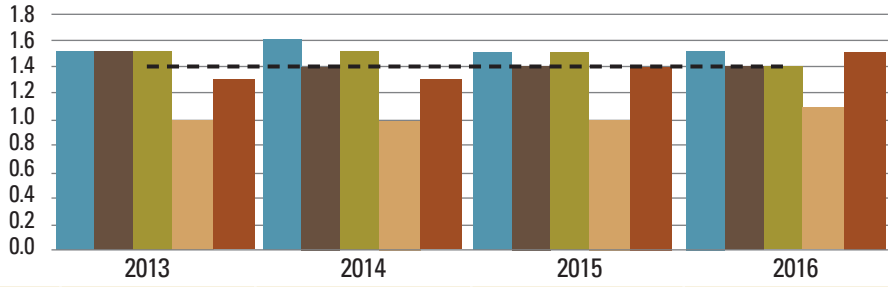
The current ratio measures the liquidity of a facility and is used to determine the degree to which current liabilities are covered by current assets or the ability of a facility to pay short-term obligations as they come due. Current assets consist of a facility's cash and other assets such as accounts receivable, prepaid expenses, and investments that can be easily converted into cash. Current liabilities include accounts payable, accrued expenses, current portion of long-term debt, and other obligations payable within one year.

The higher the current ratio, the greater the ability a facility has in meeting its short-term obligations. A high liquidity must be weighed against the ability of a facility to obtain higher investment earnings by investing in longer-term investments. A ratio of less than 1.0 may represent a severe liquidity problem for a facility. A trend of a decreasing current ratio may provide an early signal that the facility is experiencing financial difficulties.

2016 data perspective

Despite reduced operating results, skilled nursing facilities have maintained consistent current ratios when compared to prior years. This indicates that organizations are preserving cash on the balance sheet to pay for current liabilities, as opposed to providing returns to operators in the form of distributions. The Southwest region continues to experience markedly lower current ratios when compared to other regions in the country, primarily driven by lower occupancy rates.

Median Current Ratio



	2013	2014	2015	2016
Midwest	1.5	1.6	1.5	1.5
Northeast	1.5	1.4	1.4	1.4
Southeast	1.5	1.5	1.5	1.4
Southwest	1.0	1.0	1.0	1.1
West	1.3	1.3	1.4	1.5
National	**1.4**	**1.4**	**1.4**	**1.4**

Totals	Quartiles		
	25th	Median	75th
2013	0.7	1.4	2.5
2014	0.8	1.4	2.6
2015	0.7	1.4	2.6
2016	0.7	1.4	2.6

Source: Centers for Medicare and Medicaid Services (CMS)

Days Revenue in Accounts Receivable = Accounts Receivable / (Resident Revenue/365)

Days revenue in accounts receivable

This ratio calculates the average number of days that receivables are outstanding, or how quickly a facility converts its receivables to cash.

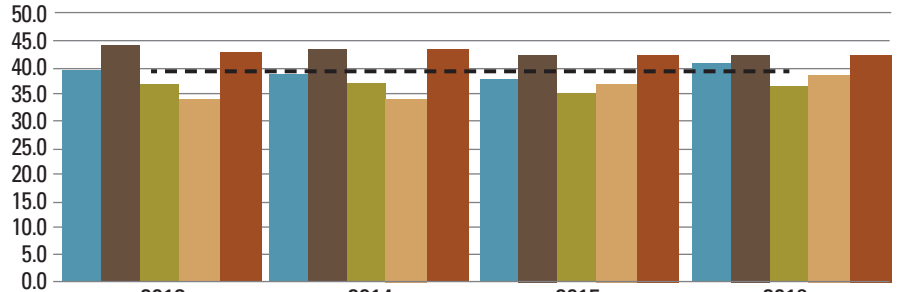
A lower value of days revenue in accounts receivable is desirable, because this suggests a facility takes less time to convert its receivables to cash. Historically, more than 70 percent of resident service revenue is paid by third-party payers who traditionally pay for services following the month of service, so theoretically, a value of approximately 30 days revenue in accounts receivable should be an attainable goal for SNFs.

Improved technology solutions have increased the efficiency of business offices in the collection of third party receivables over the past decade, resulting in many SNFs approaching the 30 days revenue in accounts receivable benchmark. However, as penetration rates of Medicare Advantage plans have increased, the technology improvements have been offset by the complexity of Medicare Advantage billing, and providers have struggled to maintain their days revenue in accounts receivable.

2016 data perspective

For the first time in many years, we are seeing an increase in the days revenue in accounts receivable, with the current value of 39.8. Our client experience has suggested that there are some organizations that have navigated Medicare Advantage billing effectively, where others have struggled. The data supports this, given the lowest performing quartile has seen a 1.3 day increase in this metric over the prior year, while the better performing providers have only experienced a 0.6 day increase.

Median Days in Accounts Receivable



	2013	2014	2015	2016
Midwest	39.7	39.3	38.9	41.2
Northeast	44.5	43.3	42.1	42.7
Southeast	36.9	37.4	36.3	35.5
Southwest	34.8	34.5	37.2	38.0
West	42.5	43.6	42.8	43.0
National	**39.9**	**39.6**	**39.1**	**39.8**

Totals	Quartiles		
	25th	Median	75th
2013	29.9	39.9	52.7
2014	29.6	39.6	52.6
2015	28.8	39.1	52.6
2016	29.4	39.8	53.9

Source: Centers for Medicare and Medicaid Services (CMS)

Days Cash on Hand = $\frac{\text{Cash and Cash Equivalents}}{\text{(Operating Expenses – Depreciation)/365}}$

Days cash on hand

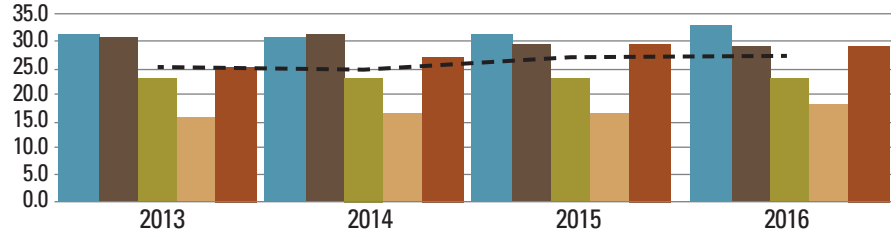
This ratio measures how long cash on hand will cover average expenses.

Similar to the current ratio, a high number of days cash on hand is considered favorable; however, an extremely high ratio may indicate that the facility could earn a higher rate of return by investing in longer-term investments. A cash position of 60+ days is a target, allowing facilities to pay employees and vendors without the worry of when reimbursement from third-party payers will arrive. This ratio is representative of the liquid resources available to cover average daily expenses. The impact of additional investments on hand are excluded from the ratios presented.

2016 data perspective

Despite reduced financial performance, median levels of days cash on hand have increased from prior years. This indicates that providers are increasingly cautious to use cash for capital purchases and owner distributions. While days cash on hand levels nationally have modestly increased, 26.9 days cash on hand continues to be much lower than targeted levels, which highlights the vulnerability of many skilled nursing providers and their month-to-month reliance on operational performance. Of particular concern is the results of the Southwest region, with less than 20 days of operating cash on hand. This likely correlates with their relatively low median occupancy of 71.1 percent. It is also noteworthy that the bottom quartile of performers have less than two weeks of cash on hand, which suggests that these organizations may have recurring concerns about making payroll.

Median Days Cash on Hand



	2013	2014	2015	2016
Midwest	31.9	30.5	31.2	33.1
Northeast	31.3	31.2	29.6	28.5
Southeast	22.9	23.0	23.5	23.1
Southwest	15.5	16.1	16.2	17.4
West	25.4	26.6	29.1	28.3
National	**25.8**	**25.8**	**26.6**	**26.9**

	Quartiles		
Totals	**25th**	**Median**	**75th**
2013	12.2	25.8	65.8
2014	12.3	25.8	63.4
2015	12.8	26.6	64.8
2016	13.1	26.9	66.6

Source: Centers for Medicare and Medicaid Services (CMS)

Debt to Capitalization (Leverage Ratio) = Total Debt / Total Debt + Equity or Net Assets

Debt to capitalization (leverage ratio)

The debt-to-capitalization ratio determines how leveraged a facility is, or its ability to incur additional debt.

A low debt-to-capitalization ratio is generally considered favorable. A facility is considered to be leveraged if its outstanding debt is greater than its net assets or equity. The higher a facility is leveraged, the more difficulty it may have in obtaining additional financing.

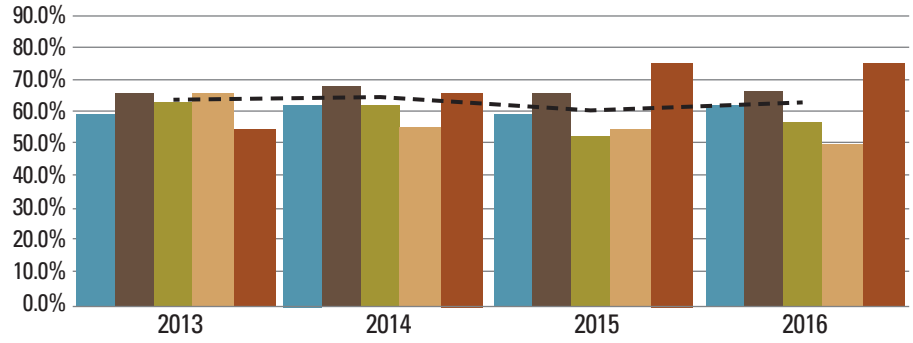
One factor that may impact the ideal debt-to-equity target for an organization is its own cost of capital. In certain instances, providers may benefit from a higher leveraged structure, since the interest expense may be tax deductible, and the cost of capital versus the cost of equity to the owners may yield a preference toward a higher debt load.

Another factor that can affect the analysis of the long-term debt to equity ratio is the age of the facility. If a facility is relatively new or has incurred additional debt for major renovations, it will likely have a higher ratio, since it will have a sizable amount of debt and has not converted the investment in assets into equity. It is important for facilities to evaluate their leverage ratio as they strategically plan their future capital needs.

2016 data perspective

SNFs were more highly leveraged in 2016 than prior years, which suggests that the median facility either secured additional debt, or negative financial performance resulted in reduced equity when compared to the prior year. This ratio highlights the overall sentiment that low performing SNFs are on a significant downward trajectory when compared with their better performing peers. Low performing SNFs have a debt to total capitalization ratio of 107 percent, which is a full four percentage points higher than the prior year. In contrast, high performing SNFs actually have a lower debt to total capitalization ratio. Said differently, low performing SNFs have negative equity, and that deficit is greater in 2016 than it was in 2015. High performing SNFs, on the contrary, experienced a 40 basis point (0.4 percent) decrease in the ratio, which suggests they are better equipped to handle additional debt when compared to the prior year.

Median Debt to Total Capitalization



	2013	2014	2015	2016
Midwest	59.6%	61.2%	59.1%	61.0%
Northeast	64.6%	68.1%	66.6%	67.1%
Southeast	62.9%	61.6%	51.7%	58.2%
Southwest	64.5%	53.5%	53.1%	50.0%
West	53.1%	65.2%	76.9%	75.1%
National	**62.4%**	**63.3%**	**60.8%**	**63.3%**

Totals	Quartiles		
	25th	Median	75th
2013	18.4%	62.4%	100.7%
2014	17.6%	63.3%	101.9%
2015	17.2%	60.8%	103.0%
2016	16.8%	63.3%	107.0%

Source: Centers for Medicare and Medicaid Services (CMS)

Average Age of Plant = Accumulated Depreciation / Depreciation Expense

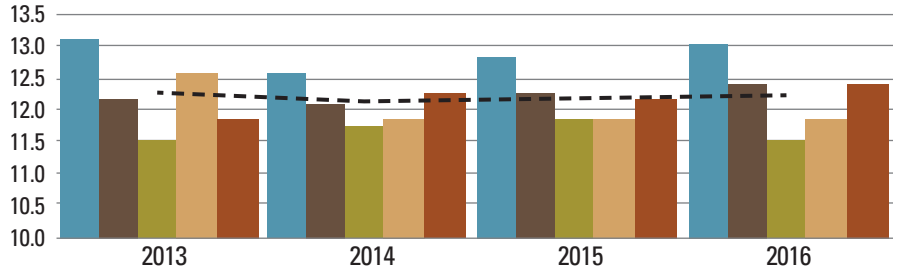
Average age of plant

This ratio measures the average age of a facility by estimating the number of years depreciation that have already been realized for a facility by dividing accumulated depreciation by depreciation expense.

A lower value indicates a newer facility or that a major remodeling project was recently completed. A higher value may indicate that a facility may be in need of remodeling or renovation and that the facility should be evaluating its current level of reinvestment and financing options for fixed asset replacements. This ratio should be analyzed in relation to the liquidity and operating margins. This is important because organizations can, at times, improve their days cash-on-hand by deferring capital improvements.

As a SNF positions itself for success in the future, it is critical to consider the changing expectations of the post-acute consumer. Higher margin residents tend to be rehabilitation short-stay residents, and the median age of those individuals is clearly lower than traditional long-stay residents. Therefore, if a SNF is going to remain relevant, it will need to cater to the expectations of a younger resident, which may require a facility to invest in a renovation.

Median Average Age of Plant



	2013	2014	2015	2016
Midwest	13.1	12.6	12.8	13.0
Northeast	12.2	12.1	12.3	12.4
Southeast	11.5	11.7	11.8	11.5
Southwest	12.1	11.8	11.8	11.8
West	11.8	12.3	12.2	12.4
National	**12.3**	**12.2**	**12.3**	**12.3**

	Quartiles		
Totals	**25th**	**Median**	**75th**
2013	9.4	12.3	15.7
2014	9.5	12.2	15.7
2015	9.3	12.3	15.9
2016	9.5	12.3	15.9

Source: Centers for Medicare and Medicaid Services (CMS)

Capital Spending Ratio = Capital Purchases / Operating Revenues

Capital spending ratio

The capital spending ratio measures the capital spending of a facility in relation to annual operating revenues. This ratio indicates how aggressively a facility re-invests revenue into its facility.

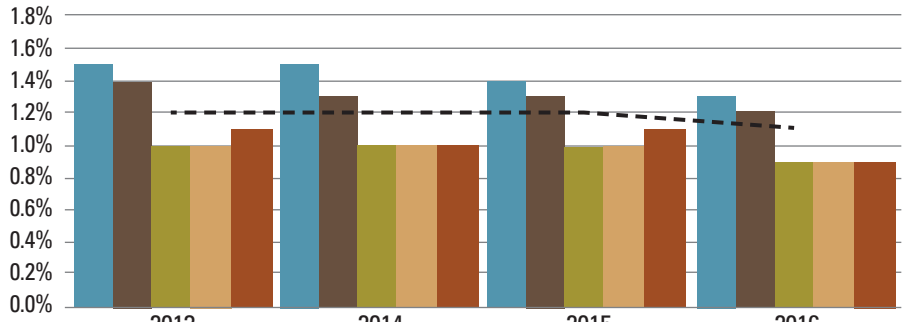
Similar to the age of plant indicator, a lower ratio can indicate a newer facility or that a major remodeling project was recently completed, and therefore routine capital purchases were unnecessary. A higher value may indicate that a facility may be in the need of larger capital improvements. This ratio should be analyzed in relation to the liquidity and operating margins to determine the appropriate level of capital investment that should go back into the facility.

2016 data perspective

The 75th percentile SNFs reinvest four times more of their revenue into their facilities than 25th percentile SNFs. As resident preferences evolve, it is expected that some facilities will simply be undesirable to the post-acute consumer, which will impact admissions, occupancy, and ultimately financial performance.

> The 75th percentile SNFs reinvest four times more of their revenue into their facilities than the 25th percentile SNFs.

Median Capital Spending as a Percentage of Operating Revenues



	2013	2014	2015	2016
Midwest	1.5%	1.5%	1.4%	1.3%
Northeast	1.4%	1.3%	1.3%	1.2%
Southeast	1.0%	1.0%	1.0%	0.9%
Southwest	1.0%	1.0%	1.0%	0.9%
West	1.1%	1.0%	1.1%	0.9%
National	**1.2%**	**1.2%**	**1.2%**	**1.1%**

	Quartiles		
Totals	**25th**	**Median**	**75th**
2013	0.6%	1.2%	2.6%
2014	0.6%	1.2%	2.6%
2015	0.6%	1.2%	2.5%
2016	0.6%	1.1%	2.4%

Source: Centers for Medicare and Medicaid Services (CMS)

Net Margin Ratio = Net Income (Loss) or Charge in Unrestricted Net Assets / Total Revenue

Net margin ratio

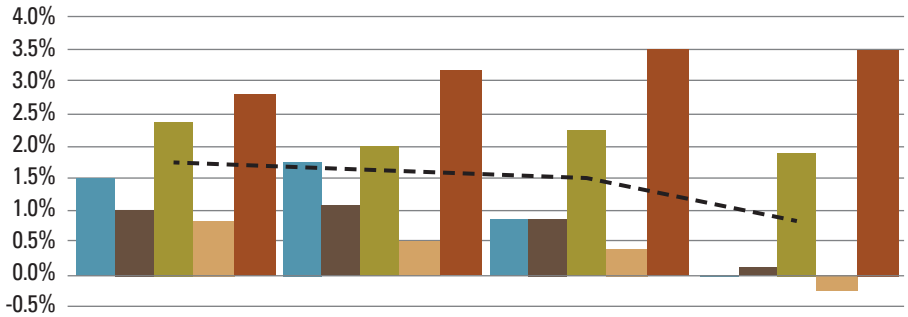
The net margin ratio measures a facility's efficiency in controlling costs in relation to its total revenue. This profitability measure is calculated by comparing a facility's net income or loss to its total revenue.

The ability of an organization to maintain its net margin ratio is vital to its long-term sustainability. With challenges in reimbursement levels and occupancy, this has often been accomplished through controlling expenses. While frugality is important, it is also critical to seek out a payor mix that is financially sustainable.

2016 data perspective

Changes in referral patterns are favoring high performing facilities at the expense of lower performing SNFs. This trend is evident in the substantial decline in the 25th percentile SNFs' net margin. The 130 basis point drop in net margins is staggering when compared to the 40 basis point decrease in 75th percentile SNFs. The increased variation in profitability supports our assertion that referral patterns are changing — a greater number of referrals to a smaller number of providers. If this trend continues at this rate — even for the next few years — the result could be consolidation, changes of ownership, and the emergence of two distinct categories of SNFs: one that receives the bulk of post-acute short-stays, and another that serves primarily long-term residents at a lower cost structure.

Median Net Margin



	2013	2014	2015	2016
Midwest	1.5%	1.7%	0.8%	0.0%
Northeast	1.0%	1.1%	0.8%	0.1%
Southeast	2.4%	2.0%	2.3%	1.9%
Southwest	0.8%	0.5%	0.4%	-0.2%
West	2.7%	3.2%	3.5%	3.5%
National	**1.7%**	**1.6%**	**1.5%**	**0.8%**

Totals	Quartiles		
	25th	Median	75th
2013	-3.3%	1.7%	6.5%
2014	-3.4%	1.6%	6.3%
2015	-3.8%	1.5%	6.2%
2016	-5.1%	0.8%	5.8%

Source: Centers for Medicare and Medicaid Services (CMS)

Operating Margin = Net Operating Income (Loss) / Operating Revenue

Operating margin

The operating margin measures the profitability of a facility by comparing a facility's net operating income or loss to its operating revenue. This ratio represents the profitability of a facility's operations from its primary revenue sources, as it excludes contribution and investment income.

Similar to the net margin ratio, the ability to maintain operating margins is vital for long-term sustainability. The ratio, however, excludes the impacts of non-operating revenues and expenses and focuses on those that are directly related to operations of the organization.

2016 data perspective

Consistent with the net margin ratio reported above, lower performing SNFs are clearly struggling compared to higher performing peers. Again, this supports the premise that, as the SNF environment evolves and becomes more complicated, organizations that respond nimbly to the changes will secure referrals and promote financial success. Of particular concern is that the median operating margin is now 0.5 percent, which is less than half of the 1.2 percent median performance of just one year ago. If this trend continues, the median SNF will experience negative operating margins in 2017.

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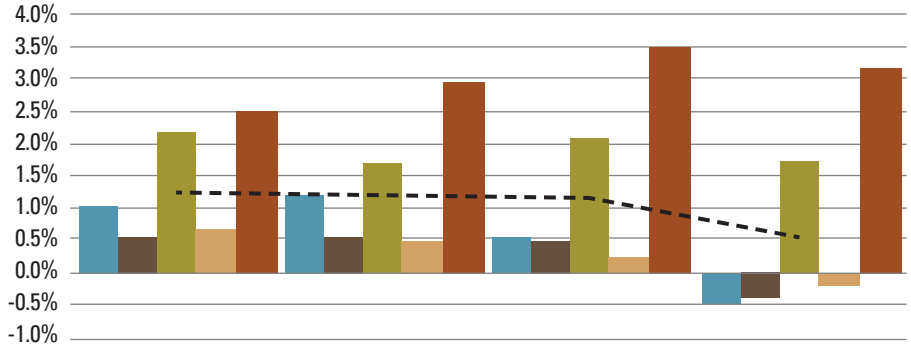
Median Operating Margin



	2013	2014	2015	2016
Midwest	1.0%	1.2%	0.5%	-0.5%
Northeast	0.5%	0.5%	0.4%	-0.4%
Southeast	2.2%	1.7%	2.1%	1.7%
Southwest	0.6%	0.4%	0.2%	-0.2%
West	2.5%	2.9%	3.5%	3.1%
National	**1.3%**	**1.3%**	**1.2%**	**0.5%**

Totals	Quartiles		
	25th	Median	75th
2013	-3.8%	1.3%	6.0%
2014	-3.8%	1.3%	6.0%
2015	-4.1%	1.2%	5.9%
2016	-5.5%	0.5%	5.4%

Source: Centers for Medicare and Medicaid Services (CMS)

EBITDA = Net Income (Loss) or Change in Unrestricted Net Assets + Assets + Interest Expense + Taxes + Depreciation Expense + Amortization Expense / Total Revenue

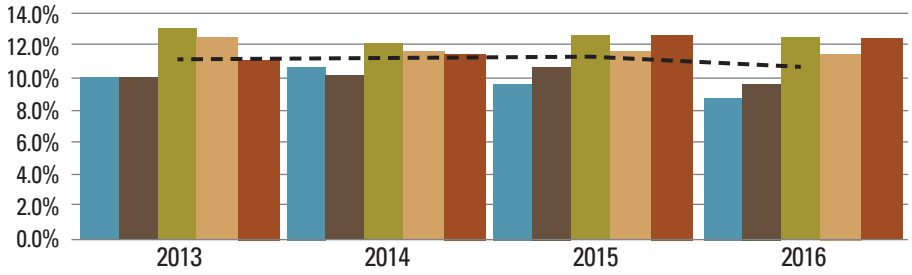
EBITDA

Earnings before interest, taxes, depreciation, and amortization (EBITDA) is a commonly used profitability measure because it eliminates non-interest and capital-related costs. EBITDA is a rough measurement of cash flow for skilled nursing providers, so measuring changes in this ratio provides a sense for how providers are generating cash relative to prior years.

2016 data perspective

From 2013 to 2015, the national average for EBITDA was steady at 11.1 percent. In 2016, this ratio decreased by 50 basis points to 10.6 percent, indicating that the multitude of challenges facing the industry are beginning to negatively impact operating margins and cash flow. Similar to our observations on occupancy levels, the high-performing skilled nursing facilities are experiencing a less dramatic decrease in EBITDA than low-performing facilities. Organizations in the 75th percentile experienced a modest 20 basis point reduction in EBITDA in 2016, when compared to a 90 basis point reduction for 25th percentile performers.

Median Earnings Before Interest, Depreciation, and Amortization



	2013	2014	2015	2016
Midwest	10.0%	10.4%	9.7%	8.8%
Northeast	10.0%	10.1%	10.5%	9.7%
Southeast	12.7%	12.0%	12.4%	12.2%
Southwest	12.1%	11.6%	11.8%	11.6%
West	11.2%	11.5%	12.4%	12.2%
National	**11.1%**	**11.1%**	**11.1%**	**10.6%**

Totals	Quartiles		
	25th	Median	75th
2013	5.5%	11.1%	16.5%
2014	5.6%	11.1%	16.5%
2015	5.5%	11.1%	16.5%
2016	4.6%	10.6%	16.3%

Source: Centers for Medicare and Medicaid Services (CMS)

Debt Service Coverage Ratio = $\frac{\text{Net Income (Loss) or Change in Unrestricted Net Assets + Depreciation Expense + Amortization Expense + Interest Expense}}{\text{Principal Payments + Interest Expense}}$

Debt service coverage ratio

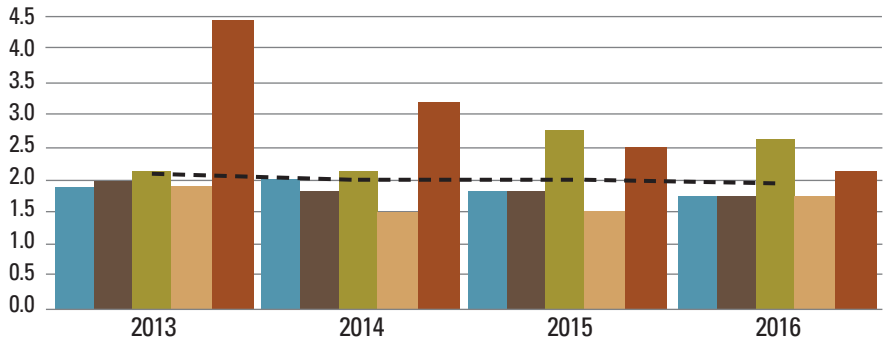
The debt service coverage ratio measures a facility's ability to meet its annual debt payments by dividing its net income available for debt service by its annual debt service requirements.

Similar to the long-term debt to equity ratio, the debt service coverage ratio is an indicator used by lenders to determine an organization's ability to incur additional financing or service its existing debt.

2016 data perspective

Debt service coverage is a common ratio that lenders require when negotiating in funding transactions. Nationally, this ratio decreased from 2.0 to 1.9 in 2016, indicating that the operating strain providers are experiencing is reducing operating margins necessary to fund capital requirements. Reductions in this margin highlight the need for providers to manage operating costs and service outstanding debt obligations given the capital-intense nature of the skilled nursing environment. We believe that the debt service coverage ratio will continue to be a critical ratio for organizations to measure, because low levels will contribute to an organization's inability to access additional capital. Without access to capital, the facility may become less attractive than competitors, which can impact occupancy and exacerbate the financial strain.

Median Debt Service Coverage



	2013	2014	2015	2016
Midwest	1.9	2.0	1.8	1.7
Northeast	2.0	1.8	1.8	1.7
Southeast	2.1	2.1	2.7	2.6
Southwest	1.9	1.5	1.5	1.7
West	4.4	3.2	2.5	2.2
National	**2.1**	**2.0**	**2.0**	**1.9**

Totals	Quartiles		
	25th	Median	75th
2013	1.0	2.1	5.8
2014	0.9	2.0	6.0
2015	0.9	2.0	5.7
2016	0.8	1.9	5.8

Source: Centers for Medicare and Medicaid Services (CMS)

Operating indicators

While assessing financial ratios is important, understanding the operational metrics that create the financial results of your SNF is equally significant. Clearly, occupancy and payor mix are the primary drivers of revenue for a SNF, and these metrics are largely impacted by referral source activity. As margins shrink, SNFs must actively manage their business in a manner that balances cost control and quality outcomes. Several factors impact personnel spending decisions, which account for more than 50 percent of total cash expenses for SNFs nationwide.

One factor that is of great concern to SNF providers is the workforce shortage. Providers are struggling to recruit and retain talent, and wage pressure is a primary consideration for many providers seeking to fill open positions. A SNF's five-star rating is influenced by staffing ratios, so providers are under constant pressure to achieve and maintain the staffing model that economically provides them with the five-star staffing measures they are seeking. In summary, operating metrics create the financial metrics of a SNF, so monitoring your operating measures in comparison to peers is critical to attaining the financial results you are seeking.

> Monitoring your operating measures in comparison to peers is critical to attaining the financial results you are seeking.

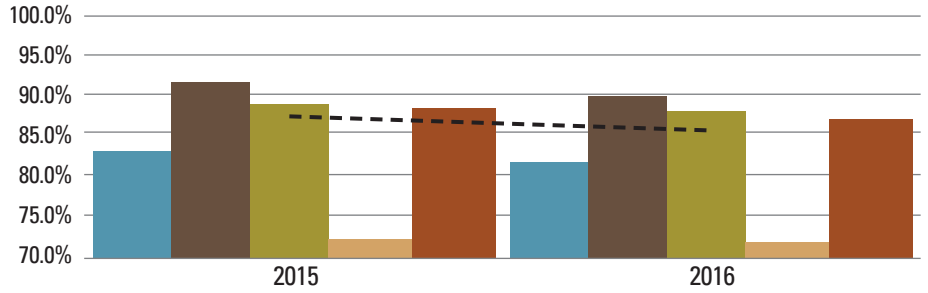
Occupancy Percentage = Resident Days / Facility Beds x 365

Occupancy percentage

2016 data perspective

As health care payment transitions to value-based reimbursement, physicians and hospitals are beginning to embrace care protocols that reduce overall health care spending. Such efforts are not only reducing per capita hospitalizations, but they are also resulting in substitutions for post-acute care. These influences, along with the increased proliferation of managed care, are reducing skilled nursing facility admissions and average length of stays. In just one year, our data indicates a 120 basis point reduction in occupancy, which is one of a myriad of factors creating financial challenges for many SNFs. Reduced occupancy is impacting all regions of the United States, and the overall occupancy median is now at 85 percent. As post-acute networks solidify, we expected to see greater variance in occupancy rates as some providers retain a larger percentage of post-acute discharges from hospitals. The data indicates that this is beginning to occur, as the 25th percentile experienced a 170 basis point reduction in occupancy, while the 75th percentile only experienced a 50 basis point decline in occupancy levels.

Median Occupancy Percentage



	2015	2016
Midwest	83.0%	81.6%
Northeast	90.5%	89.8%
Southeast	87.9%	87.5%
Southwest	71.4%	71.1%
West	87.5%	87.2%
National	**86.2%**	**85.0%**

Totals	Quartiles		
	25th	Median	75th
2015	75.5%	86.2%	92.1%
2016	73.8%	85.0%	91.6%

Source: Centers for Medicare and Medicaid Services (CMS)

Average Pay Mix = Resident Day Mix / Total Resident Days

Payor mix

The average payor mix measures the percentage of resident days paid by various third-party payers.

2016 data perspective

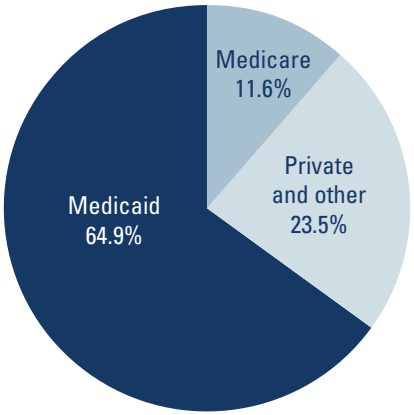
In 2016, 11.2 percent of SNF days were paid by the Medicare program, which is 0.4 percent less than 2015. This reduction can be attributed to the surge in Medicare Advantage plans in many markets, and perhaps an uptick in hospitals discharging to other sites of service. Private pay and other payors increased by 0.6 percent to 24.1 percent, which corroborates the shift from traditional Medicare to Medicare Advantage plans. In order to maintain financial solvency in this shift to Medicare Advantage plans, it is important for facilities to ensure they are being paid in accordance with their Medicare Advantage contracts, and that their business office understands the unique billing requirements of each participating plan. State Medicaid programs continue to pay the bulk of SNF days, and Medicaid programs in many states pay at a rate that is lower than operating expenses. Consequently, SNFs with high Medicaid populations often struggle to maintain positive margins, which highlights the need for referral relationships that drive Medicare and Medicare Advantage volumes.

> Medicaid programs in many states pay at a rate that is lower than operating expenses, so SNFs with high Medicaid populations often struggle to maintain positive margins.

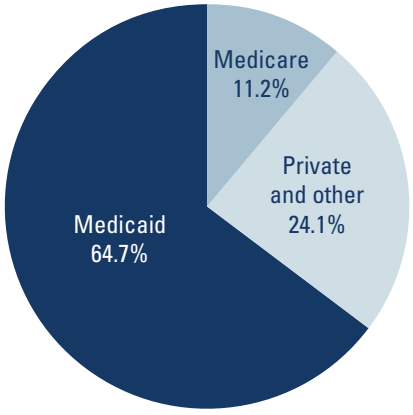
2015 Median Payor Mix by Geographic Area			
	Private and other	Medicaid	Medicare
Midwest	33.6%	56.4%	10.0%
Northeast	19.3%	69.3%	11.4%
Southeast	19.2%	67.1%	13.7%
Southwest	20.4%	68.2%	11.4%
West	22.1%	65.3%	12.6%

2016 Median Payor Mix by Geographic Area			
	Private and other	Medicaid	Medicare
Midwest	34.0%	56.4%	9.6%
Northeast	21.7%	67.0%	11.2%
Southeast	18.9%	68.3%	12.8%
Southwest	21.4%	67.6%	11.0%
West	21.0%	66.1%	12.9%

2015 Median Payor Mix



2016 Median Payor Mix



Source: Centers for Medicare and Medicaid Services (CMS)

Wages Per Compensated Hour = Wages / Compensated Hours

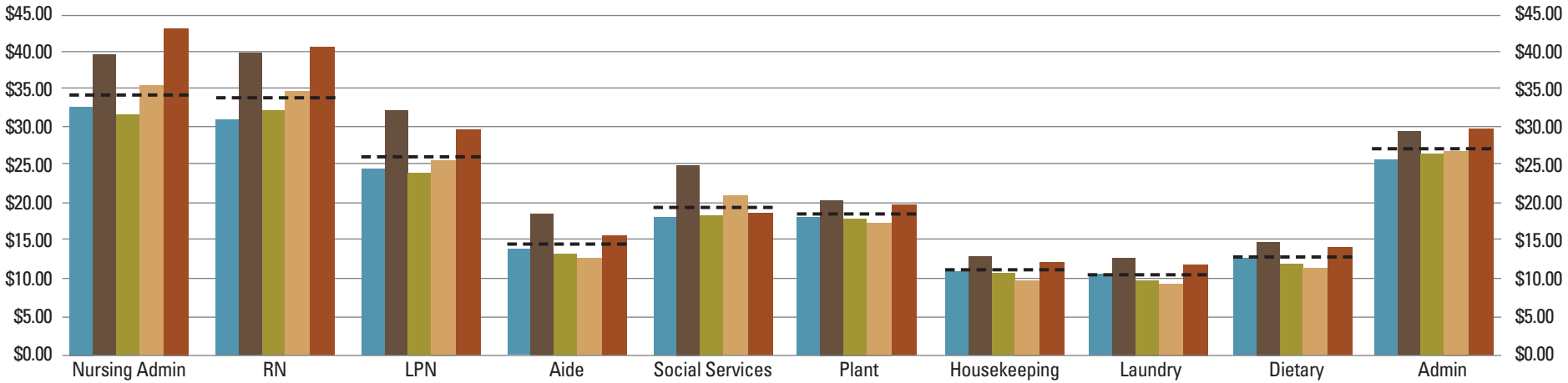
Wages per compensated hour

As discussed above, personnel costs are the primary expense in SNF operations; therefore, it is important to monitor these costs and the factors that affect them.

2016 data perspective

Total median salaries per compensated hour increased by approximately 3.4 percent from the prior year, with the largest increases occurring in the registered nurse (RN) and licensed practical nurse (LPN) categories. Nursing shortages are pushing nursing wage rates at a year-over-year increase of more than 4 percent. Overall wages are higher in the Northeast and West regions, where cost of living tends to be higher. In working with clients throughout the country, we have seen upwards wage pressure for SNFs in states that have enacted higher minimum wage legislation.

Median Salaries Per Compensated Hour



	Nursing Admin	RN	LPN	Aide	Social Services	Plant	Housekeeping	Laundry	Dietary	Admin
Midwest	$32.75	$31.22	$24.65	$14.58	$18.19	$18.04	$10.96	$10.88	$12.15	$25.37
Northeast	$39.04	$39.97	$32.14	$17.99	$24.93	$20.29	$12.72	$12.33	$14.69	$29.12
Southeast	$32.62	$32.69	$24.02	$13.38	$18.77	$17.66	$10.19	$9.60	$11.41	$26.19
Southwest	$35.02	$34.78	$25.05	$12.86	$21.59	$17.12	$9.70	$9.12	$11.02	$26.54
West	$43.66	$40.32	$29.80	$15.87	$18.86	$19.36	$11.83	$11.39	$14.05	$29.26
National	**$34.67**	**$34.49**	**$26.10**	**$14.73**	**$19.72**	**$18.39**	**$10.98**	**$10.70**	**$12.51**	**$26.76**

Source: Centers for Medicare and Medicaid Services (CMS)

Payroll Taxes and Fringe Benefits = Benefits Mix / Total Salary Expense

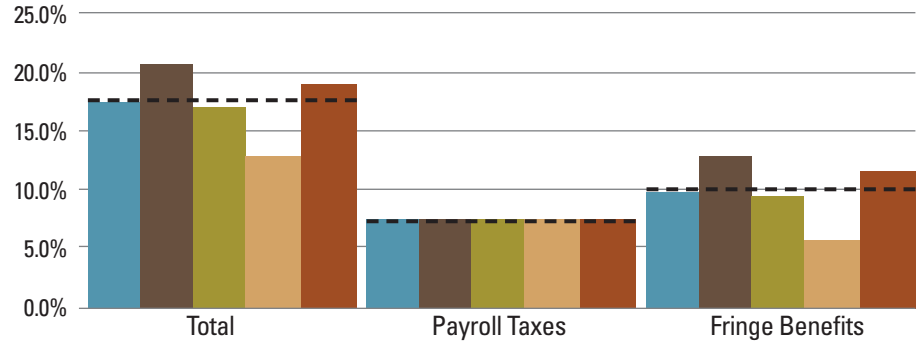
Payroll taxes and fringe benefits

This ratio represents the additional cost of labor associated with payroll taxes and fringe benefits. In addition to direct payroll costs, payroll taxes and fringe benefits are additional costs of labor. Payroll taxes include the nursing facility's share of Federal Insurance Contributions Act (FICA) and unemployment insurance taxes. Fringe benefits include medical, life, and other group insurance; worker's compensation insurance, pension or retirement contributions; uniform allowance; and other miscellaneous employee benefits.

2016 data perspective

While payroll taxes have remained consistent compared to the prior year, the median SNF has reduced fringe benefits by 0.4 percent. The median fringe benefits as a percent of salaries is 10 percent for 2016. As we compare regions across the country, we see that the Southwest region provides significantly less fringe benefits than the remainder of the country (5.5 percent of salaries), where the Northeast and West regions provide a richer benefits package than the national median at 12.9 percent and 11.8 percent, respectively.

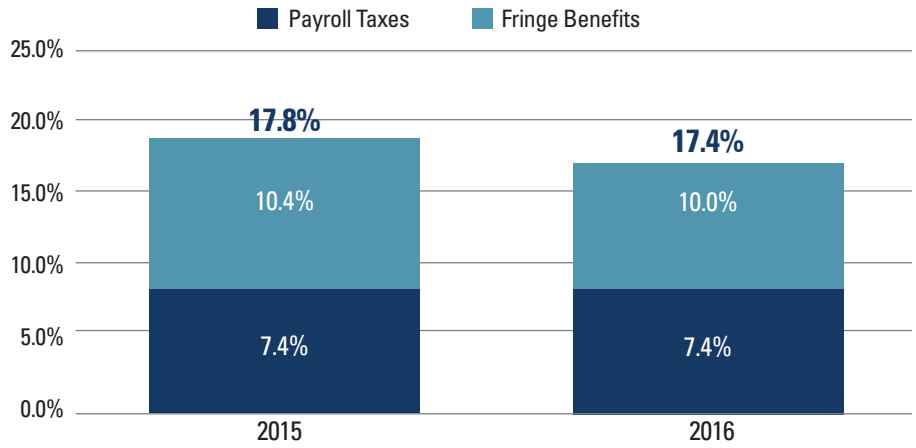
Benefits as a Percentage of Salaries



	Total	Payroll Taxes	Fringe Benefits
Midwest	17.3%	7.4%	9.9%
Northeast	20.3%	7.4%	12.9%
Southeast	17.0%	7.4%	9.6%
Southwest	12.9%	7.4%	5.5%
West	19.2%	7.4%	11.8%
National	**17.4%**	**7.4%**	**10.0%**

Source: Centers for Medicare and Medicaid Services (CMS)

Benefits as a Percentage of Salaries Trend



Source: Centers for Medicare and Medicaid Services (CMS)

Hours Per Resident Day = Compensated Hours / Resident Days

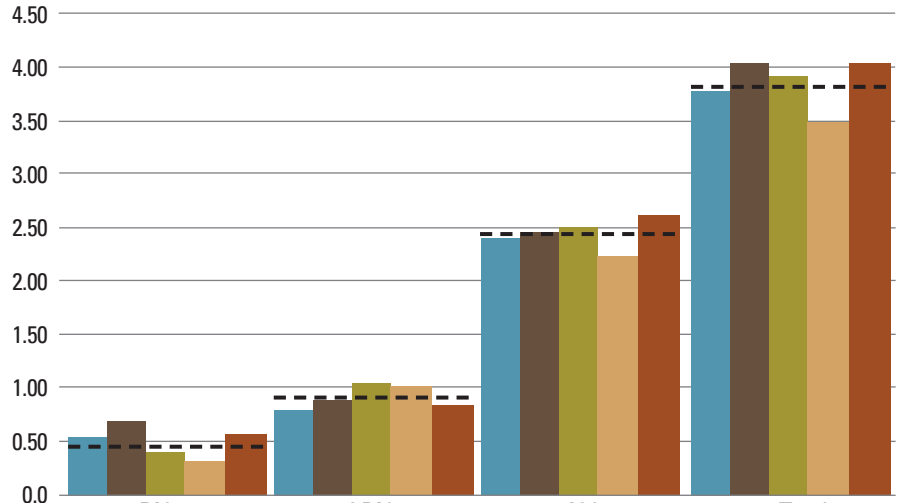
Hours per resident day

This ratio calculates the actual compensated hours paid per resident day.

2016 data perspective

The 2016 medians included in the graphs represent only those facilities that employ individuals in the respective departments. Facilities that contract for services were eliminated in calculating the respective averages. Nursing hours per resident day of 3.87 were consistent with prior year, with only a 0.01 hour decrease in 2016. The mix of nursing hours is also fairly consistent between 2015 and 2016. In fact, nearly all paid hours per resident day are consistent when compared to 2015 values. Only housekeeping and laundry departments experienced a change of greater than 0.03 hours per resident day, with each decreasing by 0.05 hours. The only department that experienced an increase in hours per resident day is the administrative department, which could be a sign that the complexity of the SNF business is requiring greater administrative oversight.

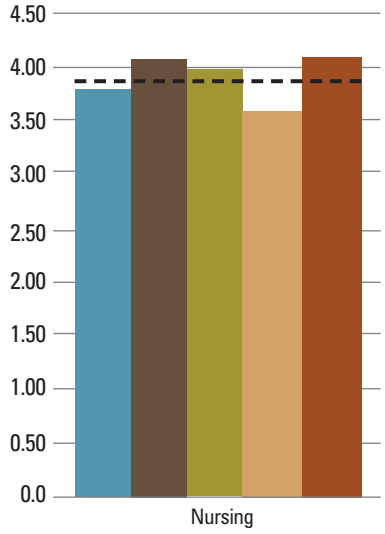
Paid Nursing Hours Per Resident Day



	RN	LPN	Aide	Total
Midwest	0.51	0.78	2.41	3.77
Northeast	0.63	0.86	2.45	4.01
Southeast	0.37	1.03	2.53	3.96
Southwest	0.27	1.00	2.21	3.53
West	0.54	0.87	2.62	4.09
National	**0.47**	**0.90**	**2.45**	**3.87**

Source: Centers for Medicare and Medicaid Services (CMS)

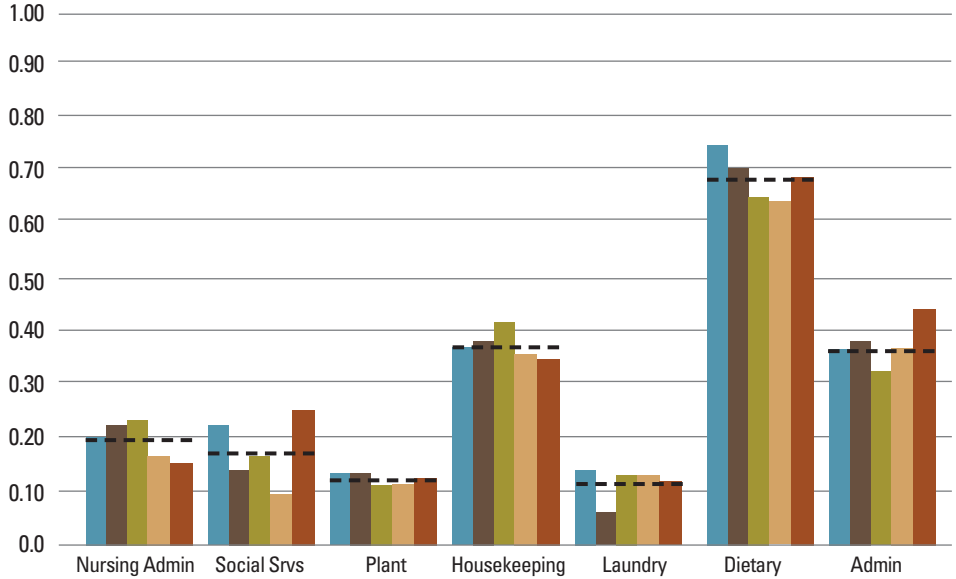
Paid Hours Per Resident Day



	Nursing
Midwest	3.77
Northeast	4.01
Southeast	3.96
Southwest	3.53
West	4.09
National	**3.87**

Source: Centers for Medicare and Medicaid Services (CMS)

Paid Hours Per Resident Day



	Nursing Admin	Social Srvs	Plant	Housekeeping	Laundry	Dietary	Admin
Midwest	0.20	0.21	0.13	0.37	0.14	0.73	0.36
Northeast	0.21	0.13	0.13	0.38	0.06	0.70	0.38
Southeast	0.22	0.16	0.11	0.41	0.13	0.63	0.32
Southwest	0.16	0.09	0.11	0.35	0.13	0.62	0.37
West	0.15	0.25	0.12	0.34	0.11	0.68	0.43
National	**0.19**	**0.17**	**0.12**	**0.37**	**0.12**	**0.68**	**0.36**

Source: Centers for Medicare and Medicaid Services (CMS)

Total Costs Per Resident Day

	Nursing	Social Services	Ancillary Services	Plant	Housekeeping	Laundry	Dietary	Admin	Benefits	Totals
Midwest 25th percentile	$61.66	$2.26	$12.77	$9.07	$4.26	$1.78	$14.94	$30.96	$12.89	$150.58
Midwest 50th percentile	$76.24	$3.95	$18.78	$11.05	$5.37	$2.60	$17.60	$40.71	$18.24	$194.54
Midwest 75th percentile	$95.94	$6.32	$26.90	$13.78	$6.94	$3.55	$21.71	$52.19	$26.00	$253.34
Northeast 25th percentile	$82.91	$2.28	$17.24	$10.14	$5.36	$2.40	$17.23	$42.97	$19.14	$199.67
Northeast 50th percentile	$99.14	$3.37	$23.85	$12.45	$7.09	$3.44	$20.56	$55.02	$26.64	$251.54
Northeast 75th percentile	$120.78	$5.06	$32.18	$16.30	$9.33	$4.58	$25.75	$67.74	$38.90	$320.63
Southeast 25th percentile	$63.01	$1.83	$15.95	$8.58	$4.61	$1.95	$14.65	$36.53	$10.33	$157.44
Southeast 50th percentile	$76.89	$3.00	$22.68	$10.19	$5.63	$2.61	$16.52	$45.60	$15.11	$198.21
Southeast 75th percentile	$93.84	$4.94	$31.23	$12.55	$7.01	$3.28	$19.43	$57.16	$21.74	$251.18
Southwest 25th percentile	$57.19	$1.43	$15.29	$7.66	$3.85	$1.67	$13.28	$27.61	$9.77	$137.75
Southwest 50th percentile	$69.64	$2.11	$22.17	$9.06	$4.61	$2.29	$14.71	$34.99	$11.94	$171.51
Southwest 75th percentile	$86.41	$3.47	$31.69	$11.46	$5.65	$3.05	$17.29	$48.97	$15.73	$223.72
West 25th percentile	$79.18	$3.43	$16.40	$8.81	$4.80	$2.32	$16.23	$50.54	$16.47	$198.20
West 50th percentile	$94.66	$5.12	$24.56	$10.80	$5.97	$3.18	$18.58	$63.62	$22.47	$248.98
West 75th percentile	$115.61	$6.97	$37.95	$13.66	$7.55	$4.23	$22.40	$77.73	$30.94	$317.03
National 25th percentile	$64.93	$2.07	$15.01	$8.84	$4.48	$1.93	$14.97	$34.70	$11.94	$158.86
National 50th percentile	$82.15	$3.48	$21.64	$10.81	$5.64	$2.77	$17.56	$46.23	$18.53	$208.81
National 75th percentile	$103.88	$5.61	$30.98	$13.76	$7.38	$3.72	$21.74	$60.74	$27.39	$275.20

Source: Centers for Medicare and Medicaid Services (CMS)

Salaries Per Resident Day

	Nursing	Social Services	Plant	Housekeeping	Laundry	Dietary	Admin	Totals
Midwest 25th percentile	$54.88	$2.12	$1.68	$2.71	$0.00	$6.99	$6.66	$75.03
Midwest 50th percentile	$67.81	$3.70	$2.34	$4.02	$1.47	$8.88	$8.73	$96.94
Midwest 75th percentile	$85.95	$5.77	$3.31	$5.47	$2.30	$11.46	$11.66	$125.91
Northeast 25th percentile	$72.97	$2.08	$1.91	$0.00	$0.00	$8.20	$7.66	$92.83
Northeast 50th percentile	$88.93	$3.15	$2.62	$4.59	$0.66	$10.45	$10.49	$120.87
Northeast 75th percentile	$105.96	$4.66	$4.03	$6.82	$2.00	$13.25	$15.63	$152.35
Southeast 25th percentile	$56.14	$1.66	$1.46	$0.00	$0.00	$5.57	$6.37	$71.20
Southeast 50th percentile	$67.59	$2.69	$1.94	$4.16	$1.16	$7.10	$8.00	$92.64
Southeast 75th percentile	$80.97	$4.31	$2.62	$5.39	$1.81	$8.80	$10.70	$114.61
Southwest 25th percentile	$52.08	$1.24	$1.37	$0.00	$0.00	$5.68	$7.12	$67.49
Southwest 50th percentile	$61.78	$1.92	$1.85	$3.32	$1.18	$6.94	$9.31	$86.30
Southwest 75th percentile	$77.30	$2.97	$2.50	$4.50	$1.76	$8.50	$12.46	$109.99
West 25th percentile	$70.18	$3.07	$1.68	$0.00	$0.00	$7.92	$9.06	$91.91
West 50th percentile	$84.53	$4.57	$2.34	$4.10	$1.26	$9.58	$12.17	$118.55
West 75th percentile	$103.77	$6.09	$3.42	$5.65	$2.34	$11.64	$17.73	$150.64
National 25th percentile	$57.65	$1.89	$1.60	$0.12	$0.00	$6.47	$6.91	$74.64
National 50th percentile	$72.68	$3.18	$2.21	$4.02	$1.23	$8.51	$9.26	$101.09
National 75th percentile	$91.99	$5.03	$3.18	$5.59	$2.06	$11.13	$12.93	$131.92

Source: Centers for Medicare and Medicaid Services (CMS)

Salaries Per Compensated Hour

	Nursing Admin	RN	LPN	Aides	Total Nursing	Social Services	Plant	Housekeeping	Laundry	Dietary	Admin
Midwest 25th percentile	$28.78	$27.65	$21.71	$12.89	$16.98	$15.30	$15.66	$9.85	$9.58	$10.98	$21.99
Midwest 50th percentile	$32.75	$31.22	$24.65	$14.58	$19.29	$18.19	$18.04	$10.96	$10.88	$12.15	$25.37
Midwest 75th percentile	$37.23	$35.40	$28.01	$16.53	$21.83	$21.61	$20.69	$12.34	$12.58	$13.46	$29.08
Northeast 25th percentile	$32.90	$35.43	$27.45	$16.20	$22.00	$20.75	$17.53	$11.34	$10.99	$13.13	$25.05
Northeast 50th percentile	$39.04	$39.97	$32.14	$17.99	$24.86	$24.93	$20.29	$12.72	$12.33	$14.69	$29.12
Northeast 75th percentile	$45.78	$44.56	$36.15	$20.01	$27.41	$29.43	$23.33	$14.51	$14.51	$16.46	$35.15
Southeast 25th percentile	$28.98	$28.76	$21.49	$11.76	$15.92	$15.63	$15.33	$9.28	$8.69	$10.21	$22.86
Southeast 50th percentile	$32.62	$32.69	$24.02	$13.38	$18.07	$18.77	$17.66	$10.19	$9.60	$11.41	$26.19
Southeast 75th percentile	$36.74	$36.21	$26.86	$14.97	$20.28	$22.24	$20.05	$11.32	$10.89	$12.88	$30.38
Southwest 25th percentile	$31.07	$31.11	$22.82	$11.50	$16.40	$15.87	$14.58	$8.84	$8.42	$10.07	$23.05
Southwest 50thpercentile	$35.02	$34.78	$25.05	$12.86	$18.14	$21.59	$17.12	$9.70	$9.12	$11.02	$26.54
Southwest 75th percentile	$41.68	$39.08	$27.47	$14.33	$20.34	$26.53	$19.83	$10.54	$10.13	$12.36	$30.73
West 25th percentile	$34.82	$35.89	$26.78	$13.97	$19.80	$16.13	$16.81	$10.88	$10.67	$12.69	$25.28
West 50th percentile	$43.66	$40.32	$29.80	$15.87	$22.30	$18.86	$19.36	$11.83	$11.39	$14.05	$29.26
West 75th percentile	$54.20	$44.35	$32.96	$18.12	$25.16	$22.43	$22.37	$13.30	$13.04	$15.56	$34.31
National 25th percentile	$30.12	$29.87	$22.79	$12.79	$17.26	$16.18	$15.87	$9.78	$9.31	$11.00	$23.13
National 50th percentile	$34.67	$34.49	$26.10	$14.73	$19.97	$19.72	$18.39	$10.98	$10.70	$12.51	$26.76
National 75th percentile	$41.54	$39.70	$30.29	$17.22	$23.33	$24.13	$21.22	$12.50	$12.40	$14.32	$31.41

Source: Centers for Medicare and Medicaid Services (CMS)

History and experience

CLA is a professional services firm delivering integrated wealth advisory, outsourcing, audit, tax and consulting services to help enhance our clients' enterprise value and assist them in growing and managing their related personal assets — all the way from startup to succession and beyond. Our professionals are immersed in the industries they serve and have deep knowledge of their operating and regulatory environments. With more than 5,000 people, more than 100 U.S. locations, and a global affiliation, we bring a wide array of services to help clients in all markets, foreign and domestic. *Investment advisory services are offered through CliftonLarsonAllen Wealth Advisors, LLC, an SEC-registered investment advisor.*

CLA serves privately held businesses and their owners, as well as nonprofits and governmental entities. We also serve clients globally as an independent member firm of Nexia International, a top ten worldwide network of separate and independent professional accounting and business advisory firms.

For more information about CLA visit CLAconnect.com.

Our dedication to health care

CLA has developed one of the nation's largest health care practices. Our team includes CPAs and a diverse range of experienced professionals with backgrounds and skill sets ranging from CEOs and CFOs to RNs, certified coders, and certified medical practice executives. We draw upon our diverse backgrounds to develop tailored solutions that will position our clients for success not only today but in the future. We assist our clients in building enterprise value through strategy, operations, finance, and compliance services. Our independent and objective professionals are guided by your strategic vision and your unique environment.

CLA Promise

We promise to know and help you.

CLA exists to create opportunities — for our people, our clients, and our communities. We create opportunities when we live the CLA Promise. We do this by delivering our work in an exceptional manner, caring enough to engage in a personal conversation and really listen to what our clients say, and responding with the full breadth of our firm's capabilities in wealth advisory, outsourcing, and public accounting.

We strive to be thought leaders impacting the future of health care. We accomplish this by never losing sight of our firm's mission of creating impactful interactions for success. This impact comes from our deep, passionate industry professionals that deliver seamless and integrated service capabilities.

Here's what you can expect from CLA:

National and regional relationships

We recognize the importance of supporting health care associations. On an annual basis, we participate in more than 100 health care events at a variety of levels including speaking, exhibiting, and sponsorships. In addition, we regularly contribute articles to trade publications. This level of involvement allows us to thoroughly understand the issues facing the industry and proactively address them.

Our relationships include the following organizations.

AHCA	As gold level members, we support the American Health Care Association (AHCA). Members of our team routinely attend and speak at the annual conference and trade show.
AICPA	Our CPAs are members of the American Institute of Certified Public Accountants (AICPA), and we actively attend the organization's events. We have had professionals sit on the AICPA Health Care Expert Panel as well as serve on the board of directors.
HFMA	We are active members of the Healthcare Financial Management Association (HFMA) and the state chapters in the regions we serve. We regularly attend the conferences and our principals are consistently chosen to present educational sessions. Our professionals have published articles in *Healthcare Financial Management* magazine and serve on the boards of various HFMA state chapters.
HHFMA	Home Care and Hospice Financial Managers Association (HHFMA) was created by the National Association of Home Care & Hospice (NAHC) to meet the growing needs of home care and hospice financial managers and consultants. Our involvement with HHFMA includes participation on the Finance Manager's Workgroup.
LeadingAge	We are a silver partner with LeadingAge. This arrangement offers outstanding opportunities to share knowledge and information that will be passed along directly to our clients. We also support LeadingAge by presenting educational sessions at their conferences and conducting the Executive Compensation Study. In addition, we are active members of the state affiliated associations and conduct benchmarking surveys for many of them.
Lincoln Healthcare	We are sponsor partners of several events facilitated by Lincoln Healthcare, an independent organizer of executive leadership communities in health care. Events include: • Health System 100 for hospital executives • LTC 100 for senior management in long-term care and assisted living • Home Care 100 for home care management • Post Acute 360 for large post acute providers
NAHC	We are involved members of the National Association of Home Care & Hospice (NAHC). We speak at several events annually, and are sponsors of the financial management conference. In addition, we have contributed articles to the association's magazine, *Caring*, and a member of our team has served as the guest editor.
SAHF	CLA is part of the Stewards for Affordable Housing (SAHF) Industry Leadership Circle. As members, we support SAHF's work by providing insight and reflections to advance practice-based policy and develop business and financial innovations within affordable housing.
VNAA	We are platinum partners with the Visiting Nurses Association of America. Our strategic alliance with VNAA will further expand the Center for Value Based Transformation (CVBT) resources to provide professional guidance to executive, financial, and clinical executives in agencies across the country.

Services for senior living providers

Our tailored solutions support the evolving needs of providers who serve older adults.

Due to escalating operating costs, personnel shortages, and changing reimbursement models, senior living providers are being forced to reexamine the way they do business. They need new, more efficient ways to deliver care. New technologies and alternate care models impact the venues in which care is delivered. CLA stays informed about industry trends and the legal, regulatory, and operational environment. We can help position your organization for the challenges and opportunities of tomorrow.

Our clients include skilled nursing facilities, life plan communities, post-acute care networks, homes for the developmentally disabled, assisted living facilities, independent living facilities, home and community-based services, and other long-term care providers.

Services

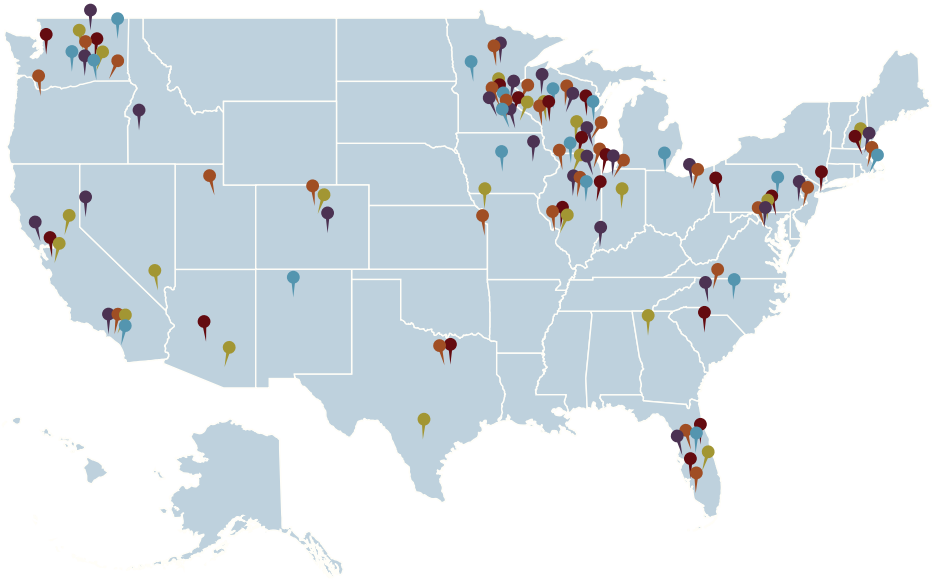
- Wealth advisory
- Outsourcing
- Audit, accounting, reimbursement, and tax
- Information security
- HIPAA compliance
- Benchmarking
- Strategic planning
- Strategic capital planning
- Operations and performance improvement
- Health reform advisory
- Financial feasibility studies
- Market research and analysis
- Marketing and sales consulting
- Mergers, acquisitions, and affiliation facilitation
- Due diligence
- Valuation
- Executive search
- Debt advisory
- Facility master planning services
- Clinical consulting

About CLA

From the beginning, we followed a simple idea: care about our clients, and support the people who serve them.

Serving clients and caring for their needs means that we continuously evolve as their business needs become more sophisticated. We've developed industry specialization with exceptional people who have a passion for honing industry specific skills.

We have more than 100 locations across the United States, with nearly 300 health care team members available to serve you.



Health care regions

If you would like to speak with someone about our health care services, see the list of contacts below.

Southwest	20 East Thomas Road Suite 2300 Phoenix, AZ 85012	Contact: **Chris Abell** Telephone: 602-604-3697 | Fax: 602-266-2907 Email: christine.abell@CLAconnect.com
Carolinas, Georgia	227 West Trade Street Suite 800 Charlotte, NC 28202	Contact: **Jeremy Hicks** Telephone: 704-998-5259 | Fax: 704-998-5250 Email: jeremy.hicks@CLAconnect.com
Florida	420 South Orange Avenue Suite 500 Orlando, FL 32801	Contact: **Sue Bunevich** Telephone: 407-802-1226 | Fax: 407-802-1250 Email: sue.bunevich@CLAconnect.com
Illinois, Indiana, Wisconsin	10700 West Research Drive Suite 200 Milwaukee, WI 53226	Contact: **Michael Peer** Telephone: 414-721-7580 | Fax: 414-476-7286 Email: michael.peer@CLAconnect.com
Massachusetts	300 Crown Colony Drive Suite 310 Quincy, MA 02169	Contact: **Trey Sturtevant** Telephone: 704-998-5230 | Fax: 704-998-5250 Email: trey.sturtevant@CLAconnect.com
Minnesota, Iowa	220 South Sixth Street Suite 300 Minneapolis, MN 55402	Contact: **Cory Rutledge** Telephone: 612-376-4524 | Fax: 612-376-4850 Email: cory.rutledge@CLAconnect.com
Southern Midwest	600 Washington Avenue Suite 1800 St. Louis, MO 63101	Contact: **Josh Wilks** Telephone: 314-925-4309 | Fax: 314-925-4350 Email: joshua.wilks@CLAconnect.com
Pennsylvania, Maryland, Ohio	610 W Germantown Pike Suite 400 Plymouth Meeting, PA 19462	Contact: **Bernadette O'Toole** Telephone: 267-419-1127 | Fax: 215-643-4030 Email: bernadette.otoole@CLAconnect.com
Texas	5001 Spring Valley Road Suite 600W Dallas, TX 75244	Contact: **Mike Siegel** Telephone: 972-383-5741 | Fax: 972-383-5750 Email: michael.siegel@CLAconnect.com
Pacific Northwest	10700 Northup Way Suite 200 Bellevue, WA 98004	Contact: **Dan Frein** Telephone: 425-250-6037 | Fax: 425-250-6050 Email: dan.frein@CLAconnect.com