PA 2018-003

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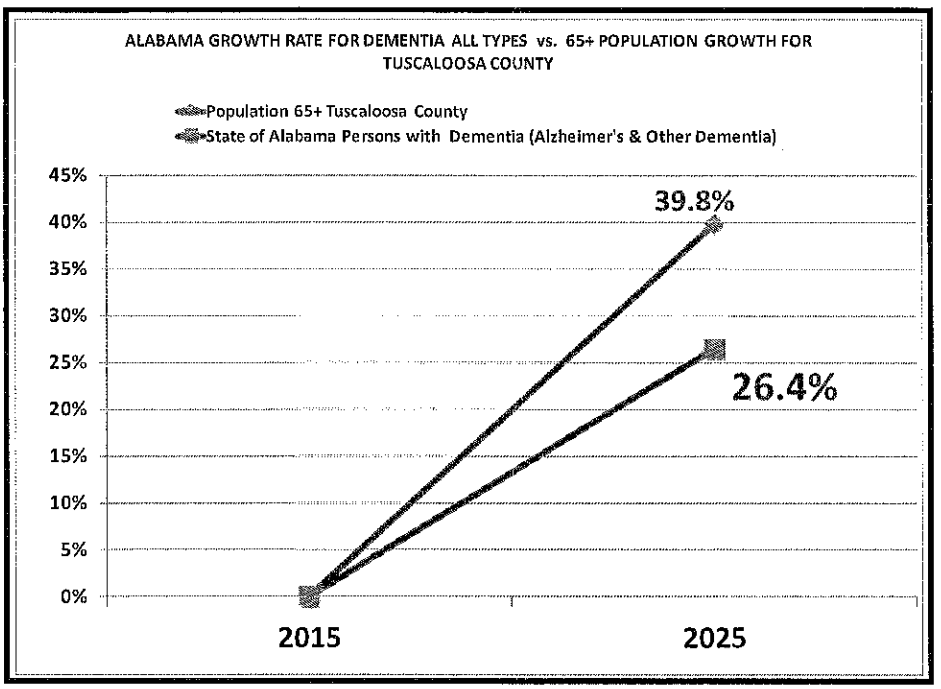
Nov 13 2017
STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

ADJUSTMENT APPLICATION FOR

36 SCALF MEMORY CARE BEDS

BY CONVERSION OF 36 EXISTING ALF BEDS

Alzheimer's is the only top 10 cause of death that cannot be prevented, cured or even slowed.



SUBMITTED BY

Morning Pointe
Senior Living & Memory Care

TUSCALOOSA COUNTY

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Morning Pointe
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GOAL OF ADJUSTMENT

The goal is to provide an adequate supply of SCALF beds to meet demand and to do so within the geographical and financial accessibility of the residents of Tuscaloosa County and the five adjacent counties that do not have SCALF beds (Fayette, Pickens, Green, Hale and Bibb).

SCALF beds located in Tuscaloosa County serve a much larger senior population than just Tuscaloosa County. The State Health Plan indicates a need for 63 SCALF beds in these five counties. There are no SCALF beds in these five counties. Therefore, the seniors in these five counties and their families must look to at least Tuscaloosa County for memory care services.

While the SHCC has approved 30 SCALF beds in 2016 for Tuscaloosa County, such did not fully respond to the lack of 63 beds in adjacent counties and the increasing advance of Alzheimer's and other forms of dementia among the senior population in Tuscaloosa County.

Projections for 2021 suggest 666 to 811 residents in Tuscaloosa County alone will qualify by age, health and income for SCALF services. Due to lack of SCALF beds in adjacent counties, this suggests additional demand from areas outside Tuscaloosa County.

PROPOSED ADJUSTMENT

The Adjustment the SHCC is requested to adopt is as follows:

410-2-4-.04: Limited Care Facilities - Specialty Care Assisted Living Facilities (SCALFs)

9.(e)(i) The SCALF bed need for Tuscaloosa County shall be adjusted to provide for 36 additional SCALF beds through conversion of ALF beds for location in a multi-level senior living community defined as providing existing licensed SCALF beds and, existing licensed Assisted Living beds on a contiguous campus under the same ownership and same management.

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Nov 29 2017
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APPLICANT

Applicant: Morning Pointe of Tuscaloosa (existing licensed ALF and SCALF), which legal name is Tuscaloosa Medical Investors, LLC.

CONTACT INFORMATION

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PROOF OF PUBLICATION:

To Be Provided to SHPDA Under Separate Cover

FEE:

$3,500

WHY IS THIS ADJUSTMENT NEEDED

Five of the keystone reasons why this Adjustment for 36 additional SCALF beds is needed are:

- "CHOICE": To maintain and promote a desirable competitive environment for "Choice" by seniors including residents of Tuscaloosa County and adjacent counties;
- NO BEDS IN FIVE ADJACENT COUNTIES: To partially respond to the seniors residing in the five adjacent counties adjacent to Tuscaloosa County that do not have SCALF beds, but which SHPDA indicates a need for 63 SCALF beds for the seniors of those five counties;
- TUSCALOOSA - REGIONAL MARKET: Tuscaloosa County is a regional drawing area for SCALF residents and families;
- DEMAND INCREASING: Demand for SCALF services is increasing even with recent new supply OF 30 SCALF beds; and
- POPULATION AND ECONOMIC GROWTH IS VERY STRONG: Demand is increasing as fast as the population is increasing, if not faster in Tuscaloosa County, along with strong growth in economic opportunities. The 65+ population is projected to have a growth rate higher than the rate of Alzheimer's for the State of Alabama.

"Choice" for Seniors - Maintain and Promote Desirable Competitive Environment Benefiting Seniors

Seniors expect and deserve a "Choice" among SCALF providers, especially choice involving the factors of quality, cost, access and bed availability. Not all SCALFs are the same and this is reflected in seniors' choices for SCALF services in Tuscaloosa County. This Adjustment is intended to promote "Choice" for seniors residing in Tuscaloosa County as well as residents of the five adjacent counties that do not offer SCALF services.

Forcing seniors to accept a SCALF facility simply because it has empty beds does not benefit seniors and was never the intent of the CON Law. Likewise, seniors have varying economic means that require, if not demand, a range of SCALF facilities having varying economic levels since seniors and their families are the primary payors, not government.

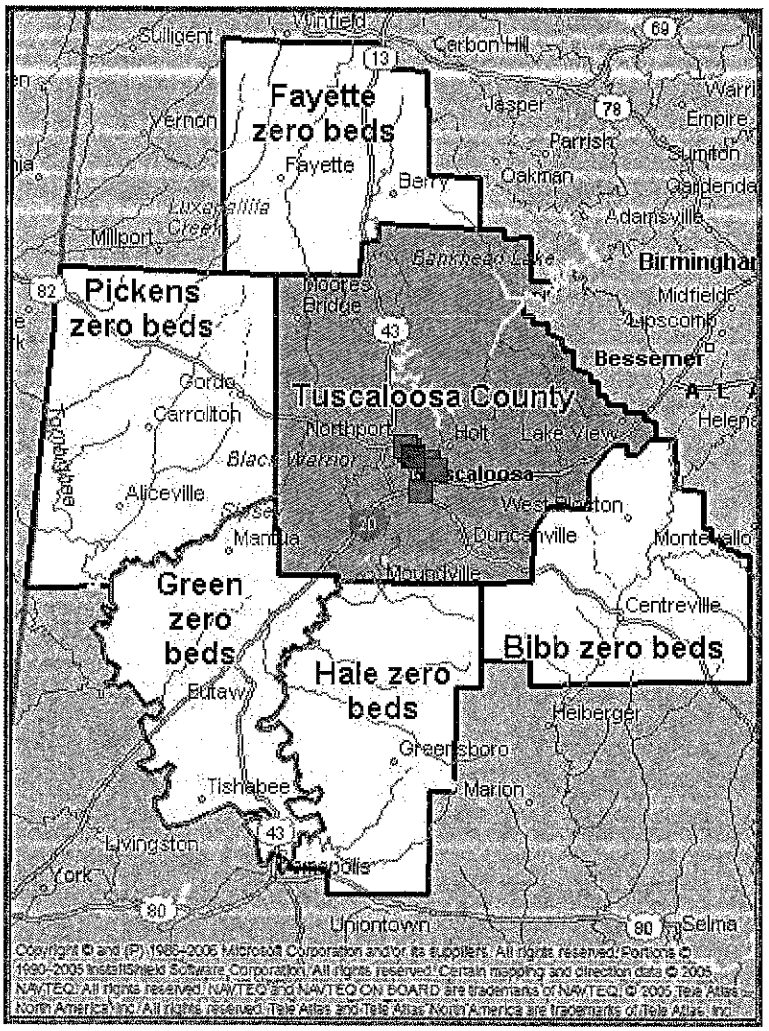
Unlike many other health services, SCALF services are a "CHOICE" by seniors - paid for by seniors and families - and the singular decision of the senior and family without a negative impact on the taxpayers of Alabama.

Five Adjacent Counties Are Without Any SCALF Beds

There are five counties adjacent to Tuscaloosa County that does not have any SCALF beds. These counties are: Bibb; Fayette; Greene; Hale and Pickens. For these five counties, the effective SHP shows a total need for 63 SCALF beds. Since these counties do not have SCALF beds, some of the seniors of these five counties must look to Tuscaloosa County for SCALF beds.

MAP 1 illustrates these five adjacent counties not having any SCALF beds. SHPDA's latest Update indicates a need for 63 beds in these five counties.

MAP 1 ADJACENT COUNTIES NOT HAVING ANY SCALF BEDS FOR SENIOR'S "CHOICE"



Tuscaloosa - A Regional Market For SCALF Services

Tuscaloosa County is a regional market for SCALF services. This fact of being a regional market is not adequately considered by the SCALF Bed Need Methodology for Tuscaloosa County or any other urban county. Being a regional market is attributable to the growth of Tuscaloosa County including expanding economic opportunities for the siblings of seniors who reside in Tuscaloosa County.

Since seniors, spouses and families have "Choice" for SCALF services, Tuscaloosa County can be expected to remain a regional market for SCALF services serving seniors from several counties in Alabama.

Market Demand Increasing

The Market Demand for SCALF services in Tuscaloosa County has been significant historically.

In the last four years, 64 new SCALF beds were licensed with an overall uptick in utilization. Another 30 beds are to come on line at Remembrance Village sometime in 2018. This is illustrated in the following three tables.

Table 1 New SCALF Beds

SCALF	2014 Annual Report	2015 Annual Report	2016 Annual Report	2017 Annual Report	New Beds Operational Last Four Years
Martinview - East	16	16	16	16	16
Brookdale Northport	16	16	AR Not Filed	16	16
Morning Pointe	24	24	24	24	
Traditions Way	16	16	16	16	
Remembrance Village	26	26	26	26	
Tides at Crimson Village	0	0	32	32	32
Totals	98	98	114	130	
New Beds Added On-Line	32		32		64

Note: (1) Red font indicates first year of operation.
Note: (2) Annual Report time period is March 1 through February 28.
Note: (3) The 30 beds approved for Regency not on line in 2017.
Source: Filed Annual Reports

Table 2 Patient Days

SCALF	2014 Annual Report	2015 Annual Report	2016 Annual Report	2017 Annual Report
Martinview - East	3,422	4,396	3,999	5,231
Brookdale Northport	1,467	4,015	AR Not Filed	3,632
Morning Pointe	7,452	5,680	8,152	7,533
Traditions Way	5,768	5,761	5,803	5,685
Remembrance Village	8,315	7,665	7,402	7,429
Tides at Crimson Village			11,712	6,927
Totals	26,424	27,517	37,068	36,437

Note: (1) Red font indicates reported first year of operation.
Source: Filed Annual Reports

Table 3 Occupancy Rates

SCALF	2014 Annual Report	2015 Annual Report	2016 Annual Report	2017 Annual Report
Martinview - East	78%	75%	68%	90%
Brookdale Northport	61%	69%	AR Not Filed	62%
Morning Pointe	85%	65%	93%	86%
Traditions Way	99%	99%	99%	97%
Remembrance Village	88%	81%	78%	78%
Tides at Crimson Village			100%	59%
Occupancy Rate Overall wo Adjustment for Semi-Private Accommodations	89%	77%	89%	77%

Note: (1) Red font indicates first year of operation.
Note: (2) Unadjusted for Semi-Private Beds.
Source: Filed Annual Reports

Note: In the above table, occupancy rates were not adjusted for Semi-Private beds. At times, Semi-Private beds are restricted in use due to sex, family desires and other factors. Semi-Private beds reduce the effective occupancy rate that can be achieved; therefore, occupancy rate can be a less than ideal indicator of utilization when Semi-Private beds are available. However, Semi-Private beds are important to some seniors because of lower costs compared to a Private bed. At Morning Pointe, cost is a major consideration for nearly all of its residents.

Population and Economic Growth - Very Strong

Population and Economic Growth have been and continue to be very strong for Tuscaloosa County. This section addresses population factors, which economic factors are addressed in a separate section.

In reviewing the need of seniors in Tuscaloosa County, population data was obtained from two sources. One source was CBER for the 65+ population. A second source was ESRI, a proprietary independent source many organizations in Alabama use. This second source was made necessary because CBER does not publish projections on the strata of age groups above 65+. Additionally, CBER data could not be adapted for customized geographical areas within Tuscaloosa County, which ESRI data offered. Therefore, for population details on the 65+ population, CBER was not the best source of such data. Where possible, population data from both sources are provided.

Tuscaloosa County - 65+ Population

Looking at the five year increments in 65+ population growth for the time period 2010 to 2025 indicates growth in Tuscaloosa County is projected to well exceed that for the State of Alabama. Most of the growth in 65+ in Tuscaloosa County is projected to occur in the near years of 2015 to 2025 and a lower growth in the far years 2025 to 2040. This indicates a stronger near term demand for SCALF services.

Table 4 Tuscaloosa County 65+ Population

Alabama County Population Aged 65 and Over 2000-2010 and Projections 2015-2040

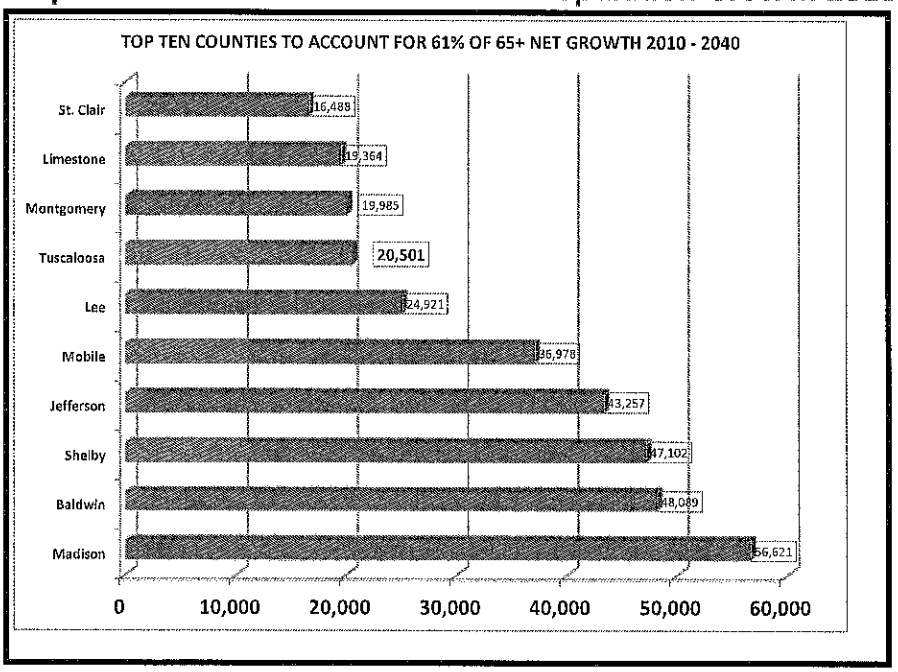
	Census 2000	Census 2010	2015	2020	2025	2030	2035	2040	Change 2010-2040 Number	Change 2010-2040 Percent
POPULATION										
Alabama 65+	579,798	857,792	757,714	877,298	1,010,198	1,118,712	1,169,685	1,201,193	543,401	82.6%
Tuscaloosa County 65+	18,565	21,050	24,691	29,700	34,519	37,863	39,680	41,551	19,985	**94.9%**
POPULATION GROWTH EVERY FIVE YEARS										
Alabama 65+			15.2%	15.8%	15.1%	10.7%	4.6%	2.7%		82.6%
Tuscaloosa County 65+			**17.3%**	**20.3%**	**16.2%**	9.7%	4.8%	4.7%		94.9%
65+ AS PERCENT OF TOTAL POPULATION										
Alabama 65+	13.0%	13.8%	15.4%	17.2%	19.3%	20.8%	21.3%	21.5%		
Tuscaloosa County 65+	11.3%	10.8%	12.0%	13.7%	15.3%	16.2%	16.4%	16.7%		

Note: These projections are driven by population change between Census 2000 and Census 2010. Recent data on births and deaths from the Alabama Department of Public Health are used to derive birth and death rates for the state and each county. Projections were revised in 2014 based on trends in population and development from 2010 to 2013.

Source: U.S. Census Bureau and Center for Business and Economic Research, The University of Alabama, March 2015.

Tuscaloosa County is ranked the 7th most important county in terms of the projected net growth in the 65+ population.

Table 5 Top Ten Alabama Counties For 65+ Population Growth 2010 - 2040



Source: CBER.

Population 65+ - Aged Cohorts

A reputable proprietary database, ESRI, was obtained for five age cohorts within the age group 65+ for Tuscaloosa County, which was narrowed to three age cohorts plus the total 65+. Such age cohorts are not projected by CBER. This data is presented in the following table.

The keystone elements for the time period 2016 to 2021 are:

in the next five years, 6,034 new seniors 65+ are anticipated

the age groups 65+ are projected to increase 23% in the next five years

the age group 65 - 74 is projected to have the largest increase at 24%; and

the age group 75 -84 is projected to experience the next largest increase at 22%.

Table 6 Age Cohorts 65+ By Age

AGE COHORTS
TUSCALOOSA COUNTY

	65 - 74	75 - 84	85+	Total 65+
65+ Population				
2010 Census	11,349	7,185	2,516	21,050
2016 Estimate	15,621	7,985	3,084	26,690
2021 Projection	19,390	9,780	3,554	32,724
Net Change				
2010 - 2016	4,272	800	568	5,640
2016 - 2021	3,769	1,795	470	6,034
Percent Growth				
2010 - 2016	38%	11%	23%	27%
2016 - 2021	**24%**	**22%**	**15%**	**23%**

Source: ESRI Senior Housing Profile

Population 65+ - Aged Cohorts By Sex

In addition to age cohorts, data was obtained by sex for the time period 2016 to 2021, which is presented in the following table. The keystone elements tend to suggest the male population will increase at a rate above that of females; however, females are expected to continue to dominate the 65+ population in each age cohort.

Table 7 Age Cohorts 65+ By Sex

TUSCALOOSA COUNTY				
	65 - 74	**75 - 84**	**85+**	**Total 65+**
2016				
Male	7,260	3,189	1,027	11,476
Female	8,361	4,796	2,057	15,214
2021				
Male	9,015	4,053	1,230	14,298
Female	10,375	5,727	2,324	18,426
Net Change				
Male	1,755	864	203	2,822
Female	2,014	931	267	3,212
Percent Growth				
Male	**24%**	**27%**	**20%**	**25%**
Female	**24%**	**19%**	**13%**	**21%**

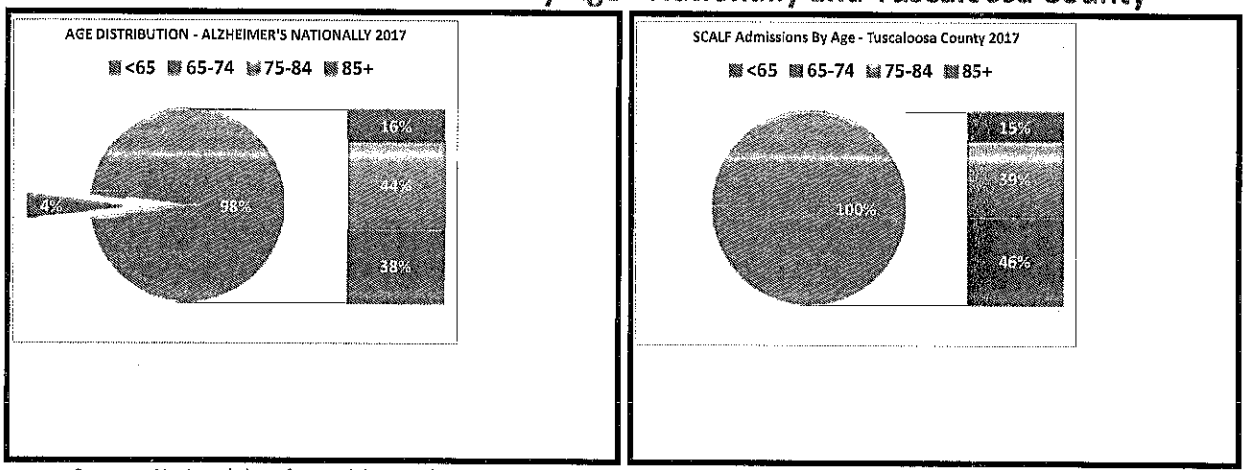
Source: ESRI Senior Housing Profile

Use of SCALFs By Age Group

The following chart on the left shows the national prevalence of Alzheimer's by age cohorts. This shows seniors 65+ are the primary target for Alzheimer's, but that the population below 65 is not immune to early onset. Some reports suggest the below 65 population is increasing in prevalence of Alzheimer's.

The chart on the right shows SCALF admissions by age group in Annual Reports 2017 for Tuscaloosa County. The two charts suggest a higher percentage use of SCALF Services in Tuscaloosa County compared to nationally for the age cohort 85+ years of age and less percentage for the age cohort 75 - 84.

CHART 1 SCALF Distribution By Age - Nationally and Tuscaloosa County



Source: National data from Alzheimer's Association 2017 and Tuscaloosa County data from 2017 Annual Reports filed with SHPDA.

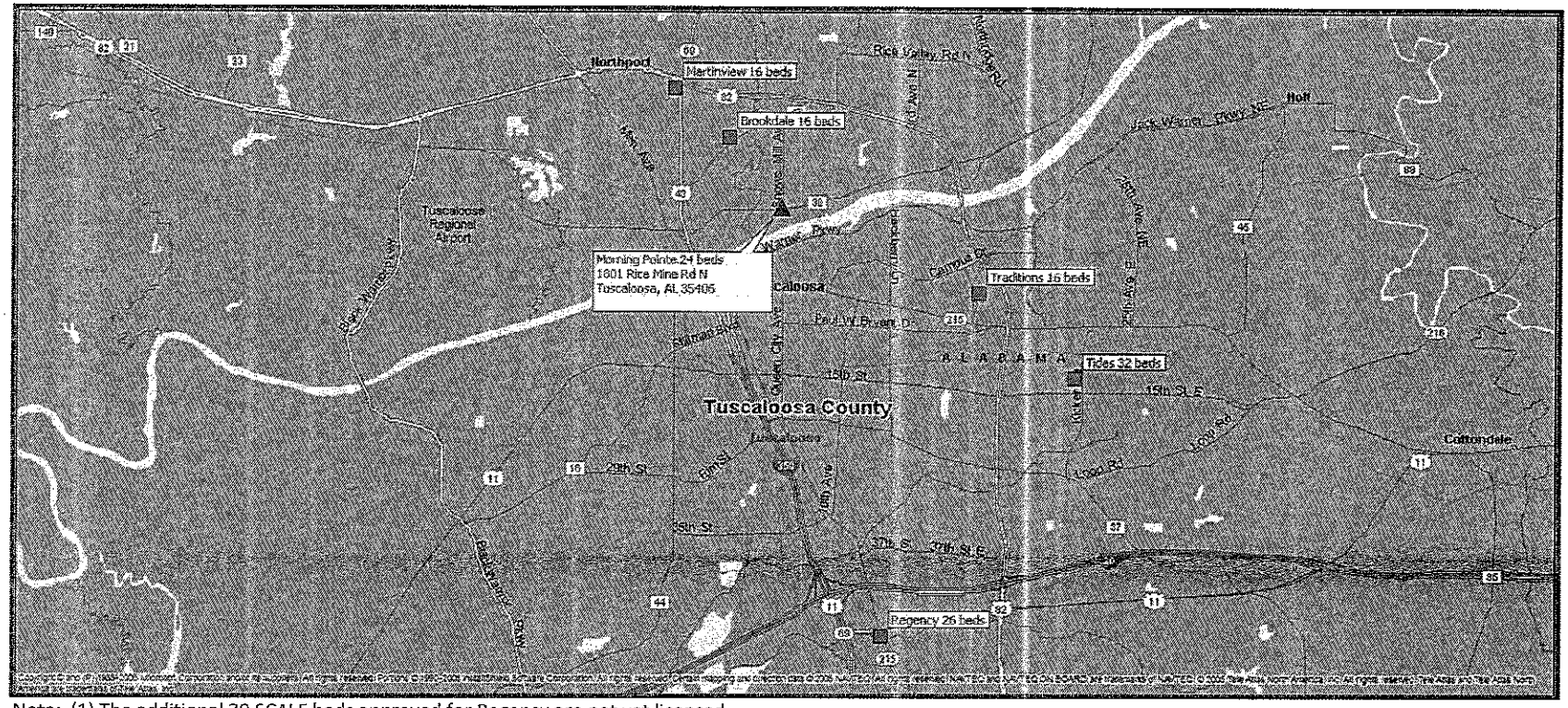
GEOGRAPHICAL AREA FOR PROPOSED ADJUSTMENT

The geographical area for the proposed adjustment is Tuscaloosa County.

MAP OF CURRENT SCALF LOCATIONS & MORNING POINTE OF TUSCALOOSA (SCALF)

A map of licensed SCALF locations is presented below, which also shows the location of Morning Pointe marked by a blue triangle.

MAP 2 CURRENT SCALF LOCATIONS & LOCATION OF MORNING POINTE



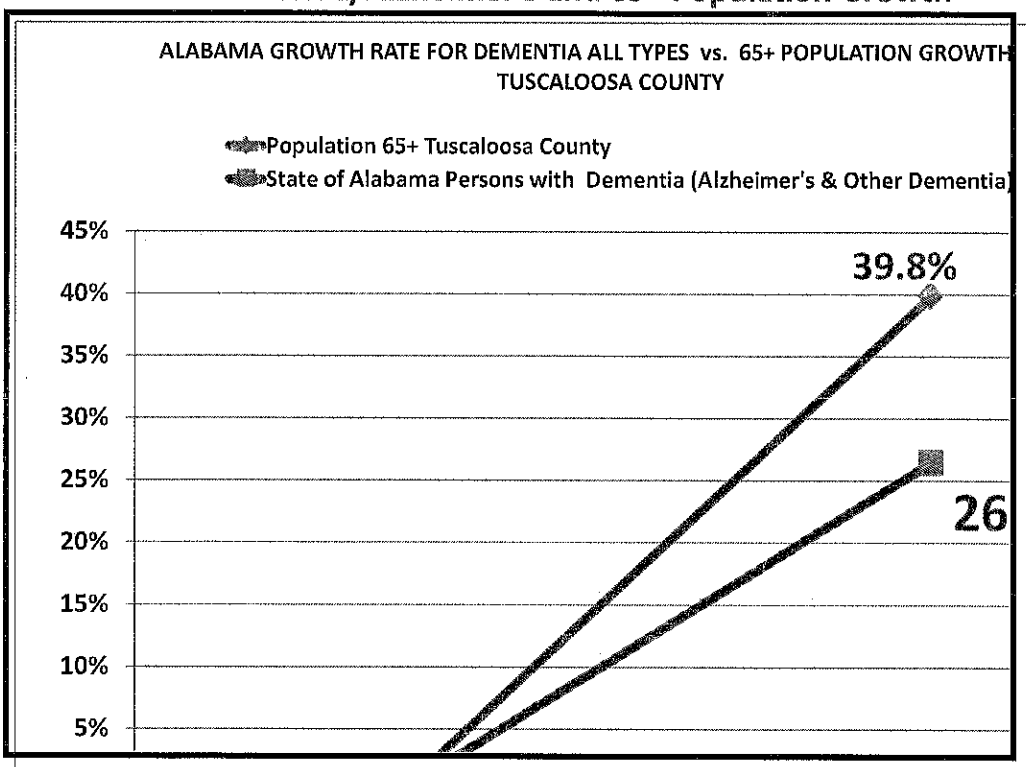
Note: (1) The additional 30 SCALF beds approved for Regency are not yet licensed.

DEMENTIA AND ALZHEIMERS

Dementia and Alzheimer's Compared To 65+ Population Growth

Dementia and the growth in the 65+ population for Tuscaloosa County are anticipated to essentially experience close to the same growth rate between 2015 and 2025. The following chart illustrates the growth rates.

CHART 2 Dementia/Alzheimer's and 65+ Population Growth



Note: Based on population data from CBER and Dementia figures from Alabama Alzheimer's Association.

The above chart shows that the growth of the 65+ population in Tuscaloosa County is projected to be greater than the growth in the number of residents with Alzheimer's and other forms of Dementia. This suggests the growth of Dementia in Tuscaloosa County could be greater than the statewide rate of 26.4% and possibly 39.8% should Dementia increase at the rate of population growth for those 65+.

Dementias - Prevalence

In its 2017 Report, the Alzheimer's Association has updated its Prevalence for Alzheimer's and Dementias. This 2017 Report's part on Prevalence is presented in ATTACHMENT 1 on page 22.

Several of the points in the Report on Prevalence are:

- For Alabama, in the next 8 years, 22,200 more Alabamians are projected to have Alzheimer's bringing the total to 110,000 Alabamians in 2025.
- One in 10 people age 65 and older (10 percent) has Alzheimer's dementia.
- The percentage of people with Alzheimer's dementia increases with age: 3 percent of people age 65-74; 17 percent of people age 75-84; and 32 percent of people age 85 and older have Alzheimer's dementia.
- Of people who have Alzheimer's dementia, 82 percent are age 75 or older.

The full 88 page 2017 Report by the Alzheimer's Association can be found at the web link below. The Report also has a section on the 15,000,000 "unpaid" Caregivers for loved ones with Alzheimer's, which reading is encouraged.

https://www.alz.org/documents_custom/2017-facts-and-figures.pdf

Dementias - Mortality & Morbidity

In its 2017 Report, the Alzheimer's Association also updated its Mortality for Alzheimer's and Dementias. This 2017 Report on Mortality is presented in ATTACHMENT 2 on page 31.

Several of the points in the Report on Mortality are:

- Alzheimer's is the only top 10 cause of death that cannot be prevented, cured or even slowed.
- According to 2014 Medicare claims data, about one-third of all Medicare beneficiaries who die in a given year have been diagnosed with Alzheimer's or another dementia.
- Among people age 70, 61 percent of those with Alzheimer's are expected to die before age 80 compared with 30 percent of people without Alzheimer's.

MORNING POINTE

Morning Pointe of Tuscaloosa is located in the City of Tuscaloosa at 1801 Rice Mine Road North. This location is essentially in the middle of Tuscaloosa and convenient to most, if not all, population components of Tuscaloosa County.

An overhead picture of Morning Pointe is presented on page 19. In Tuscaloosa County there are 12 licensed ALF locations and 6 licensed SCALF locations. A map of the 6 SCALF locations in Tuscaloosa County is presented on page 14.

SCALF - Morning Pointe

The SCALF unit is licensed for 24 beds and is licensed as Morning Pointe of Tuscaloosa Specialty Care Assisted Living Facility. The SCALF Unit has 24 private beds. The SCALF is located at 1801 Rice Mine Road North in the same building as the ALF.

ALF - Morning Pointe

The ALF unit is licensed for 36 beds and is licensed as Morning Pointe of Tuscaloosa. The ALF has 30 rooms of which 24 are private and 6 are semi-private. It is also located at 1801 Rice Mine Road North in the same building as the SCALF. There are 12 semi-private SCALF beds and 24 private SCALF beds for a total of 36 beds. These 36 beds are proposed to be converted to SCALF beds resulting in a 60 bed SCALF facility. With the ALF conversion, the facility would be completely SCALF.

People of Morning Pointe

Over 1,200 people are employed by Morning Pointe in the states of Alabama, Georgia, Indiana,

Kentucky and Tennessee. It is the people of Morning Pointe that serve more than 1,600 residents and their families every day. The people of Morning Pointe's 30+ locations are dedicated to providing services that enhance the wellness, lifestyle and enjoyment of senior living in a caring, secure environment with hospitality and dignity while maintaining quality of life for the Meaningful Days.

Morning Pointe - History

Morning Pointe was founded in 1996 by Greg A. Vital and Franklin Farrow. Morning Pointe and its related company Independent Healthcare Properties, LLC have developed and manage over 30 senior living communities. Morning Pointe operates in five states including Alabama.

Morning Pointe's 2016 Annual Report can be found at:

https://www.morningpointe.com/wp-content/uploads/V5_AnnualReport_web3_May2017.pdf

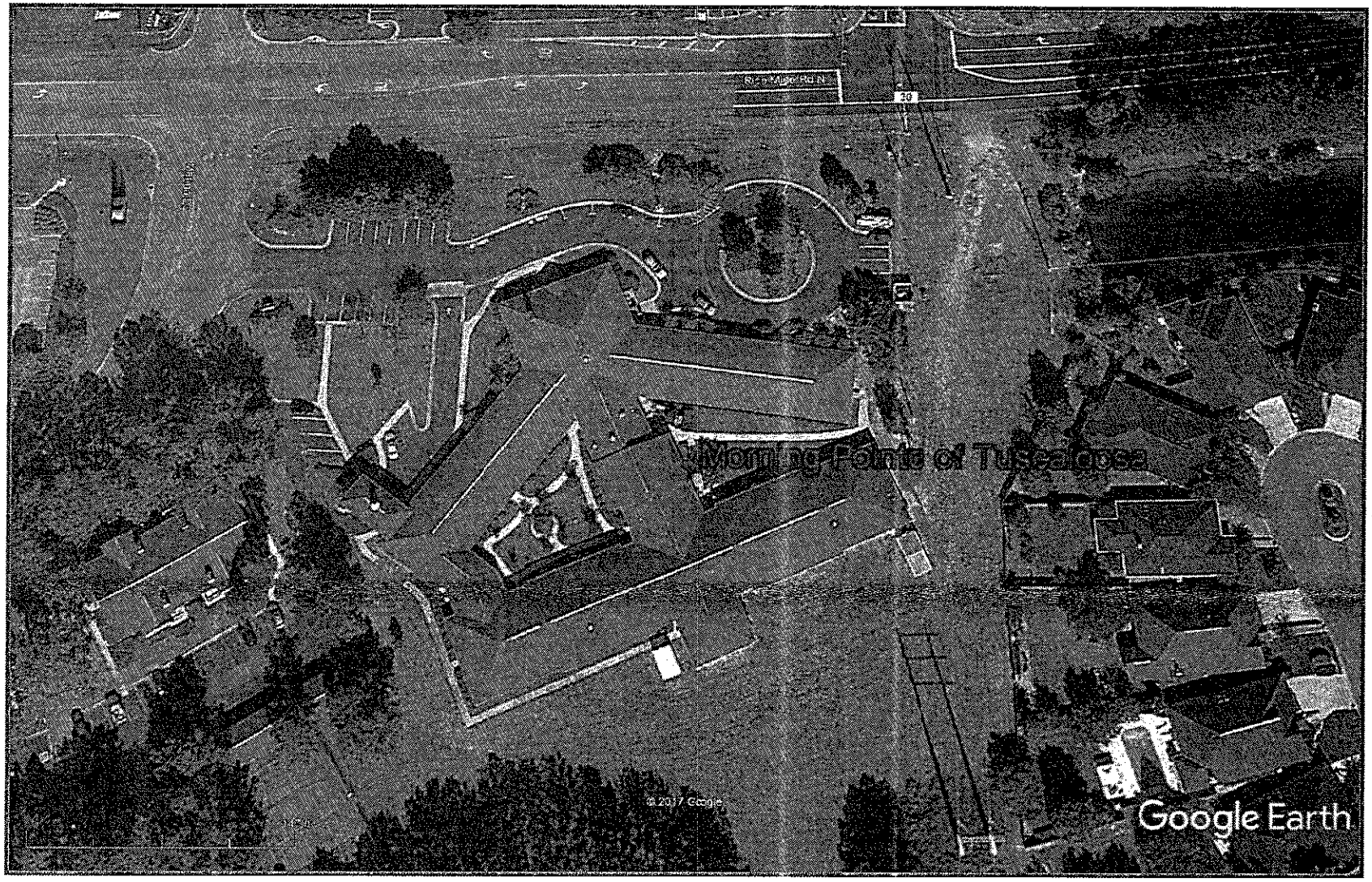
J. FRANKLIN FARROW
Co-Founder, Chief Operating Officer
Morning Pointe & Independent Healthcare Properties, LLC

Franklin Farrow, 42, is co-founder and chief operating officer of Independent Healthcare Properties, LLC (IHP). Farrow has over 18 years of knowledge and experience in real estate development, construction, operations and financing of senior healthcare services. He has been actively involved in the direct supervision and launching of new nursing care and assisted living communities along with development of senior housing campuses in several southern states. Farrow currently oversees the construction, accounting, operations and financing of 23 assisted living communities for IHP. Along side IHP's healthcare investments, he manages several commercial properties and development activities for residential housing and government leases.

Prior to the founding of IHP, Farrow served as director of marketing at Life Care Centers of America, Inc., a long-term care management and development company. Coupled with his IHP responsibilities, Farrow also provides leadership and support to several area non-profit organizations as a board member for the East Tennessee Symphony Orchestra, Samaritan Center, Inc. (a community service organization), Kids In Discipleship, Bible In The Schools board, the board of trustees for Southern Adventist University and the Tennessee advisory board of the Trust for Public Land.

A graduate of Southern Adventist University with Magna Cum Laude honors and a degree in business administration, he is also an alumnus of Leadership Chattanooga. Along with being actively involved in his church, Farrow enjoys triathlons and gentleman's farming. He and his wife, along with two children, have lived in Chattanooga, Tennessee for the past 29 years.

MAP 3 OVERHEAD VIEW OF MORNING POINTE OF TUSCALOOSA



SCALF ANNUAL REPORTS FILED WITH SHPDA

Presented in ATTACHMENT 1 on page 22 is a summary of the Annual Reports filed by Tuscaloosa County SCALF providers to SHPDA for the years 2013 through 2017.

PHYSICIANS COMMITTED TO PRACTICE IN AREA

Tuscaloosa County is fortunate to have an excellent foundation of physicians. This includes physicians that visit residents today at Morning Pointe as well as at other ALFs and SCALFs in Tuscaloosa County.

The Adjustment for 36 SCALF beds does not depend on the need for additional physicians or additional physician specialties in Tuscaloosa County. The selection of a physician is that of the resident and his/her family/caregivers.

STAFFING

The estimated staffing would represent about 12 to 15 new jobs to be obtained from the local and regional labor markets as is the mechanism today.

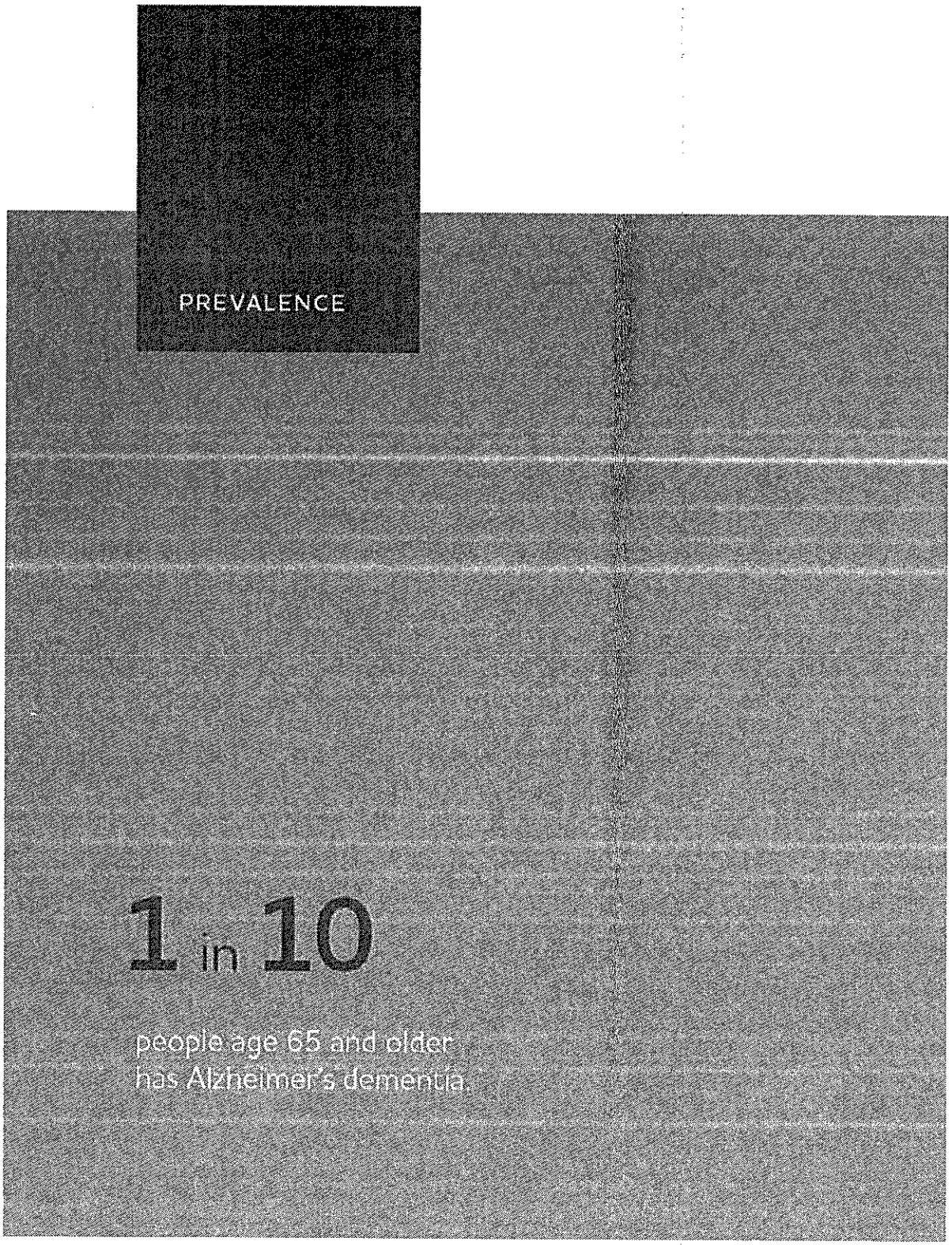
NAMES OF PATIENTS DENIED SERVICES

Although this question is presented in the SHP Adjustment Organizational Outline, the Applicant is prohibited by various laws and regulations from listing list the names of persons. State law may prevent SHPDA from receiving names of patients, residents, families and caregivers.

The Applicant has achieved the purpose of the Outline question by instead showing quantitatively when and where denial of service was evident without resorting to release of private, confidential information (names).

ATTACHMENTS

ATTACHMENT 1 - ALZHEIMER'S ASSOCIATION - Prevalence 2017


PREVALENCE
1 in 10
people age 65 and older
has Alzheimer's dementia

Millions of Americans have Alzheimer's or other dementias. As the size and proportion of the U.S. population age 65 and older continue to increase, the number of Americans with Alzheimer's or other dementias will grow. This number will escalate rapidly in coming years, as the population of Americans age 65 and older is projected to nearly double from 48 million to 88 million by 2050.[133] The baby boom generation has already begun to reach age 65 and beyond,[134] the age range of greatest risk of Alzheimer's, in fact, the first members of the baby boom generation turned 70 in 2016.

This section reports on the number and proportion of people with Alzheimer's dementia to describe the magnitude of the burden of Alzheimer's on the community and health care system. The prevalence of Alzheimer's dementia refers to the proportion of people in a population who have Alzheimer's dementia at a given point in time. Incidence, the number of new cases per year, is also provided as an estimate of the risk of developing Alzheimer's or other dementias for different age groups. Estimates from selected studies on the number and proportion of people with Alzheimer's or other dementias vary depending on how each study was conducted. Data from several studies are used in this section.

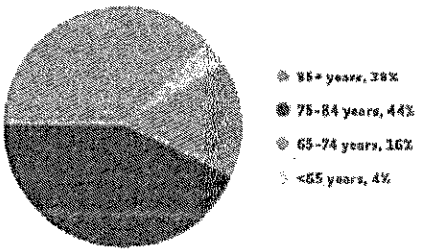
Prevalence of Alzheimer's and Other Dementias in the United States

An estimated 5.5 million Americans of all ages are living with Alzheimer's dementia in 2017. This number includes an estimated 5.3 million people age 65 and older[42,31] and approximately 200,000 individuals under age 65 who have younger-onset Alzheimer's, though there is greater uncertainty about the younger-onset estimate.[137]

- One in 10 people age 65 and older (10 percent) has Alzheimer's dementia.[33,45]
- The percentage of people with Alzheimer's dementia increases with age: 3 percent of people age 65–74, 17 percent of people age 75–84, and 32 percent of people age 85 and older have Alzheimer's dementia.[31]
- Of people who have Alzheimer's dementia, 82 percent are age 75 or older (Figure 1).[44,31]

FIGURE 1

Ages of People with Alzheimer's Dementia in the United States, 2017



Created from data from Hebert et al.[44,31]
Percentages do not total 100 because of rounding.

The estimated number of people age 65 and older with Alzheimer's dementia comes from a study using the latest data from the 2010 U.S. Census and the Chicago Health and Aging Project (CHAP), a population-based study of chronic health conditions of older people.[31]

National estimates of the prevalence of all dementias are not available from CHAP, but they are available from other population-based studies including the Aging, Demographics, and Memory Study (ADAMS), a nationally representative sample of older adults.[45,135–139] Based on estimates from ADAMS, 14 percent of people age 71 and older in the United States have dementia.[138]

Prevalence studies such as CHAP and ADAMS are designed so that everyone in the study is tested for dementia. But outside of research settings, only about half of those who would meet the diagnostic criteria for Alzheimer's and other dementias are diagnosed with dementia by a physician.[140–142] Furthermore, as discussed in *2015 Alzheimer's Disease Facts and Figures*, fewer than half of those who have a diagnosis of Alzheimer's or another dementia in their Medicare records (or their caregiver, if the person was too impaired to respond to the survey) report being told of the diagnosis.[143–146] Because Alzheimer's dementia is underdiagnosed and underreported, a large portion of Americans with Alzheimer's may not know they have it.

18 Alzheimer's Association. 2017 Alzheimer's Disease Facts and Figures. Alzheimers Dement. 2017;13:325–373.

The estimates of the number and proportion of people who have Alzheimer's in this section refer to people who have Alzheimer's dementia. But as described in the Overview section (see pages 4–16) and Special Report (see pages 61–68), revised diagnostic guidelines[20-23] propose that Alzheimer's disease begins many years before the onset of dementia. More research is needed to estimate how many people may have MCI due to Alzheimer's disease and how many people may be in the preclinical stage of Alzheimer's disease. However, if Alzheimer's disease could be accurately detected before dementia develops, the number of people reported to have Alzheimer's disease would change to include more than just people who have been diagnosed with Alzheimer's dementia.

Subjective Cognitive Decline

The experience of worsening or more frequent confusion or memory loss (often referred to as subjective cognitive decline) is one of the earliest warning signs of Alzheimer's disease and may be a way to identify people who are at high risk of developing Alzheimer's or other dementias as well as MCI.[147-149] Subjective cognitive decline does not refer to someone occasionally forgetting their keys or the name of someone they recently met; it refers to more serious issues such as having trouble remembering how to do things one has always done or forgetting things that one would normally know. Not all of those who experience subjective cognitive decline go on to develop MCI or dementia, but many do.[150-154] According to a recent study, only those who over time consistently reported subjective cognitive decline that they found worrisome were at higher risk for developing Alzheimer's dementia.[155] Data from the 2015 Behavioral Risk Factor Surveillance System (BRFSS) survey, which included questions on self-perceived confusion and memory loss for people in 33 U.S. states and the District of Columbia, showed that 12 percent of Americans age 45 and older reported subjective cognitive decline, but 56 percent of those who reported it had not consulted a health care professional about it.[156] Individuals concerned about declines in memory and other cognitive abilities should consult a health care professional.

Differences Between Women and Men in the Prevalence of Alzheimer's and Other Dementias

More women than men have Alzheimer's or other dementias. Almost two-thirds of Americans with Alzheimer's are women.[65,91] Of the 5.3 million people age 65 and older with Alzheimer's in the United States, 3.3 million are women and 2.0 million are men.[65,91] Based on estimates from ADAMS, among people age 71 and older, 16 percent of women have Alzheimer's or other dementias compared with 11 percent of men.[158,159]

There are a number of potential biological and social reasons why more women than men have Alzheimer's or other dementias.[158] The prevailing view has been that this discrepancy is due to the fact that women live longer than men on average, and older age is the greatest risk factor for Alzheimer's.[157,160-165] Many studies of incidence (which indicates risk of developing disease) of Alzheimer's or any dementia[163] have found no significant difference between men and women in the proportion who develop Alzheimer's or other dementias at any given age. A recent study using data from the Framingham Heart Study suggests that because men in middle age have a higher rate of death from cardiovascular disease than women in middle age, men who survive beyond age 65 may have a healthier cardiovascular risk profile and thus an apparent lower risk for dementia than women of the same age.[166] Epidemiologists call this "survival bias" because the men who survive to older ages and are included in studies tend to be the healthiest men; as a result, they may have a lower risk of developing Alzheimer's and other dementia than the men who died at an earlier age from cardiovascular disease. More research is needed to support this finding.

However, researchers have recently begun to revisit the question of whether the risk of Alzheimer's could actually be higher for women at any given age due to biological or genetic variations or differences in life experiences.[162] A large study showed that the APOE-e4 genotype, the best known genetic risk factor for Alzheimer's dementia, may have a stronger association with Alzheimer's dementia in women than

TABLE 4

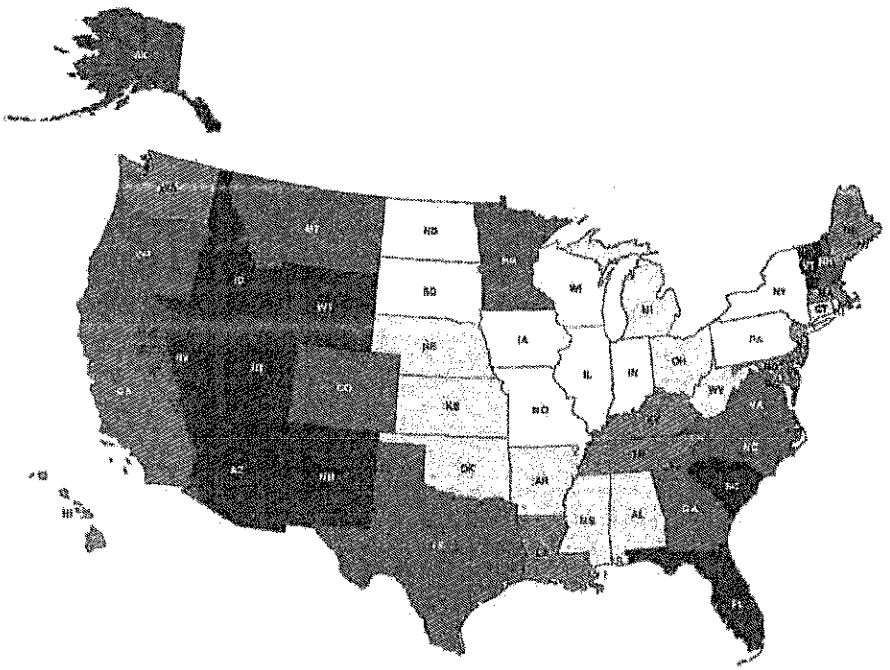
Projections of Total Numbers of Americans Age 65 and Older with Alzheimer's Dementia by State

State	Projected Number with Alzheimer's (in thousands) 2017	2025	Percentage Change 2017-2025	State	Projected Number with Alzheimer's (in thousands) 2017	2025	Percentage Change 2017-2025
Alabama	90	110	22.2	Montana	20	27	35.0
Alaska	7.1	11	54.9	Nebraska	33	40	21.2
Arizona	130	200	53.8	Nevada	43	64	48.8
Arkansas	55	67	21.8	New Hampshire	24	32	33.3
California	630	840	33.3	New Jersey	170	210	23.5
Colorado	69	92	33.3	New Mexico	38	53	39.5
Connecticut	75	91	21.3	New York	390	460	17.9
Delaware	18	23	27.8	North Carolina	160	210	31.3
District of Columbia	9	9	0.0	North Dakota	14	16	14.3
Florida	530	720	38.5	Ohio	210	250	19.0
Georgia	140	190	35.7	Oklahoma	63	76	20.6
Hawaii	27	35	29.6	Oregon	63	84	33.3
Idaho	24	33	37.5	Pennsylvania	270	320	18.5
Illinois	220	260	18.2	Rhode Island	23	27	17.4
Indiana	110	130	18.2	South Carolina	86	120	39.5
Iowa	64	73	14.1	South Dakota	17	20	17.6
Kansas	52	62	19.2	Tennessee	110	140	27.3
Kentucky	70	86	22.9	Texas	360	490	36.1
Louisiana	85	110	29.4	Utah	30	42	40.0
Maine	27	35	29.6	Vermont	12	17	41.7
Maryland	100	130	30.0	Virginia	140	190	35.7
Massachusetts	120	150	25.0	Washington	110	140	27.3
Michigan	180	220	22.2	West Virginia	37	44	18.9
Minnesota	92	120	30.4	Wisconsin	110	130	18.2
Mississippi	53	65	22.6	Wyoming	9.4	13	38.3
Missouri	110	130	18.2				

Created from data provided to the Alzheimer's Association by Weuve et al.[88]

FIGURE 2

Projected Increases Between 2017 and 2025 in Alzheimer's Dementia Prevalence by State



Change from 2017 to 2025 for Washington, D.C.: 9.0%
Created from data provided to the Alzheimer's Association by Wu Y-S et al.[15]

As shown in Figure 2, between 2017 and 2025 every state across the country is expected to experience an increase of at least 14 percent in the number of people with Alzheimer's due to increases in the population age 65 and older. The West and Southeast are expected to experience the largest percentage increases in people with Alzheimer's between 2017 and 2025. These increases will have a marked impact on states' health care systems, as well as the Medicaid program, which covers the costs of long-term care and support for some older residents with dementia.

Incidence of Alzheimer's Dementia

While prevalence refers to *existing* cases of a disease in a population at a given time, incidence refers to *new* cases of a disease that develop in a given period of time in a defined population — in this case, the U.S. population age 65 or older. Incidence provides a measure of *risk* for developing a disease. According to one study using data from the Established Populations for Epidemiologic Study of the Elderly (EPESE), approximately 480,000 people age 65 or older will

develop Alzheimer's dementia in the United States in 2017.[62] The number of new cases of Alzheimer's increases dramatically with age: in 2017, there will be approximately 64,000 new cases among people age 65 to 74, 173,000 new cases among people age 75 to 84, and 243,000 new cases among people age 85 and older (the "oldest-old").[49,156] This translates to approximately two new cases per 1,000 people age 65 to 74, 12 new cases per 1,000 people age 75 to 84, and 37 new cases per 1,000 people age 85 and older.[62] A more recent study using data from the Adult Changes in Thought (ACT) study, a cohort of members of the Group Health health care delivery system in the Northwest United States, reported even higher incidence rates for Alzheimer's dementia.[181] Because of the increasing number of people age 65 and older in the United States, particularly the oldest-old, the annual number of new cases of Alzheimer's and other dementias is projected to double by 2050.[156]

- Every 66 seconds, someone in the United States develops Alzheimer's dementia.[410]
- By 2050, someone in the United States will develop Alzheimer's dementia every 33 seconds.[410]

Lifetime Risk of Alzheimer's Dementia

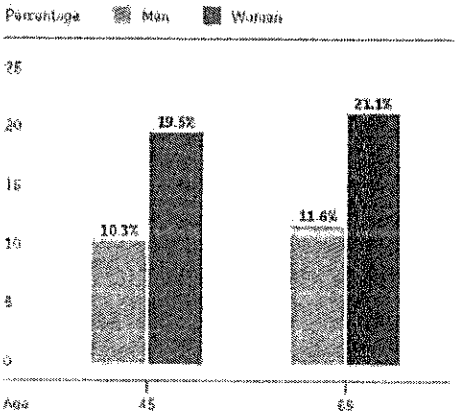
Lifetime risk is the probability that someone of a given age will develop a condition during his or her remaining life span. Data from the Framingham Heart Study were used to estimate lifetime risks of Alzheimer's dementia by age and sex.[61,169] As shown in Figure 3, the study found that the estimated lifetime risk for Alzheimer's dementia at age 45 was approximately one in five (20 percent) for women and one in 10 (10 percent) for men. The risks for both sexes were slightly higher at age 65.[169]

Trends in the Prevalence and Incidence of Alzheimer's Dementia

A growing number of studies indicate that the age-specific risk of Alzheimer's and other dementias in the United States and other higher-income Western countries may have declined in the past 25 years,[181-202] though results are mixed.[30] These declines have been

FIGURE 3

Estimated Lifetime Risk for Alzheimer's Dementia, by Sex, at Age 45 and Age 65



Created from data from Chene et al.[169]

attributed to increasing levels of education and improved control of cardiovascular risk factors.[181,192,202] Such findings are promising and suggest that identifying and reducing risk factors for Alzheimer's and other dementias may be effective. Although these findings indicate that a person's risk of dementia at any given age may be decreasing slightly, it should be noted that the total number of Americans with Alzheimer's or other dementias is expected to continue to increase dramatically because of the population's shift to older ages. Furthermore, it is unclear whether these positive trends will continue into the future given worldwide trends showing increasing mid-life diabetes and obesity — potential risk factors for Alzheimer's dementia — which may lead to a rebound in dementia risk in coming years.[200,203-204] Thus, while recent findings are promising, the social and economic burden of Alzheimer's and other dementias will continue to grow. Moreover, 58 percent of the projected increase in the global prevalence and burden of dementia by 2050 will take place in low- and middle-income countries, where there is no evidence for a decline in the risk of Alzheimer's and other dementias.[205]

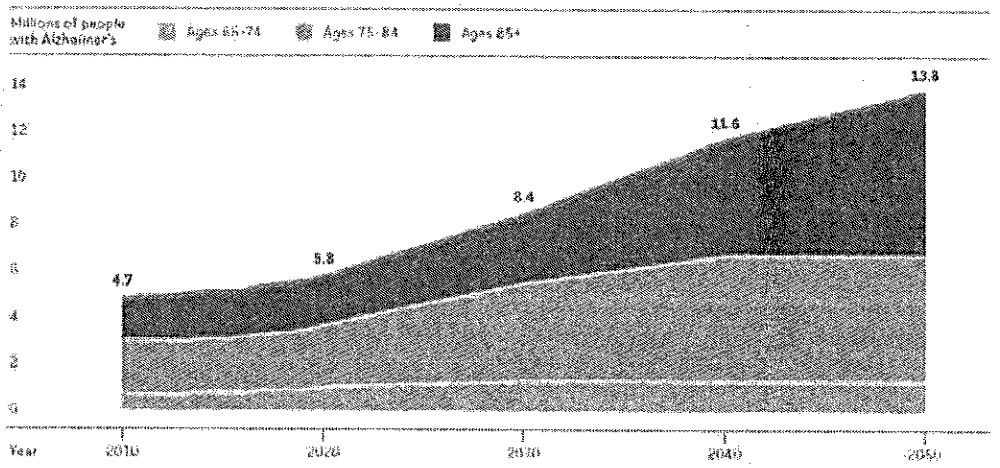
Looking to the Future

The number of Americans surviving into their 80s, 90s and beyond is expected to grow dramatically due to medical advances, as well as social and environmental conditions.[206] Additionally, a large segment of the American population — the baby boom generation — has begun to reach age 65 and older, ages when the risk for Alzheimer's and other dementias is elevated. By 2030, the segment of the U.S. population age 65 and older will increase substantially, and the projected 74 million older Americans will make up over 20 percent of the total population (up from 14 percent in 2012).[206] As the number of older Americans grows rapidly, so too will the numbers of new and existing cases of Alzheimer's dementia, as shown in Figure 4.[A12,31]

- In 2010, there were an estimated 454,000 new cases of Alzheimer's dementia. By 2030, that number is projected to be 615,000 (a 35 percent increase), and by 2050, 959,000 (a 110 percent increase from 2010).[199]
- By 2025, the number of people age 65 and older with Alzheimer's dementia is estimated to reach 7.1 million — almost a 35 percent increase from the 5.3 million age 65 and older affected in 2017.[A13,31]
- By 2050, the number of people age 65 and older with Alzheimer's dementia may nearly triple, from 5.3 million to a projected 13.8 million, barring the development of medical breakthroughs to prevent or cure Alzheimer's disease.[A12,31] Previous estimates based on high-range projections of population growth provided by the U.S. Census suggest that this number may be as high as 16 million.[A14,205]

FIGURE 4

Projected Number of People Age 65 and Older (Total and by Age Group) in the U.S. Population with Alzheimer's Dementia, 2010 to 2050



Created from data from Hebert et al.[A12,31]

Growth of the Oldest-Old Population

Longer life expectancies and aging baby boomers will also increase the number and percentage of Americans who will be 85 and older. Between 2012 and 2050, the oldest-old are expected to increase from 14 percent of all people age 65 and older in the United States to 22 percent of all people age 65 and older.[20] This will result in an additional 12 million oldest-old people — individuals at the highest risk for developing Alzheimer's dementia.[20]

- In 2017, about 2.1 million people who have Alzheimer's dementia are age 85 or older, accounting for 38 percent of all people with Alzheimer's dementia.[23]
- When the first wave of baby boomers reaches age 85 (in 2031), it is projected that more than 3 million people age 85 and older will have Alzheimer's dementia.[24]
- By 2050, as many as 7 million people age 85 and older may have Alzheimer's dementia, accounting for half (51 percent) of all people 65 and older with Alzheimer's dementia.[24]

ATTACHMENT 2 - ALZHEIMER'S ASSOCIATION - Mortality and Morbidity 2017

MORTALITY AND MORBIDITY

89 percent

Increase in deaths due to Alzheimer's between 2000 and 2014. Deaths from Alzheimer's have nearly doubled during this period while those from heart disease — the leading cause of death — have declined.

Alzheimer's disease is officially listed as the sixth-leading cause of death in the United States.[203] It is the fifth-leading cause of death for those age 65 and older.[158] However, it may cause even more deaths than official sources recognize. Alzheimer's is also a leading cause of disability and poor health (morbidity). Before a person with Alzheimer's dies, he or she lives through years of morbidity as the disease progresses.

Deaths from Alzheimer's Disease

It is difficult to determine how many deaths are caused by Alzheimer's disease each year because of the way causes of death are recorded. According to data from the National Center for Health Statistics of the Centers for Disease Control and Prevention (CDC), 93,541 people died from Alzheimer's disease in 2014.[209] The CDC considers a person to have died *from* Alzheimer's if the death certificate lists Alzheimer's as the underlying cause of death, defined by the World Health Organization as "the disease or injury which initiated the train of events leading directly to death."[209]

Severe dementia frequently causes complications such as immobility, swallowing disorders and malnutrition that significantly increase the risk of serious acute conditions that can cause death. One such condition is pneumonia, which is the most commonly identified cause of death among elderly people with Alzheimer's or other dementias.[210-211] Death certificates for individuals with Alzheimer's often list acute conditions such as pneumonia as the primary cause of death rather than Alzheimer's.[212-214] As a result, people with Alzheimer's disease who die due to these acute conditions may not be counted among the number of people who died from Alzheimer's disease according to the World Health Organization definition, even though Alzheimer's disease may well have caused the acute condition listed on the death certificate. This difficulty in using death certificates to accurately determine the number of deaths from Alzheimer's has been referred to as a "blurred distinction between death with dementia and death from dementia."[215]

Another way to determine the number of deaths from Alzheimer's disease is through calculations that compare the estimated risk of death in those who have Alzheimer's with the estimated risk of death in those who do not have Alzheimer's. A study using data from the Rush Memory and Aging Project and the Religious Orders Study estimated that 500,000 deaths among people age 75 and older in the United States in 2010 could be attributed to Alzheimer's (estimates for people age 65 to 74 were not available), meaning that those deaths would not be expected to occur in that year if those individuals did not have Alzheimer's.[216]

The true number of deaths caused by Alzheimer's is somewhere between the number of deaths from Alzheimer's recorded on death certificates and the number of people who have Alzheimer's disease when they die. According to 2014 Medicare claims data, about one-third of all Medicare beneficiaries who die in a given year have been diagnosed with Alzheimer's or another dementia.[159] Based on data from the Chicago Health and Aging Project (CHAP) study, in 2017 an estimated 700,000 people age 65 and older in the United States will have Alzheimer's when they die.[217] Although some seniors who have Alzheimer's disease at the time of death die from causes that are unrelated to Alzheimer's, many of them die from Alzheimer's disease itself or from conditions in which Alzheimer's was a contributing cause, such as pneumonia.

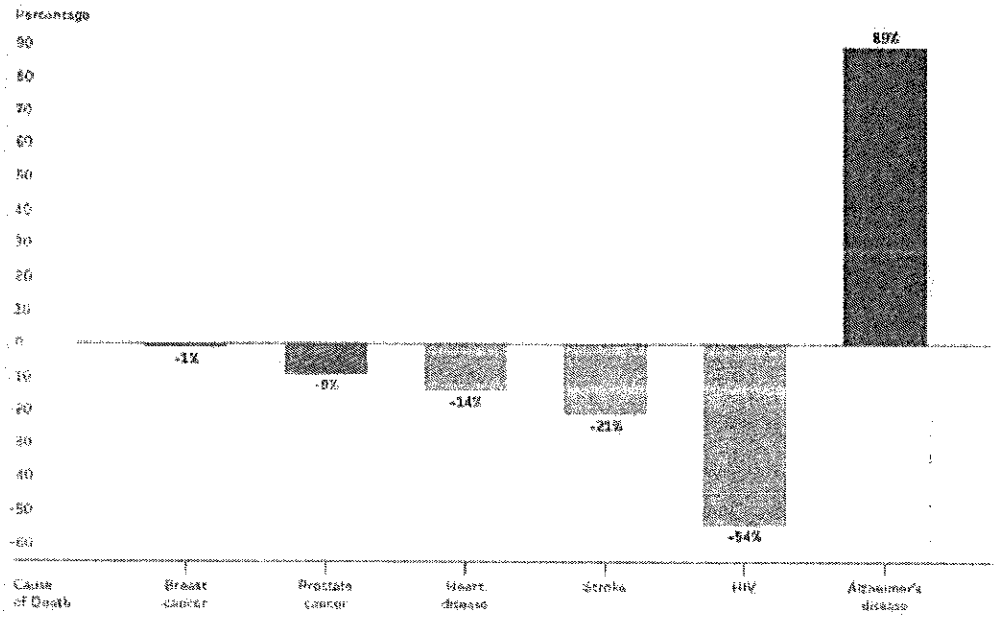
Irrespective of the cause of death, among people age 70, 61 percent of those with Alzheimer's are expected to die before age 80 compared with 30 percent of people without Alzheimer's.[218]

Public Health Impact of Deaths from Alzheimer's Disease

As the population of the United States ages, Alzheimer's is becoming a more common cause of death, and it is the only top 10 cause of death that cannot be prevented, cured or even slowed. Although deaths from other major causes have decreased significantly, official records indicate that deaths from Alzheimer's disease have increased significantly.

FIGURE 5

Percentage Changes in Selected Causes of Death (All Ages) Between 2000 and 2014



Created from data from the National Center for Health Statistics [88,89]

Between 2000 and 2014, deaths from Alzheimer's disease as recorded on death certificates increased 89 percent, while deaths from the number one cause of death (heart disease) decreased 14 percent (Figure 5).[308] The increase in the number of death certificates listing Alzheimer's as the underlying cause of death reflects both changes in patterns of reporting deaths on death certificates over time as well as an increase in the actual number of deaths attributable to Alzheimer's.

State-by-State Deaths from Alzheimer's Disease

Table 5 provides information on the number of deaths due to Alzheimer's by state in 2014, the most recent year for which state-by-state data are available. This information was obtained from death certificates and reflects the condition identified by the physician as the underlying cause of death. The table also provides annual mortality rates by state to compare the risk of death due to Alzheimer's disease across states with varying population sizes. For the United States as a whole, in 2014, the mortality rate for Alzheimer's disease was 29 deaths per 100,000 people.[4,15,308]

TABLE 5

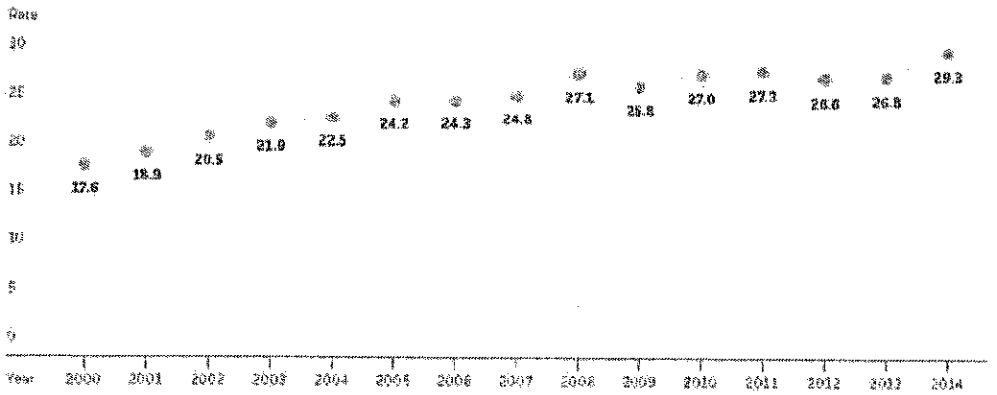
Number of Deaths and Annual Mortality Rate (per 100,000 People) Due to Alzheimer's Disease, by State, 2014

State	Number of Deaths	Mortality Rate	State	Number of Deaths	Mortality Rate
Alabama	1,985	38.9	Montana	253	24.7
Alaska	68	9.2	Nebraska	515	27.4
Arizona	2,485	36.9	Nevada	606	21.3
Arkansas	1,193	40.2	New Hampshire	396	29.8
California	12,644	32.8	New Jersey	1,962	22.0
Colorado	1,364	25.5	New Mexico	442	21.2
Connecticut	923	25.7	New York	2,639	13.4
Delaware	188	20.1	North Carolina	3,246	32.6
District of Columbia	119	18.1	North Dakota	364	49.2
Florida	5,874	29.5	Ohio	4,083	35.2
Georgia	2,670	26.4	Oklahoma	1,227	31.8
Hawaii	326	23.0	Oregon	1,411	35.5
Idaho	376	23.0	Pennsylvania	3,486	27.8
Illinois	3,266	25.4	Rhode Island	403	38.2
Indiana	2,204	33.4	South Carolina	1,938	40.1
Iowa	1,313	42.3	South Dakota	434	50.9
Kansas	790	27.2	Tennessee	2,672	40.8
Kentucky	1,523	34.5	Texas	6,772	25.1
Louisiana	1,670	35.9	Utah	584	19.6
Maine	434	32.6	Vermont	266	42.5
Maryland	934	15.6	Virginia	1,775	21.3
Massachusetts	1,688	25.0	Washington	3,344	47.4
Michigan	3,349	33.8	West Virginia	620	33.5
Minnesota	1,628	29.8	Wisconsin	1,876	32.6
Mississippi	1,098	36.7	Wyoming	162	27.7
Missouri	2,053	33.9	U.S. Total	93,541	29.3

Created from data from the National Center for Health Statistics.[15,16]

FIGURE 6

U.S. Annual Alzheimer's Death Rate (per 100,000 People) by Year



Created from data from the National Center for Health Statistics.[208]

Alzheimer's Disease Death Rates

As shown in Figure 6, the rate of deaths attributed to Alzheimer's has risen substantially since 2000.[208] Table 6 shows that the rate of death from Alzheimer's increases dramatically with age, especially after age 65.[208] The increase in the Alzheimer's death rate over time has disproportionately affected the oldest-old.[209] Between 2000 and 2014, the death rate from Alzheimer's increased only slightly for people age 65 to 74, but increased 33 percent for people age 75 to 84, and 51 percent for people ago 85 and older.

Duration of Illness from Diagnosis to Death

Studies indicate that people age 65 and older survive an average of 4 to 8 years after a diagnosis of Alzheimer's dementia, yet some live as long as 20 years with Alzheimer's.[161,207-208] This reflects the slow, insidious progression of Alzheimer's. Of the total number of years that they live with Alzheimer's dementia, individuals will spend an average of 40 percent of this time in dementia's most severe stage.[218] Much of the time will be spent in a nursing home. At age 80, approximately 75 percent of people living with Alzheimer's dementia are expected to be in a nursing home compared with only 4 percent of the general population at age 80.[218] In all, an estimated two-thirds of those who die of dementia do so in nursing homes, compared with 20 percent of people with cancer and 28 percent of people dying from all other conditions.[218]

Burden of Alzheimer's Disease

The long duration of illness before death contributes significantly to the public health impact of Alzheimer's disease because much of that time is spent in a state of disability and dependence. Scientists have developed methods to measure and compare the burden of different diseases on a population in a way that takes into account not only the number of people with the condition, but also both the number of years of life lost due to that disease as well as the number of healthy years of life lost by virtue of being in a state of disability. These measures indicate that Alzheimer's is a very burdensome disease and that the burden of Alzheimer's has increased more dramatically in the United States than other diseases in recent years. The primary measure of disease burden is called disability-adjusted

TABLE 6

U.S. Annual Alzheimer's Death Rates (per 100,000 People) by Age and Year

Age	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
45-54	0.2	0.2	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.2	0.2	0.2	0.2
55-64	2.0	2.1	1.9	2.0	1.8	2.1	2.1	2.2	2.2	2.0	2.1	2.2	2.2	2.2	2.1
65-74	18.7	18.6	18.6	20.7	19.5	20.2	19.9	20.2	21.1	19.4	19.6	19.2	17.9	18.1	19.6
75-84	139.6	149.2	157.7	164.1	168.5	177.0	175.0	175.8	192.5	179.1	184.5	183.9	175.4	171.6	165.6
85+	667.7	728.4	790.9	846.2	875.1	976.6	928.4	928.9	1,002.2	946.3	987.1	967.1	936.1	929.6	1,006.8

Created from data from the National Center for Health Statistics.[66]

life years (DALYs), which is the sum of the number of years of life lost due to premature mortality and the number of years lived with disability, totaled across all those with the disease. Using this measure, Alzheimer's rose from the 25th most burdensome disease in the United States in 1990 to the 12th in 2010. No other disease or condition increased as much.[2,10] In terms of years of life lost, Alzheimer's disease rose from 32nd to 9th, the largest increase for any disease. In terms of years lived with disability, Alzheimer's disease went from ranking 17th to 12th; only kidney disease equaled Alzheimer's in as high a jump in rank.

Taken together, these statistics indicate that not only is Alzheimer's disease responsible for the deaths of more and more Americans, but also that the disease is contributing to more and more cases of poor health and disability in the United States.

ATTACHMENT 3 - SUMMARY OF SCALF ANNUAL REPORTS FILED WITH SHPDA

Table 8 Summary of SCALF Annual Reports 2014 - 2017

Tuscaloosa	2017																									
Facility ID Number	Year	Facility Name	Days In Operation	Waiting List	Total Beds	Approved Beds In Use	Approved Beds Not In Use	Beds Closed	Total Patient Days Used	Occupancy Rate - Licensed Beds	Occupancy Rate - Beds In Use	Admissions	Discharges	Average Daily Census	Private Room Daily	Semi-Private Room Daily	White Admissions	Black Admissions	Other Admissions	<65 Admissions	65 - 74 Admissions	75 - 84 Admissions	85> Admissions	Male Admissions	Female Admissions
125-S6301	2017	Martinview - East	365	NS(1)	16	NS(1)	NS(1)	NS(1)	5,231	90%	NS(1)	21	17	14	NS(1)	NS(1)	20	1	0	0	4	5	12	12	9
125-S6302	2017	Brookdale Northport	365	NS	16	NS	NS	NS	3,632	62%	NS	8	9	10	NS	NS	8	0	0	0	2	4	2	5	3
125-S6303	2017	Morning Pointe	365	NS	24	NS	NS	NS	7,593	86%	NS	18	22	21	NS	NS	17	1	0	0	1	7	10	3	15
125-S6304	2017	Traditions Way	365	NS	16	NS	NS	NS	5,685	97%	NS	4	4	16	NS	NS	4	0	0	0	0	2	2	0	4
125-S6305	2017	Remembrance Village	365	NS	26	NS	NS	NS	7,429	78%	NS	14	17	20	NS	NS	13	1	0	0	2	7	5	5	9
125-S6307	2017	Tides at Crimson Village	365	NS	32	NS	NS	NS	6,927	59%	NS	30	18	19	NS	NS	29	1	0	0	5	12	13	12	18
Total	2017	6	365	NS	130	NS	NS	NS	36,437	77%	NS	95	87	100	NS	NS	91	4	0	0	0	0	0	0	0

Tuscaloosa	2016																									
Facility ID Number	Year	Facility Name	Days In Operation	Waiting List	Total Beds	Approved Beds In Use	Approved Beds Not In Use	Beds Closed	Total Patient Days Used	Occupancy Rate - Licensed Beds	Occupancy Rate - Beds In Use	Admissions	Discharges	Average Daily Census	Private Room Daily	Semi-Private Room Daily	White Admissions	Black Admissions	Other Admissions	<65 Admissions	65 - 74 Admissions	75 - 84 Admissions	85> Admissions	Male Admissions	Female Admissions
125-S6301	2016	Martinview - East	366	NS	16	16	0	0	3,999	68%	68%	11	4	11	NS	NS	11	0	0	0	0	3	8	3	8
125-S6302	2016	Brookdale Northport	AR Not Filed	NS	AR Not Filed	AR Not Filed	AR Not Filed	AR Not Filed	AR Not Filed	AR Not Filed	AR Not Filed	AR Not Filed	AR Not Filed	AR Not Filed	AR Not Filed	AR Not Filed	AR Not Filed	AR Not Filed	AR Not Filed	AR Not Filed	AR Not Filed	AR Not Filed	AR Not Filed	AR Not Filed	AR Not Filed
125-S6303	2016	Morning Pointe	366	NS	24	24	0	0	8,152	93%	93%	21	17	22	NS	NS	21	0	0	1	2	8	10	9	12
125-S6304	2016	Traditions Way	366	NS	16	16	0	0	5,803	99%	99%	8	8	16	NS	NS	8	0	0	0	0	5	3	3	5
125-S6305	2016	Remembrance Village	366	NS	26	24	2	2	7,402	78%	84%	26	20	20	NS	NS	24	2	0	1	0	11	14	10	16
125-S6307	2016	Tides at Crimson Village	366	NS	32	32	0	0	11,712	100%	100%	23	6	32	NS	NS	22	1	0	0	1	22	0	7	16
Total	2016	5	366	0	114	112	2	2	37,068	89%	90%	89	55	101			86	3	0	2	3	49	35	32	57

Tuscaloosa	2015																									
Facility ID Number	Year	Facility Name	Days In Operation	Waiting List	Total Beds	Approved Beds In Use	Approved Beds Not In Use	Beds Closed	Total Patient Days Used	Occupancy Rate - Licensed Beds	Occupancy Rate - Beds In Use	Admissions	Discharges	Average Daily Census	Private Room Daily	Semi-Private Room Daily	White Admissions	Black Admissions	Other Admissions	<65 Admissions	65 - 74 Admissions	75 - 84 Admissions	85> Admissions	Male Admissions	Female Admissions
125-S6301	2015	Martinview - East	365	No	16	16	0	0	4,396	75%	75%	13	6	12	$113	$0	13	0	0	1	2	6	4	5	8
125-S6302	2015	Brookdale Northport	365	Yes	16	16	0	0	4,015	69%	68%	10	4	11	$150	$27	10	0	0	0	0	10	0	2	8
125-S6303	2015	Morning Pointe	365	No	24	24	0	0	5,680	65%	65%	16	20	16	$144	$0	15	1	0	0	0	8	8	7	9
125-S6304	2015	Traditions Way	365	Yes	16	16	0	0	5,761	99%	99%	5	5	16	$146	$0	3	0	0	1	0	1	3	1	4
125-S6305	2015	Remembrance Village	365	No	26	24	2	2	7,665	81%	88%	9	8	21	$151	$109	8	1	0	0	1	4	4	1	8
125-S6307	2015	Tides at Crimson Village	0	0	0	0	0	0	0	#DIV/0!	#DIV/0!	0	0	#DIV/0!	$0	$0	0	0	0	0	0	0	0	0	0
Total	2015	5	365	0	98	96	2	2	27,517	77%	79%	53	43	75			17	2	0	1	0	3	15	8	11

Tuscaloosa	2014																									
Facility ID Number	Year	Facility Name	Days In Operation	Waiting List	Total Beds	Approved Beds In Use	Approved Beds Not In Use	Beds Closed	Total Patient Days Used	Occupancy Rate - Licensed Beds	Occupancy Rate - Beds In Use	Admissions	Discharges	Average Daily Census	Private Room Daily	Semi-Private Room Daily	White Admissions	Black Admissions	Other Admissions	<65 Admissions	65 - 74 Admissions	75 - 84 Admissions	85> Admissions	Male Admissions	Female Admissions
125-S6301	2014	Martinview - East	273	No	16	16	0	0	3,422	78%	78%	10	7	13	$116	$113	9	1	0	0	3	4	3	3	7
125-S6302	2014	Brookdale Northport	151	Yes	16	16	0	0	1,467	61%	61%	2	3	10	$148	$0	2	0	0	0	0	1	1	1	1
125-S6303	2014	Morning Pointe	365	Yes	24	24	0	0	7,452	85%	85%	19	16	20	$144	$0	17	2	0	1	0	3	15	8	11
125-S6304	2014	Traditions Way	365	Yes	16	16	0	0	5,768	99%	99%	4	4	16	$146	$0	3	1	0	0	0	1	3	0	4
125-S6305	2014	Remembrance Village	365	No	26	24	2	2	8,315	88%	95%	15	19	23	$145	$105	14	1	0	0	0	1	14	4	11
125-S6307	2014	Tides at Crimson Village	0	0	0	0	0	0	0	#DIV/0!	#DIV/0!	0	0	#DIV/0!	$0	$0	0	0	0	0	0	0	0	0	0
Total	2014	5	304	0	98	96	2	2	26,424	89%	91%	50	49	87			0	0	0	0	0	0	0	0	0

ATTACHMENT 4 - STATE HEALTH PLAN SCALF SERVICES INCLUDING EFFECTIVE SHP STATISTICAL UPDATE OF OCTOBER 27, 2015

410-2-4-.04 Limited Care Facilities – Specialty Care Assisted Living Facilities

(1) Definition. Specialty Care Assisted Living Facilities are intermediate care facilities which provide their residents with increased care and/or supervision which is designed to address the residents' special needs due to the onset of dementia, Alzheimer's disease or similar cognitive impairment and which is in addition to assistance with normal daily activities including, but not limited to, restriction of egress for residents where appropriate and necessary to protect the resident and which require a license from the Department of Public as a Specialty Care Assisted Living Facilities pursuant to Ala. Admin. Code § 420-5-20, *et seq.*

(2) Specialty Care Assisted Living Facility Bed Need Methodology

(a) Purpose. The purpose of this specialty care assisted living facility bed need methodology is to identify, by county, the number of beds needed to assure the continued availability, accessibility, and affordability of quality care for residents of Alabama.

(b) General. Formulation of this bed need methodology was accomplished by a committee of the Statewide Health Coordinating Council (SHCC). The committee which provided its recommendations to the SHCC, was composed of providers and consumers of health care. Only the SHCC, with the Governor's final approval, can make changes to this methodology except that the SHPDA staff shall annually update bed need projections and inventories to reflect more current population and utilization statistics. Such updated information is available for a fee upon request. Adjustments are addressed in paragraph (E).

(c) Basic Methodology. Considering the availability of more community and home based services for the elderly in Alabama, there should be a minimum of 4 beds per 1,000 population 65 and older for each county.

The bed need formula is as follows:

(4 beds per thousand) x (population 65 and older) =
Projected Bed Need

(d) Planning Policies

1. Projects to develop specialty care assisted living facilities or units in areas where there exist medically underserved, low income, or minority populations should be given priority over projects not being developed in these critical areas when the project to develop specialty care assisted living facilities in areas where there exists medically underserved, low income or minority populations is not more costly to develop than other like projects.

2. Bed need projections will be based on a three-year planning horizon.

3. Planning will be on a countywide basis.

4. Subject to SHCC adjustments, no beds will be added in any county where that county's projected ratio exceeds 4 beds per 1,000 population 65 and older.

5. When any specialty care assisted living facility relinquishes its license to operate, either voluntarily or involuntarily other than by a Certificate of Need approved transfer, or by obtaining title by a foreclosure as specified in the opinion rendered by the Alabama Attorney General, November 17, 1980, the need for the facility and its resources will automatically be eliminated from the facilities portion of the State Health Plan. The new bed need requirement in the county where the facility was located will be that number which will bring the county ratio up to 4 beds per 1,000 population 65 and older.

6. Additional need may be shown in situations involving a sustained high occupancy rate either for a county or for a single facility. An applicant may apply for additional beds, and thus the establishment of need above and beyond the standard methodology, utilizing one of the following two policies. Once additional beds have been applied for under one of the policies, that applicant shall not qualify to apply for additional beds under either of these policies unless and until the established time limits listed below have passed. All CON authorized SCALF beds shall be included in consideration of occupancy rate and bed need.

(i) If the occupancy rate for a county is greater than 92% utilizing the census data in the most recent full year "Annual Report(s) for Specialty Care Assisted Living Facilities (Form DM-1)" published by or filed with SHPDA, an additional need of the greater of either ten percent (10%) of the current total CON Authorized bed capacity of that county or sixteen (16) total beds may be approved for either the creation of a new facility or for the expansion of existing facilities within that county. However, due to the priority of providing the most cost effective health care services available, a new facility created under this policy shall only be allowed through the conversion of existing beds at an Assisted Living Facility currently in possession of a regular, non-probationary license from the Alabama Department of Public Health. Once additional need has been shown under this policy, no new need shall be shown in that county based upon this rule for twenty-four (24) months following issuance of the initial CON, to allow for the impact of those beds in that county to be analyzed. Should the initial applicant for beds in a county not apply for the total number of beds allowed to be created under this rule, the remaining beds would then be available to be applied for by other providers in the county, so long as said providers meet the conditions listed in this rule.

(ii) If the occupancy rate for a single facility is greater than 92% utilizing the census data in the last two (2) most recent full year "Annual Report(s) for Specialty Care Assisted Living Facilities (Form DM-1)" published by or filed with SHPDA, irrespective of the total occupancy rate of the county over that time period, up to sixteen (16) additional beds may be approved for the expansion of that facility only. Once additional beds have been approved under this policy, no new beds shall be approved for that facility for twenty-four (24) months following issuance of the CON, to allow for the impact of those beds at that facility to be analyzed.

7. No application for the establishment of a new, freestanding SCALF shall be approved for fewer than sixteen (16) beds, to allow for the financial feasibility and viability of a project. Because of this, need may be adjusted by the Agency for any county currently showing a need of more than zero (0) but fewer than sixteen (16) total beds to a total need of sixteen (16) new beds, but only in the consideration of an application for the construction of a new facility in that county. Need shall not be adjusted in consideration of an application involving the expansion of a currently authorized and licensed SCALF or for the conversion of beds at an existing Assisted Living Facility.

8. Any CON Application filed by a licensed SCALF shall not be deemed complete until, and unless:

(i) The applicant has submitted all survey information requested by SHPDA prior to the application date; and

(ii) The SHPDA Executive Director determines that the survey information is complete.

9. No licensed SCALF filing an intervention notice or statement in opposition in any CON proceeding may cite or otherwise seek consideration by SHPDA of such facility's utilization data until, and unless:

(i) The intervenor or opponent has submitted all survey information requested by SHPDA prior to the application date; and

(ii) The SHPDA Executive Director determines that the survey information is complete.

(e) Adjustments. The bed need, as determined by the methodology, is subject to adjustments by the SHCC. The specialty care assisted living facility bed need may need to be adjusted by the SHCC if an applicant can prove that the identified needs of a targeted population are not being met by existing specialty care assisted living facilities in the county of the targeted population.

(f) Notwithstanding the foregoing, any application for certificate of need for specialty care assisted living facility beds for which a proper letter of intent was duly filed with SHPDA prior to the adoption of the bed need methodology shall not be bound by this bed need methodology.

(g) The determination of need for specialty care assisted living facility beds shall not be linked to the number of existing assisted living beds in the county.

Author: Statewide Health Coordinating Council
Statutory Authority: § 22-21-260(4), Code of Alabama, 1975.
History: Effective November 22, 2004; Amended: Filed August 14, 2012; Effective September 18, 2012.

*** CON 2442-SCALF-E (24 Beds) and Project AL2011-002-E (12 Beds) are the subjects of litigation. Current status of CON 2442-SCALF-E and Projects AL2010-190, -192, -193, -195, and AL2011-002-E will not be known until the end of litigation. Need cannot be calculated for Shelby County at this time.**

Closure dates listed are as reported to SHPDA by the ADPH Division of Provider Services.

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
100 NORTH UNION STREET, SUITE 870
MONTGOMERY, ALABAMA 36104

October 27, 2015

MEMORANDUM

TO: Recipients of the 2014-2017 *Alabama State Health Plan*

FROM: Alva M. Lambert
Executive Director

SUBJECT: Statistical Update to the 2014-2017 *Alabama State Health Plan*

Enclosed are statistical updates to the 2014-2017 *Alabama State Health Plan.* The following sections should be replaced:

410-2-4-.04, Limited Care Facilities (SCALF), pages 105-106.

AML/blw

Enclosure: As stated

MAILING ADDRESS: P.O. BOX 303025, MONTGOMERY, ALABAMA 36130-3025
PHONE: (334) 242-4103 FAX: (334) 242-4113

Specialty Care Assisted Living Facilities
Bed Need
2015

COUNTY	Pop 65 & Older 2018	Total Beds Needed	Total Licensed Beds	Beds Authorized But Not Licensed	Net Beds Needed	Notes
Autauga	8,985	36	48	0	(12)	
Baldwin	43,779	175	168	0	7	
Barbour	4,793	19	0	0	19	
Bibb	3,709	15	0	0	15	
Blount	11,033	44	50	0	(6)	
Bullock	1,793	7	0	0	7	
Butler	4,122	16	16	0	0	
Calhoun	20,413	82	140	0	(58)	
Chambers	6,522	26	16	0	10	
Cherokee	6,005	24	36	0	(12)	
Chilton	7,332	29	0	0	29	
Choctaw	2,790	11	0	0	11	
Clarke	4,793	19	0	0	19	
Clay	2,773	11	0	0	11	
Cleburne	3,002	12	0	0	12	
Coffee	8,917	36	16	18	2	*
Colbert	10,925	44	45	0	(1)	
Conecuh	2,891	12	0	0	12	
Coosa	2,529	10	0	0	10	
Covington	7,941	32	0	0	32	
Crenshaw	2,600	10	0	0	10	
Cullman	15,514	62	16	0	46	
Dale	8,309	33	0	0	33	
Dallas	7,257	29	16	0	13	
Dekalb	12,264	49	16	0	33	
Elmore	13,889	55	0	0	55	
Escambia	6,736	27	0	0	27	
Etowah	19,512	78	74	0	4	
Fayette	3,506	14	0	0	14	
Franklin	5,302	21	0	0	21	
Geneva	5,644	23	0	0	23	
Greene	1,826	7	0	0	7	
Hale	2,924	12	0	0	12	
Henry	4,114	16	0	0	16	
Houston	19,174	77	32	0	45	
Jackson	10,650	43	16	0	27	
Jefferson	101,406	406	570	86	(250)	(1),(2),(3),(4)
Lamar	3,150	13	0	0	13	
Lauderdale	19,158	77	32	0	45	
Lawrence	6,156	25	0	0	25	
Lee	18,763	75	136	0	(61)	
		105				

COUNTY	Pop 65 & Older 2018	Total Beds Needed	Total Licensed Beds	Beds Authorized But Not Licensed	Net Beds Needed	Notes
Limestone	14,704	59	32	0	27	
Lowndes	1,930	8	0	0	8	
Macon	3,833	15	0	0	15	
Madison	54,797	219	182	64	(37)	(5),(6),(7)
Marengo	3,982	16	16	0	0	
Marion	6,546	26	0	26	0	(8)
Marshall	17,059	68	22	0	46	
Mobile	66,667	267	285	0	(18)	
Monroe	4,348	17	0	0	17	
Montgomery	33,625	135	178	0	(43)	
Morgan	21,332	85	78	0	7	
Perry	1,900	8	0	0	8	
Pickens	3,862	15	0	0	15	
Pike	5,215	21	16	0	5	
Randolph	4,809	19	16	0	3	
Russell	7,921	32	0	0	32	
St. Clair	15,724	63	60	0	3	
Shelby	33,956	136	128	36	(28)	(9),(10)
Sumter	2,503	10	0	0	10	
Talladega	14,359	57	16	0	41	
Tallapoosa	6,731	35	46	0	(11)	
Tuscaloosa	27,699	111	130	0	(19)	
Walker	12,512	50	14	0	36	
Washington	3,206	13	0	0	13	
Wilcox	2,107	8	0	0	8	
Winston	5,326	21	16	0	5	
TOTAL	831,288	3,325	2,688	230	408	

27-Oct-15

NOTES (Beds Authorized but not License d)

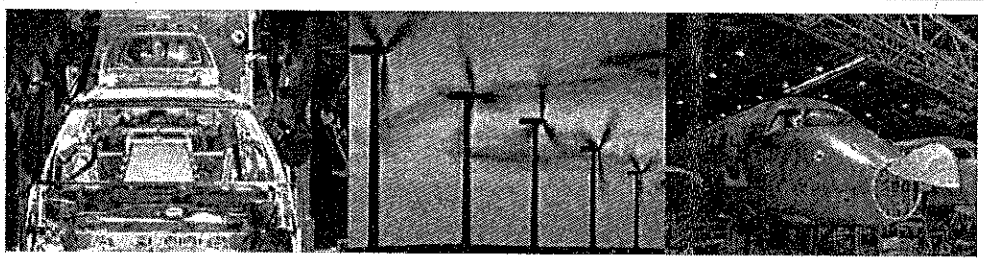
[8] - AL2015-032 - Twenty/Twenty, LLC - 16 Beds (Approved 10/21/2015)
(1) - AL2013-009, CON 2611-SCALF - St. Martin's in the Pines - 16 Beds
(2) - AL2013-073, CON 2659-SCALF - Regency Birmingham - 36 Beds
(3) - AL2014-004, CON 2663-SCALF - Chateau Vestavia - 16 Beds
(4) - AL2015-021, CON 2716-SCALF - Oaks on Parkwood - 16 Beds
(5) - AL2014-005, CON 2662-SCALF - Merrill Gardens at Madison - 32 Beds
(6) - AL2014-024, CON 2682-SCALF[8] - Regency Retirement Village of Huntsville - 16 Beds
(7) - AL2014-030, CON 2685-SCALF - Redstone Military Retirement Residence Ass'n - 16 Beds
(8) - AL2012-031, CON 2586-SCALF - St. Clair Services, Inc. - 26 Beds
(9) - AL2010-192, CON 2691-SCALF - Noland Health Services, Inc. - 24 Beds
(10) - AL2014-032, CON 2693-SCALF - LakeView Estates - 12 Beds

ATTACHMENT 5 - INDUSTRY TUSCALOOSA COUNTY

INDUSTRY

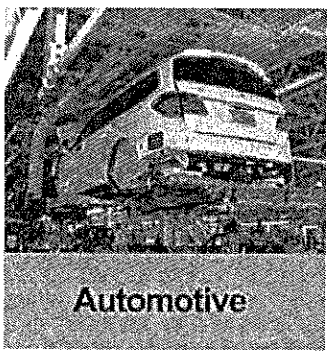
Business Development

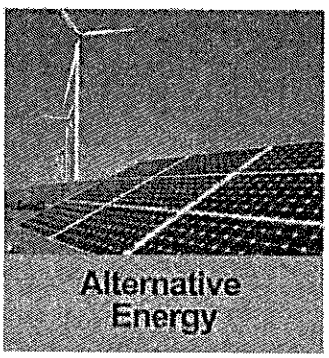
Alabama named one of the best states to do business by Area Development magazine, 2012.



Tuscaloosa County - Target Industries

Tuscaloosa County is the right location for manufacturing and production facilities, not limited to the Automotive Industry. This Includes:





Top Ten Employers - Tuscaloosa County

Organization	Product	Employees
The University of Alabama	Higher Education	11,347
DCH Regional Medical Center	Medical Services	3,525
Mercedes-Benz U.S. International	Automobile Manufacturing	3,500
County Board of Education	Public Education	2,283
City Board of Education	Public Education	1,431
City of Tuscaloosa	City Services	1,360
Michelin/BFGoodrich Tire Manufacturing	Aftermarket Tire Manufacturing	1,356
Veterans Administration Hospital	Specialized Health Care	1,036
Phifer Incorporated	Aluminum/Fiberglass Screening Manufacturing	1,003
Northport Medical Center	Medical Services	868

Top Manufacturing Employers - Tuscaloosa County

Organization	Product	Employees
Mercedes-Benz U.S. International	Automobiles	3,500
Michelin/BFGoodrich Tire Manufacturing	Aftermarket Tires	1,356
Phifer Incorporated	Aluminum/Fiberglass Screening	1,003
Brose Tuscaloosa	Automotive Components & Systems	680
Faurecia Automotive (Cottondale)	Automotive Seating Systems	634
ZF Industries	Axle Systems Assemblies; Metal Stamping (automotive)	451
Yanfeng (formerly Johnson Controls)	Automotive Components	436
Nucor Tuscaloosa	Coil & Cut Plate Steel	433
Hunt Refining Company	Transportation Fuel to Asphalt Products	360
Coral Industries, Inc.	Bathroom Enclosures	342
Inteva Products, LLC	Automotive Components & Systems	250
Eberspaecher North America Inc.	Automotive Technology Components	204
Hanna Steel Corporation	Steel Coils/ Steel Tubing	149
Faurecia Interior Systems	Automotive Components	143

Note: Information updated second quarter of 2016

Tuscaloosa County
Manufacturing Investment
Information Updated July 29, 2016

New Companies

Airgas Merchant Gases, LLC (2015)
299 North Radnor-Chester Road (PO Box 6675) 610.263.6160
Radnor, PA 19087 New Jobs: 29
Web www.airgas.com
Site located at Hall Road NE (Across from Nucor Steel)
Product: Oxygen, Nitrogen, Argon Gases (NAICS 325120)
Construction estimated to start: 9/1/2015
Project placed in service: 4/1/2017
General Contractor: Airgas (John.Fick@airgas.com)

Band of Brothers Brewing Company (2016)
1695 23rd Avenue 205.268.5137
Tuscaloosa, AL 35401 New Jobs: 10
Product: Craft Beer and Sodas (NAICS 312120)
Construction estimated to start: 5/12/2014
Project placed in service: 10/1/2015
General Contractor: N/A

Blue Creek Energy (Walter Energy) (2012)
~~3000 Riverchase Galleria, Suite 1700~~ ~~205.444.3600~~
~~Birmingham, AL 35244~~ New Jobs: 450
~~Web www.walterenergy.com~~
Site located at Hwy 69 North/Brandon School Road
Product: Metallurgical Coal (NAICS 212112)
Construction estimated to start: 9/1/2012
Project placed in service: 1/1/2016
General Contractor: N/A

Bolta US, Inc. (2014)
720 Energy Center Boulevard, Suite 505 205.752.7295
Northport, AL 35473 New Jobs: 350
Site Boone Boulevard (Airport Industrial Park)
Web *www.piolax.co.uk/components/*
Product: Molded Plastic/chrome Automotive Parts (NAICS 326199)
Construction estimated to start: 6/1/2014
Project placed in service: 12/31/2016
General Contractor: Evans General Contractors (678.713.7815)

Boysen USA Alabama, LLC (2012)
17520 Brookwood Parkway 205.349.3000
Vance, AL 35490 New Jobs: 80
Web *www.boysen-online.de*
Product: Automotive Exhaust Systems (NAICS 336310)
Construction estimated to start: 8/7/2012
Project placed in service: 12/31/13
General Contractor: Evans General Contractors (Roswell, GA)

JNJ Production, LLC (2016)
1419 32nd Avenue 205.752.7748
Tuscaloosa, AL 35401 New Jobs: 30
Site: Union Station Development (off Union Chapel Rd)
Web *www.jnjapparel.net*
Product: Screen Printing (NAICS 323113)
Construction estimated to start: 9/1/2016
Project placed in service: 5/31/2017
General Contractor: Harrison Construction (Northport, AL)

O'Neal Manufacturing Services (2015)
744 North 41st Street 205.595.8100
Birmingham, AL 35222 New Jobs: 34
Site: Nucor Steel Campus (1700 Hall Road NE)
Web *www.onealmfgservices.com*
Product: Steel Processing Facility (332312)
Construction estimated to start: January 2016
Project placed in service: 12/31/2016
Developer: Nucor Steel (205.556.1310)

SMP Automotive Systems Alabama, Inc. (2015)
720 Energy Center Blvd, Suite 505 Phone: TBD
Northport, AL 35473 New Jobs: 887
Site: Cedar Cove Technology Park
Web *www.smp-automotive.com*
Product: Automotive Components (NAICS 336390)
Construction estimated to start: January 2016
Project placed in service: February 2018
General Contractor: Evans General Contractors (Roswell, GA)

Expansions

Borgers USA Corp. (2013)
17490 Brookwood Parkway 205.662.5771
Vance, AL 35490 (Town of Brookwood) New Jobs: 15
Web *www.borgers-group.com*
Product: Automotive Molding Imp (NAICS 336360)
Expansion Includes: Personnel, equipment and facility
Project placed in service: 2/1/2014
General Contractor: Harrison Construction (Northport, AL)

Coral Industries Inc. (2016)
3010 Rice Mine Road NE 205.345.1018
Tuscaloosa, AL 35406 New Jobs: 20
Web *http://coralind.com*
Site located at 600 54th Avenue (Northport)
Product: Commercial Aluminum/Glass Systems (NAICS 332321)
Expansion Includes: Personnel, equipment and facility
Project placed in service: 6/30/2017
General Contractor: WAR Construction (205.758.4723)

Eberspaecher North America, Inc. (2014)
6601 5th Street 205.333.0804
Northport, AL 35476 New Jobs: 40
Web *www.eberspaecher.com*
Located in Airport Industrial Park
Product: Automotive Exhaust Systems (NAICS 336360)
Expansion Includes: Personnel, equipment and facility
Project placed in service: 9/30/2015

EBZ SysTec, Inc. (2013)
3011 Dublin Circle 205.434.2660
Bessemer, AL 35022 New Jobs: 29
Web *www.ebz-group.com*
Location: 22351 Diesel Drive, McCalla (35111)
Product: Automotive Supplier/Equipment Contractor (NAICS 333999)
Expansion includes: Personnel, equipment and facility
Project placed in service: 11/1/2015

Faurecia Interior Systems (2010)
1401 Industrial Park Drive 205.333.9703
Tuscaloosa, AL 35401 New Jobs: 148
Web *www.faurecia.com*
Product: Automotive Parts and Components (NAICS 336360)
Expansion includes: Personnel and equipment
Project placed in service: 12/31/2015
General Contractor: N/A

Johnson Controls, Inc. (2014)
10811 Progress Drive 205.554.4900
Cottondale, AL 35453 New Jobs: 175
Web *www.johnsoncontrols.com*
Product: Automotive Components (NAICS 336360)
Expansion includes: Personnel, equipment and facility
Project placed in service: 12/31/2015

Lear Corporation Corporation (2016)
17490 Brookwood Parkway 205.535.3600
Vance, AL 35490 New Jobs: 535
Web *www.lear.com*
Product: Automotive Seating Systems (NAICS 336330)
Construction estimated to start: 9/1/2016
Project placed in service: 12/31/2018
General Contractor: Rostock Buildings Co. Inc. (Rostock, SC)

Mercedes-Benz U.S. International (2011/2012/2014) 9/2015/2015)
PO Box 100 205.507.3300
Tuscaloosa, AL 35401-0100 New Jobs: 1,800/400/500/0/0/0
Web *www.mbusi.com*
Product: Motor Vehicles (NAICS 336111)
Expansion includes: Personnel, equipment, facility (2011); Personnel, equipment, facility (2012), Personnel, equipment, facility (2013), facility (2015); Personnel, equipment, facility (2015)
Project placed in service: 9/2/15 (2011); 1/1/2015 (2012); 7/1/2014 (2013); 6/1/16 (2015), 12/1/19 (2015)
General Contractor: BL Harbert (2013) (2015)

Metalsa Tuscaloosa (formerly ISE Innovative Systems U.S.) (2013)
1150 Industrial Park Drive 205.330.5500
Tuscaloosa, AL 35491 New Jobs: 25
Web *www.metalsa.com*
Product: Automotive Parts and Assemblies (NAICS 336390)
Expansion includes: Personnel, equipment and facility
Project placed in service: 7/1/2014
General Contractor: N/A

Nucor Steel Tuscaloosa, Inc. (2014)
1700 Hall Road NE 205.556.9310
Tuscaloosa, AL 35404 New Jobs: 0
Web *www.nucorsteel.com*
Product: Steel Coil and Plate
Expansion includes: Facilities and equipment
Project placed in service: 3/1/2017 (Accelerated Cooling Project); 8/1/2017 (Baghouse)
General Contractor: N/A

ZF Chassis Systems Tuscaloosa, LLC (2013)
1200 Commerce Drive 205.333.5100
Tuscaloosa, AL 35401 New Jobs: 115
Web *www.zf.com*
Product: Chassis System Assembly/Warehouse
Expansion Includes: Personnel, equipment and facility
Project placed in service: 7/31/2014
General Contractor: Arkansy Associates

Prepared by the Tuscaloosa County Industrial Development Authority

City of Tuscaloosa Named One of 50 Invest Health Cities by Reinvestment Fund and Robert Wood Johnson Foundation

Tuscaloosa to join innovative, national program to improve health in low-income neighborhoods

May 17, 2016

The City of Tuscaloosa has been selected by Reinvestment Fund and the Robert Wood Johnson Foundation to take part in the new Invest Health initiative. Invest Health is aimed at transforming how leaders from mid-size American cities work together to help low-income communities thrive, with specific attention to community features that drive health such as access to safe and affordable housing, places to play and exercise and quality jobs.

Tuscaloosa was selected from more than 180 teams from 170 communities that applied to the initiative. Cities with populations between 50,000 and 400,000 were asked to form five-member teams including representatives from the public sector, community development and an anchor institution, preferably academic or health-related. Tuscaloosa's team comprises representatives from healthcare, housing, community development and the public sector. The Tuscaloosa Invest Health team seeks to improve the health of residents through community design, and reflect the community's pride in athletic tradition by integrating facilities and programs that encourage a healthy lifestyle.

Region 3 High Demand Occupations 2012-2022

SOC	Occupations	Employment 2012	Employment 2022	Percent Change (%)*	Average Annual Growth (%)	Average Annual Openings	Average Annual Salary ($)
17-2112	Industrial Engineers	340	480	41.84	3.51	25	83,477
49-9041	Industrial Machinery Mechanics	710	940	32.30	2.85	45	56,887
51-2092	Team Assemblers	3,780	5,420	43.47	3.67	225	42,399
51-1011	First-Line Supervisors of Prod & Operating Workers	1,160	1,480	27.74	2.47	50	63,178
17-3026	Industrial Engineering Technicians	100	150	44.23	4.14	5	63,168
13-1081	Logisticians	80	120	55.84	4.14	5	61,445
15-1121	Computer Systems Analysts	100	140	32.04	3.42	5	81,262
13-1111	Management Analysts	190	240	26.04	2.36	10	73,056
25-1072	Nursing Instructors and Teachers, Postsecondary	***	***	35.14	3.03	5	70,171
17-1011	Architects, Except Landscape and Naval	70	90	29.85	2.54	5	87,697
15-1132	Software Developers, Applications	60	80	32.78	2.92	5	89,811
27-2022	Coaches and Scouts	210	250	21.26	1.76	10	70,179
47-1011	1st-Line Sups of Constr Trades and Extraction Wkrs	850	1,020	19.55	1.84	25	62,186
29-1171	Nurse Practitioners	150	190	21.71	2.39	5	89,616
13-1051	Cost Estimators	100	130	28.28	2.66	5	54,886
29-1141	Registered Nurses	2,850	3,920	16.69	1.54	105	56,885
13-2052	Personal Financial Advisors	50	80	38.89	4.81	5	57,254
29-2032	Diagnostic Medical Sonographers	60	80	35.59	2.92	5	53,064
47-2051	Cement Masons and Concrete Finishers	240	300	26.51	2.26	10	37,203
11-9021	Construction Managers	260	330	16.79	1.66	10	92,490
29-1123	Physical Therapists	80	90	21.05	1.18	5	86,114
47-2031	Carpenters	700	880	24.43	2.31	25	32,796
11-9111	Medical and Health Services Managers	160	190	17.07	1.73	5	96,695
11-1021	General and Operations Managers	1,350	1,530	13.85	1.26	45	114,037
13-1161	Market Research Analysts and Marketing Specialists	90	110	27.06	2.03	5	60,768
21-1022	Healthcare Social Workers	210	260	22.33	1.76	10	41,546
29-2055	Surgical Technologists	110	150	31.58	3.15	5	36,746
31-2021	Physical Therapist Assistants	70	90	29.17	2.54	5	43,140
47-2141	Painters, Construction and Maintenance	280	350	24.91	2.26	10	34,283
47-2061	Construction Laborers	1,000	1,250	24.82	2.26	45	25,398
21-1013	Marriage and Family Therapists	50	70	30.19	3.42	5	46,236
17-2071	Electrical Engineers	130	160	18.05	2.10	5	74,599
13-1121	Meeting, Convention, and Event Planners	50	60	36.17	1.64	5	40,484
39-9021	Personal Care Aides	750	970	29.22	2.61	25	18,035
29-1051	Pharmacists	320	360	13.92	1.18	10	127,256
21-2011	Clergy	570	660	15.16	1.48	20	52,880
49-9044	Millwrights	60	80	29.03	2.92	5	41,507
47-2073	Operating Engineers and Other Construction Equipment Operators	660	770	17.48	1.55	25	36,371
13-2011	Accountants and Auditors	780	890	13.28	1.33	35	70,234
29-2012	Medical and Clinical Laboratory Technicians	140	170	22.30	1.96	5	35,883

Note: Occupations were selected using unrounded data based on the descending order of average ranking based on three variables: growth, openings, and wages. May 2014 wage data based on the May 2013 OES employment and wage estimate file.

Data provided by the Alabama Department of Labor, Labor Market Information Division in cooperation with the Projections Managing Partnership, and the U.S. Bureau of Labor Statistics.
Totals in some occupational groups may not add due to exclusion of sub-groups and/or individual occupations with employment of less than 10 in the base (2012) and projected (2022) years or where publication of the occupation would violate confidentiality.
*** The data for these occupations are confidential according to standards provided by the U.S. Bureau of Labor Statistics.
1. Employment is rounded to the nearest 10. 2. Average Annual Growth is compounded. 3. Openings are rounded to the nearest 5
* Percent change is based on unrounded data

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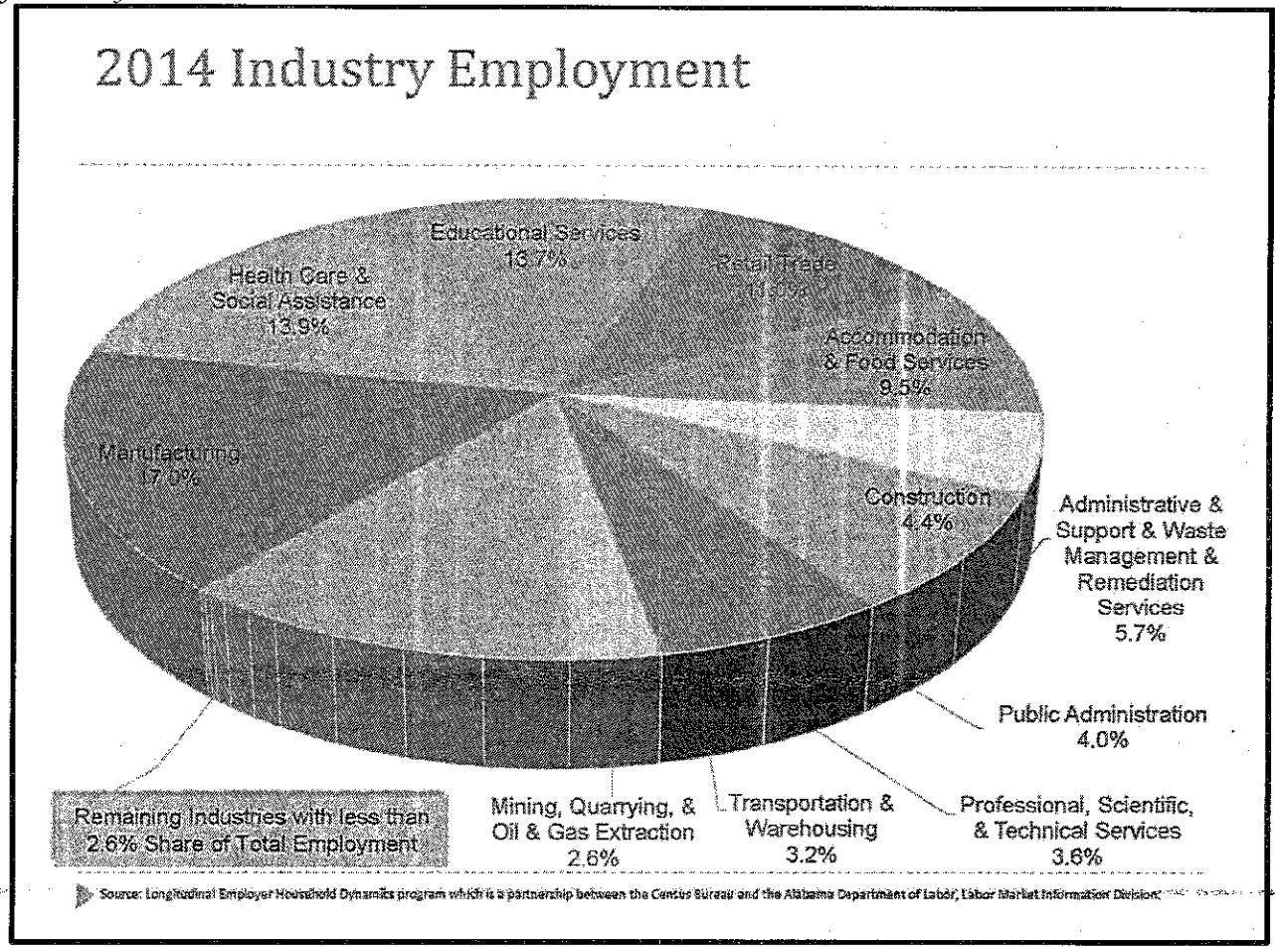
Workforce Development Regional Council 3
Projected Employment by Major Industry

NAICS	Industry	Employment 2012	Employment 2022	Net Change	Percent Change (%)	Average Annual Growth (%) Region 3	Average Annual Growth (%) AL	Location Quotient
	Total Employment	**119,030**	**132,240**	**13,210**	**11.10**	**1.06**	**0.99**	
	Total Wage and Salary Employment	**108,380**	**121,280**	**12,900**	**11.90**	**1.13**	**1.08**	
	Goods Producing	**25,020**	**28,760**	**3,740**	**14.95**	**1.40**	**0.86**	
21	Natural Resources and Mining	3,520	3,270	-250	-7.10	-0.73	-0.35	4.81
23	Construction	5,650	7,120	1,470	26.02	2.34	2.36	1.22
31-33	Manufacturing	15,850	18,370	2,520	15.90	1.49	0.39	1.12
	Durable Goods	11,020	14,000	2,980	27.04	2.42	1.14	
	Nondurable Goods	4,830	4,370	-460	-9.52	-1.00	-1.03	
	Service Providing	**83,360**	**92,520**	**9,160**	**10.99**	**1.05**	**1.10**	
	Trade, Transportation, and Utilities	18,620	19,960	1,340	7.20	0.70	0.75	
42	Wholesale Trade	2,270	2,530	260	11.45	1.09	1.07	0.94
44-45	Retail Trade	12,400	13,070	670	5.40	0.53	0.74	0.95
48-49	Transportation and Warehousing	3,630	3,900	270	10.48	1.00	0.61	0.97
22	Utilities	430	460	30	6.98	0.68	-0.28	0.52
51	Information	890	710	-180	-20.22	-2.23	-0.82	0.68
52	Finance and Insurance	2,660	2,850	190	7.14	0.69	0.63	0.65
53	Real Estate and Rental and Leasing	1,510	1,660	150	9.93	0.96	1.08	1.22
54	Professional, Scientific, and Technical Services	3,000	3,560	560	18.67	1.73	2.02	0.55
55	Management of Companies and Enterprises	560	570	10	1.79	0.18	0.34	0.57
56	Administrative and Support and Waste Management and Remediation Services	5,200	6,350	1,150	22.12	2.02	1.67	0.64
61	Educational Services	13,740	15,110	1,370	9.97	0.95	0.83	1.47
62	Health Care and Social Assistance	15,860	18,590	2,730	17.21	1.60	2.22	1.12
71	Arts, Entertainment, and Recreation	590	630	40	6.78	0.66	1.08	0.65
72	Accommodation and Food Services	9,930	10,970	1,040	10.47	1.00	0.84	1.08
81	Other Services (except Government)	4,380	4,890	510	11.64	1.11	1.16	0.90
90	Government	6,440	6,680	240	3.73	0.37	0.08	0.67
91	Federal Government, Excluding Post Office	300	270	-30	-10.00	-1.05	-1.12	0.12
92	State Government, Excluding Education and Hospitals	1,730	1,740	10	0.58	0.06	0.06	0.79
93	Local Government, Excluding Education and Hospitals	4,410	4,670	260	5.90	0.57	0.63	0.68
	All Other	**10,650**	**10,960**	**310**	**2.91**	**0.29**	**0.28**	

This data is developed and provided by the Alabama Department of Labor, Labor Market Information Division in cooperation with the Projections Managing Partnership of the U.S. Department of Labor, Employment and Training Administration.

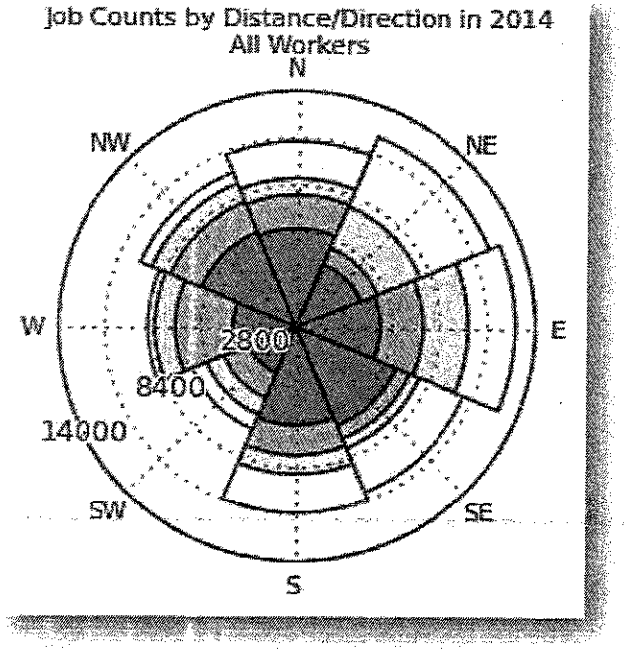
1. Natural Resources and Mining includes NAICS 1133 logging. 2. Employment data is rounded to the nearest 10 and may not add due to rounding. Percentages may not add due to rounding. 3. Average Annual Growth Rate is compounded. 4. For projections purposes Government only includes Government administration. It does not include post office, education, or hospitals. 5. All Other includes agriculture, self-employed, unpaid family workers, and private household that are not covered by unemployment insurance. 6. N/A - National Data is not available at this detail. 7. Location quotient is the comparison of respective area to Alabama.

Employment By Industry



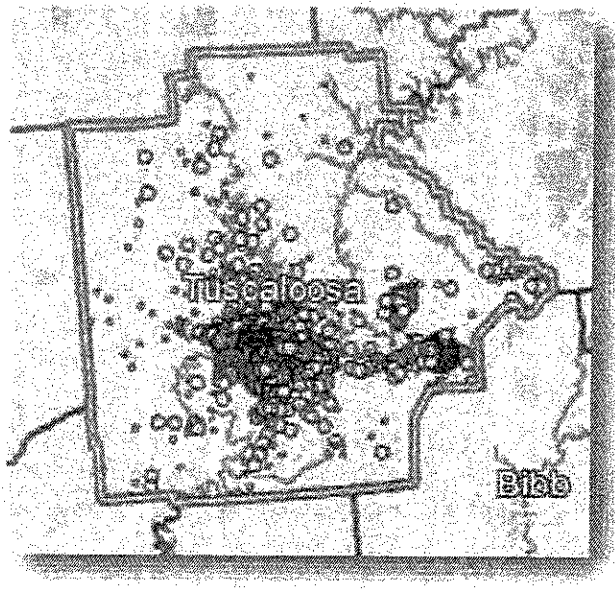
2014 Commuting Patterns

Distance Workers Travel to Tuscaloosa County to Work	Count	Share
Total Primary Jobs	82,938	100.0%
Less than 10 miles	39,781	48.0%
10 to 24 miles	15,031	18.1%
25 to 50 miles	11,566	13.9%
Greater than 50 miles	16,560	20.0%



Source: U.S. Census Bureau, OnTheMap Application and LEHD Origin-Destination Employment Statistics in Partnership with the Alabama Department of Labor, Labor Market Information Division.

2014 Commuting Patterns

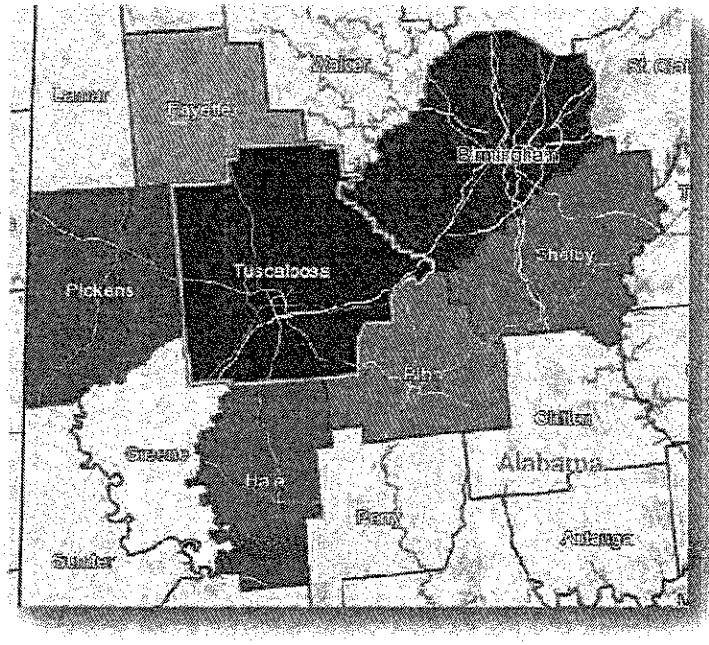


Jobs by Worker Age	Count	Share
Age 29 or younger	22,464	27.1%
Age 30 to 54	44,964	54.2%
Age 55 or older	15,510	18.7%
Jobs by Worker Educational Attainment	**Count**	**Share**
Less than high school	6,784	8.2%
High school or equivalent, no college	18,602	22.4%
Some college or Associate degree	20,565	24.8%
Bachelor's degree or advanced degree	14,523	17.5%
Educational attainment not available (workers aged 29 or younger)	22,464	27.1%
Jobs by Worker Sex	**Count**	**Share**
Male	43,392	52.3%
Female	39,546	47.7%
Jobs by Earnings	**Count**	**Share**
$1,250 per month or less	19,186	23.1%
$1,251 to $3,333 per month	30,508	36.8%
More than $3,333 per month	33,244	40.1%

Source: U.S. Census Bureau, OnTheMap Application and LEHD Origin-Destination Employment Statistics in Partnership with the Alabama Department of Labor, Labor Market Information Division.

2014 Commuting Patterns

County of Residence for Workers in Tuscaloosa County



	Count	Share
Tuscaloosa County, AL	51,351	61.9%
Jefferson County, AL	5,840	7.0%
Pickens County, AL	2,248	2.7%
Hale County, AL	2,230	2.7%
Shelby County, AL	1,924	2.3%
Bibb County, AL	1,680	2.0%
Fayette County, AL	1,116	1.3%
Mobile County, AL	952	1.1%
Greene County, AL	889	1.1%
Madison County, AL	889	1.1%
All Other Locations	13,819	16.7%

Source: U.S. Census Bureau, OnTheMap Application and LEHD Origin-Destination Employment Statistics in Partnership with the Alabama Department of Labor, Labor Market Information Division.

ATTACHMENT 6 - LETTERS and STATEMENTS OF SUPPORT

FIRST BAPTIST CHURCH
TUSCALOOSA

GIL MCKEE, D. MIN.
SENIOR PASTOR

FIRST BAPTIST CHURCH
721 GREENSBORO AVENUE
TUSCALOOSA, AL 35401
phone: 205.345.7554
fax: 205.391.3108
www.firsttuscaloosa.org

May 18, 2017

Victoria Payne
1801 Rice Mine Road N
Tuscaloosa, Alabama 35406

RE: Support Certificate of Need for Additional SCALF Beds

Dear Mrs. Payne:

I understand that Morning Pointe is seeking an adjustment to the State Health Plan for 32 additional memory care beds (SCALF). I am writing this letter to offer my support.

As a pastor and care-giver to my elderly parents, who are both dementia patients, I am very familiar with the need in our community for additional memory care beds. I am also very familiar with Morning Pointe's services and excellent reputation for quality care.

With the demographic increase of adults, age 65+, more memory care beds are not only a current need but will continue to be a growing need in the years ahead. Therefore, I respectfully request that the need for more SCALF beds be addressed as soon as possible.

If I can be of any assistance to you in this matter, please do not hesitate to let me know.

Sincerely,

Gil

Dr. Gil McKee

Magnify. Multiply. Minister.

GREENSBORO AVENUE DOWNTOWN TUSCALOOSA

5/18/17

Victoria Payne
1801 Rice Mine Road N
Tuscaloosa, AL 35406

RE: Support Certificate Of Need for Additional SCALF Beds

Dear Mrs. Payne:

I understand Morning Pointe is seeking an adjustment to the State Health Plan for 32 additional memory care beds (SCALF). I am writing this letter to offer my support.

I am a member of the community. As such, I am in a position to not only know the need for additional memory care beds, but I am also familiar with Morning Pointe's services. Morning Pointe has an excellent reputation for quality of care.

With the increase in the 65+ population, more memory care beds are required. Therefore, in my opinion the need for SCALF beds is in great demand and will continue to be.

Sincerely,

Kyle Gray

Executive Chef

R. Davidson Chophouse

5/18/17

Victoria Payne
1801 Rice Mine Road N
Tuscaloosa, AL 35406

RE: Support Certificate Of Need for Additional SCALF Beds

Dear Mrs. Payne:

I understand Morning Pointe is seeking an adjustment to the State Health Plan for 32 additional memory care beds (SCALF). I am writing this letter to offer my support.

I am a member of the community. As such, I am in a position to not only know the need for additional memory care beds, but I am also familiar with Morning Pointe's services. Morning Pointe has an excellent reputation for quality of care.

With the increase in the 65+ population, more memory care beds are required. Therefore, in my opinion the need for SCALF beds is in great demand and will continue to be.

Sincerely,

James C. Holdefer

James C. Holdefer
Dining Room Manager
The Levee

5/18/17

Victoria Payne
1801 Rice Mine Road N
Tuscaloosa, AL 35406

RE: Support Certificate Of Need for Additional SCALF Beds

Dear Mrs. Payne:

I understand Morning Pointe is seeking an adjustment to the State Health Plan for 32 additional memory care beds (SCALF). I am writing this letter to offer my support.

I am a member of the community. As such, I am in a position to not only know the need for additional memory care beds, but I am also familiar with Morning Pointe's services. Morning Pointe has an excellent reputation for quality of care.

With the increase in the 65+ population, more memory care beds are required. Therefore, in my opinion the need for SCALF beds is in great demand and will continue to be.

Sincerely,

LaCarius Lewis

LaCarius Lewis
Executive Chef
Levee Bar & Grill

5/18/17

Victoria Payne
1801 Rice Mine Road N
Tuscaloosa, AL 35406

RE: Support Certificate Of Need for Additional SCALF Beds

Dear Mrs. Payne:

I understand Morning Pointe is seeking an adjustment to the State Health Plan for 32 additional memory care beds (SCALF). I am writing this letter to offer my support.

I am a member of the community. As such, I am in a position to not only know the need for additional memory care beds, but I am also familiar with Morning Pointe's services. Morning Pointe has an excellent reputation for quality of care.

With the increase in the 65+ population, more memory care beds are required. Therefore, in my opinion the need for SCALF beds is in great demand and will continue to be.

Sincerely,

Gary B. McGee Owner
Levee Bait & Grill

5/18/17

Victoria Payne
1801 Rice Mine Road N
Tuscaloosa, AL 35406

RE: Support Certificate Of Need for Additional SCALF Beds

Dear Mrs. Payne:

I understand Morning Pointe is seeking an adjustment to the State Health Plan for 32 additional memory care beds (SCALF). I am writing this letter to offer my support.

I am a member of the community. As such, I am in a position to not only know the need for additional memory care beds, but I am also familiar with Morning Pointe's services. Morning Pointe has an excellent reputation for quality of care.

With the increase in the 65+ population, more memory care beds are required. Therefore, in my opinion the need for SCALF beds is in great demand and will continue to be.

Sincerely,

Jennifer Frith
UAC
PT Dept

May 18, 2017

Victoria Payne
1801 Rice Mine Road N
Tuscaloosa, AL 35406

RE: Support Certificate Of Need for Additional SCALF Beds

Dear Mrs. Payne:

I understand Morning Pointe is seeking an adjustment to the State Health Plan for 32 additional memory care beds (SCALF). I am writing this letter to offer my support.

I am a long time member of the Northport community, and have enjoyed leading Bible Studies in your facility for 16 years. As such, I am in a position to not only know the need for additional memory care beds, but I am also familiar with Morning Pointe's services. Morning Points has an excellent reputation for quality of care.

With the increase in the 65+ population, more memory care beds are required. Therefore, in my opinion the need for SCALF beds is in great demand and will continue to be.

Sincerely,

Pat Bohannon

Pat Bohannon
3758 Delray Lane
Northport, AL 35473

May 18, 2017

Victoria Payne
1801 Rice Mine Road N
Tuscaloosa, AL 35406

RE: Support Certificate Of Need for Additional SCALF Beds

Dear Mrs. Payne:

I understand Morning Pointe is seeking an adjustment to the State Health Plan for 32 additional memory care beds (SCALF). I am writing this letter to offer my support.

I am the Maintenance Director at Morning Pointe. I also have an elderly mother. As such, I am in a position to not only know the need for additional memory care beds, but I am also familiar with Morning Pointe's services. Morning Pointe has an excellent reputation for quality of care.

With the increase in the 65+ population, more memory care beds are required. Therefore, in my opinion the need for SCALF beds is in great demand and will continue to be.

Sincerely,

Don Beasley, Maintenance Director
Morning Pointe of Tuscaloosa

May 15, 2017

Victoria Payne
1801 Rice Mine Road N
Tuscaloosa, AL 35406

RE: Support CON for Additional SCALF Beds

Dear Mrs. Payne:

I understand Morning Pointe is seeking an adjustment to the State Health Plan for 32 additional memory care beds (SCALF). I am writing this letter to offer my support.

I am Terry Bynum, RN, Mental Health Nurse. As such, I am in a position to not only know the need for additional memory care beds, but I am also familiar with Morning Pointe's services. Morning Point has an excellent reputation for quality of care.

With the increase in the 65+ population, more memory care beds are required. Therefore, in my opinion the need for SCALF beds is in great demand and will continue to be.

Sincerely,

Terry Bynum, RN

May 15, 2017

Victoria Payne
1801 Rice Mine Road N
Tuscaloosa, AL 35406

RE: Support CON for Additional SCALF Beds

Dear Mrs. Payne:

I understand Morning Pointe is seeking an adjustment to the State Health Plan for 32 additional memory care beds (SCALF). I am writing this letter to offer my support.

I am the daughter of one of the residents of Morning Pointe. As such, I am in a position to not only know the need for additional memory care beds, but I am also familiar with Morning Pointe's services. Morning Point has an excellent reputation for quality of care.

With the increase in the 65+ population, more memory care beds are required. Therefore, in my opinion the need for SCALF beds is in great demand and will continue to be.

Sincerely, Stormy Watson

Stormy Watson

May 15, 2017

Victoria Payne
1801 Rice Mine Road N
Tuscaloosa, AL 35406

RE: Support CON for Additional SCALF Beds

Dear Mrs. Payne:

I understand Morning Pointe is seeking an adjustment to the State Health Plan for 32 additional memory care beds (SCALF). I am writing this letter to offer my support.

I am the husband of one of Morning Pointe's residents. As such, I am in a position to not only know the need for additional memory care beds, but I am also familiar with Morning Pointe's services. Morning Point has an excellent reputation for quality of care.

With the increase in the 65+ population, more memory care beds are required. Therefore, in my opinion the need for SCALF beds is in great demand and will continue to be.

Sincerely,

John Upchurch

John Upchurch

May 15, 2017

Victoria Payne
1801 Rice Mine Road N
Tuscaloosa, AL 35406

RE: Support CON for Additional SCALF Beds

Dear Mrs. Payne:

I understand Morning Pointe is seeking an adjustment to the State Health Plan for 32 additional memory care beds (SCALF). I am writing this letter to offer my support.

I am the daughter of one of Morning Pointe's residents. As such, I am in a position to not only know the need for additional memory care beds, but I am also familiar with Morning Pointe's services. Morning Point has an excellent reputation for quality of care.

With the increase in the 65+ population, more memory care beds are required. Therefore, in my opinion the need for SCALF beds is in great demand and will continue to be.

Sincerely,

Laura Fields

Laura Fields

May 15, 2017

Victoria Payne
1801 Rice Mine Road N
Tuscaloosa, AL 35406

RE: Support CON for Additional SCALF Beds

Dear Mrs. Payne:

I understand Morning Pointe is seeking an adjustment to the State Health Plan for 32 additional memory care beds (SCALF). I am writing this letter to offer my support.

I am Becky Kelley, a beautician. As such, I am in a position to not only know the need for additional memory care beds, but I am also familiar with Morning Pointe's services. Morning Point has an excellent reputation for quality of care.

With the increase in the 65+ population, more memory care beds are required. Therefore, in my opinion the need for SCALF beds is in great demand and will continue to be.

Sincerely,
Becky Kelley
Becky Kelley

THE CHAMBER
OF COMMERCE OF WEST ALABAMA

May 12, 2017

Victoria Payne

1801 Rice Mine Road N

Tuscaloosa, AL 35406

RE: Support CON for Additional SCALF Beds

Dear Mrs. Payne:

I understand Morning Pointe is seeking an adjustment to the State Health Plan for 32 additional memory care beds (SCALF). I am writing this letter to offer my support.

I am a member of the community. As such, I am in a position to not only know the need for additional memory care beds, but I am also familiar with Morning Pointe's services. Morning Points has an excellent reputation for quality of care.

With the increase in the 65+ population, more memory care beds are required. Therefore, in my opinion the need for SCALF beds is in great demand and will continue to be.

Sincerely,

Kimberly Adams

DCH Home Health Care Agency

05/11/17

Victoria Payne
1801 Rice Mine Road N
Tuscaloosa, AL 35406

1401 Greensboro Avenue
Tuscaloosa, Alabama 35401
205.759.7010

RE: Support CON for Additional SCALF Beds

Dear Mrs. Payne:

I understand Morning Pointe is seeking an adjustment to the State Health Plan for 32 additional memory care beds (SCALF). I am writing this letter to offer my support.

I am a social worker at DCH Home Health. As such, I am in a position to not only know the need for additional memory care beds, but I am also familiar with Morning Pointe's services. Morning Pointe has an excellent reputation for quality of care.

With the increase in the 65+ population, more memory care beds are required. Therefore, in my opinion the need for SCALF beds is in great demand and will continue to be.

Sincerely,

Melody Sims MSW LICSW
DCH Home Health
1401 Greensboro Ave
Tuscaloosa, AL 35401

May 11, 2017

Victoria Payne
1801 Rice Mine Road N
Tuscaloosa, AL 35406

RE: Support CON for Additional SCALF Beds

Dear Mrs. Payne:

I understand Morning Pointe is seeking an adjustment to the State Health Plan for 32 additional memory care beds (SCALF). I am writing this letter to offer my support.

I am a member of the local community. As such, I am in a position to not only know the need for additional memory care beds, but I am also familiar with Morning Pointe's services. Morning Pointe has an excellent reputation for quality of care.

With the increase in the 65+ population, more memory care beds are required. Therefore, in my opinion the need for SCALF beds is in great demand and will continue to be.

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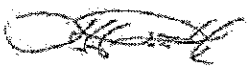

May 11, 2017

Victoria Payne
1801 Rice Mine Road N
Tuscaloosa, AL 35406

RE: Support CON for Additional SCALF Beds

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Sincerely,

Amy Williams

Amy Williams

May 11, 2017

Victoria Payne
1801 Rice Mine Road N
Tuscaloosa, AL 35406

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Sincerely,

Katherine Hardy

May 11, 2017

Victoria Payne
1801 Rice Mine Road N
Tuscaloosa, AL 35406

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Drew Pflughoft

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Sincerely,

Amy Owens

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Victoria Payne
1801 Rice Mine Road N
Tuscaloosa, AL 35406

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Sincerely,

Jake Herring

May 11, 2017

Victoria Payne
1801 Rice Mine Road N
Tuscaloosa, AL 35406

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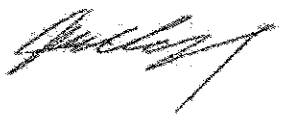

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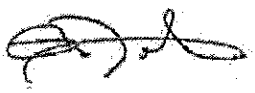

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Sincerely,

Karen M Chandler

Karen Chandler

May 11, 2017

Victoria Payne
1801 Rice Mine Road N
Tuscaloosa, AL 35406

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Sincerely,

Kim Tillery

Kim Tillery

May 11, 2017

Victoria Payne
1801 Rice Mine Road N
Tuscaloosa, AL 35406

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Sincerely,

Stephen Brad-Downs
downss@nationwide.com
(205) 345-5958

May 11, 2017

Victoria Payne
1801 Rice Mine Road N
Tuscaloosa, AL 35406

RE: Support CON for Additional SCALF Beds

Dear Mrs. Payne:

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Sincerely,

Tammy Angelroff

May 11, 2017

Victoria Payne
1801 Rice Mine Road N
Tuscaloosa, AL 35406

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Sincerely,

Kristi Nelson

May 11, 2017

Victoria Payne
1801 Rice Mine Road N
Tuscaloosa, AL 35406

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Sincerely,

Twila Sanford

May 11, 2017

Victoria Payne
1801 Rice Mine Road N
Tuscaloosa, AL 35406

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Sincerely,

Lauren Peg, VC
Amedisys Hospice

May 11, 2017

Victoria Payne
1801 Rice Mine Road N
Tuscaloosa, AL 35406

RE: Support CON for Additional SCALF Beds

Dear Mrs. Payne:

I understand Morning Pointe is seeking an adjustment to the State Health Plan for 32 additional memory care beds (SCALF). I am writing this letter to offer my support.

I am a member of healthcare community as a home health physical therapist. As such, I am in a position to not only know the need for additional memory care beds, but I am also familiar with Morning Pointe's services. Morning Pointe has an excellent reputation for quality of care.

With the increase in the 65+ population, more memory care beds are required. Therefore, in my opinion the need for SCALF beds is in great demand and will continue to be.

Sincerely,

Michele Jones PT

Michele Jones