EXHIBIT 4 *Evidence of your project being in occupancy for at least five years as of the date of the application to HUD.*

A copy of the initial Regulatory Agreement for National Church Residences of Cuyahoga Falls, Ohio, Formerly known as Cathedral Apartments, Inc.

VOL 4655 PAGE 92

CFA-932
(7-64)

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Senior Citizens Housing Loan Program

REGULATORY AGREEMENT

Name of Borrower: Cathedral Apartments, Inc. Project No.: SH-Ohio-15

Address: Cuyahoga Falls, Ohio Loan Amount: $2,263,000.00

This agreement entered into this 1st day of February, 1967, between Cathedral Apartments, Inc., a not for profit corporation organized and existing by virtue of the laws of the State of Ohio, (hereinafter called "Borrower") and the UNITED STATES OF AMERICA, acting by and through the Secretary of Housing and Urban Development (hereinafter called "Government").

WHEREAS, Borrower and Government have heretofore executed a Loan Agreement dated March 1, 1966, pursuant to which the Government agreed to make a loan to Borrower in the amount of not to exceed $2,263,000.00 to finance construction of a housing project (herein called "Project") located at Cuyahoga Falls, Ohio, pursuant to Section 202 of the Housing Act of 1959, as amended;

WHEREAS, the foregoing loan is evidenced by Borrower's Note dated February 1, 1967, and Mortgage (or Deed of Trust) dated February 1, 1967.

NOW, THEREFORE, in consideration of the foregoing loan and the disbursement of any portion thereof, Borrower covenants and agrees:

1. Borrower will not: (a) make any advance directly or indirectly, by way of loan, gift, bonus, gratuity, drawing account, commission or otherwise (except for reasonable advances for travel expenses) to any company directly or indirectly controlling or affiliated with or controlled by Borrower, or to any officer, director, member, stockholder or employee of Borrower, or of any such company; (b) guarantee a loan to or obligation of any person, firm or corporation; (c) pay any compensation to its officers, directors, members, or stockholders for services rendered as such.

2. Borrower will not: (a) rent the Project or any part thereof to any person for the purpose of subleasing; (b) rent the Project as an entirety; (c) rent any dwelling unit in the Project for any rental period less than one month or in excess of three years; (d) rent the Project or any part thereof or permit its use for hotel or transient purposes.

3. (a) Borrower will limit public occupancy of the Project to elderly persons and elderly families as defined in the Housing Act of 1959 and any amendments thereto. Borrower will adopt and submit for approval by the Government eligibility criteria for Project occupancy prior to the initial renting, and will submit for prior approval of the Government any proposed changes in such criteria.

(b) This agreement is subject to the provisions of Executive Order No. 11063 dated November 20, 1962. The Borrower covenants and agrees that it will not discriminate nor permit discrimination by its agents, lessees or any others operating housing and related facilities, in the use or occupancy of said facilities because of race, color, creed or national origin.

4. Borrower will make the dwelling accommodations, utilities, and services of the Project available to eligible occupants at charges established in accordance with a schedule to be approved in writing by the Government. Commercial facilities, if any, shall be rented only in accordance with a schedule of charges approved by the Government.

5. No life-lease contracts, founder's fees or other payments or deposits over and above those for rents, utilities and collateral services plus a security deposit in an amount not to exceed one month's rent shall be required of any tenant as a condition of occupancy or leasing of any unit, nor shall the Borrower accept any contribution or gratuity as a basis for occupancy or occupancy preference.

6. Borrower shall not, without prior written approval of the Government:

a. Transfer, dispose of or encumber any of the Mortgaged Property, Any such transfer shall be only to a person, persons, or corporation approved by the Government who shall, by legal and valid instrument in writing to be recorded or filed in the same recording office in which conveyances of the property covered by the Mortgage are required to be filed or recorded, duly assume all obligations under this Agreement and under the Note and Mortgage.

b. Assign, transfer, dispose of, or encumber any personal property of the Project, including rents or charges collected or to be collected;

and shall not disburse or pay out any of the pledged revenues or other pledged funds except as provided in the Loan Agreement.

c. Remodel, reconstruct, add to, or demolish any part of the Mortgaged Property or subtract from any real or personal property of the Project.

d. Prepay the loan except as provided in the Loan Agreement.

e. Amend its articles of incorporation or by-laws other than as permitted under the terms of the articles of incorporation and by-laws approved by the Government.

f. Enter into any contract or contracts for supervisory or management services. The terms of any management contract entered into by the Borrower shall be acceptable to the Government and shall provide for termination upon thirty days written notice by the Government.

7. Borrower shall not file any petition in bankruptcy, or for a receiver, or in insolvency, or for reorganization or composition or make any assignment for the benefit of creditors or to a trustee for creditors. Borrower will immediately satisfy or release any mechanics lien, attachment, judgment lien, or other lien which attaches to the Mortgaged property or to any personal property used in the operation of the Project, and shall dismiss or have dismissed or vacated any receivership or petition in bankruptcy or assignment for benefit of creditors, creditors' bill, or insolvency proceeding involving the Borrower, the Project or the Mortgaged Property.

8. If the Borrower engages in any business or activity other than the Project and operation of the Mortgaged Property, it shall maintain all assets, income, and other funds of the Project segregated from other funds of the Borrower and segregated from any funds of any other corporation or person.

9. No officer, director, trustee, member stockholder nor the authorized representative of Borrower shall have any financial interest in any contractual arrangement entered into by the Borrower in connection with rendition of services, the provision of goods or supplies, management of the Project, procurement of furnishings and equipment, construction of the Project, procurement of the site or other matters whatever.

10. As prescribed in Part I of the Loan Agreement, the Borrower shall, prior to the beginning of each of its fiscal years, prepare and submit to the Government an annual plan of operation and supporting budget in form and substance acceptable to the Government.

11. Basic management powers shall be vested in a Board of Trustees or Directors of no less than seven persons, acceptable to the Government, fully independent and broadly representative of public interest groups, with reasonable assurance that there will be a continuity of a qualified Board of Directors over the life of the loan. The Borrower shall file with the Government an incumbency report showing changes in its Board of Directors and officers, promptly upon the making of any such changes, and annually in any event, together with such other information concerning its Board and officers as the Government shall require.

12. Borrower shall make no payment for services,supplies, or materials unless such services have actually been rendered to the Project, or such supplies or materials have been delivered to the Project and are reasonably necessary for its operation. Payment for such services, supplies, or materials shall not exceed the amount ordinarily paid for such services, supplies or materials in the area where the services are rendered or the supplies and materials furnished.

13. The Project including the Mortgaged Property, equipment, buildings plans, offices, apparatus, devices, books, contracts, records, documents and other papers relating thereto shall be subject to examination and inspection at any reasonable time by the Government; the Borrower shall keep copies of all written contracts or other instruments which affect the Mortgaged Property or the Project, all of which shall be subject to inspection and examination by the Government.

14. The Borrower will keep accurate financial records and proper books in form and substance acceptable to the Government relating to the Project, other facilities the revenues of which are pledged to secure the Mortgage and other pledged revenues and sources, and such books and records shall be open to inspection by the Government. The Borrower further covenants that not later than 90 days after the close of each fiscal year it will furnish to the Government copies of audit reports prepared by an independent public accountant reflecting in reasonable detail the financial condition and record of operation of the Borrower, the Project, other pledged facilities, and

VOL 4655 PAGE 95

other pledged revenue sources including particularly the occupancy of, use of services provided, rates charged for the use of, insurance on, the Project and other pledged facilities, and the status of the several accounts and funds required by the Loan Agreement. At the request of the Government the Borrower shall give specific answers to questions upon which information is desired from time to time relative to the income, assets, liabilities, contracts, operation and condition of the Project and status of the Mortgage and any other information with respect to the Borrower, or the Project.

15. Upon a violation of any of the above provisions of this Agreement by the Borrower, the Government may give written notice thereof to the Borrower, by registered or certified mail, addressed to the address stated in this Agreement. If such violation is not corrected to the satisfaction of the Government within 15 days after the date such notice is mailed, without further notice the Government may declare a default under this Agreement and upon such default the Government may:

(1) Declare the whole of the indebtedness immediately due and payable and proceed with the foreclosure of the Mortgage.

(2) Collect all rents and charges in connection with the operation of the Project and use such collections to pay the Borrower's obligation under this Agreement and under the Note and Mortgage and the necessary expenses of preserving the Property and operating the Project.

(3) Take possession of the Mortgaged Property and operate the Project in accordance with the terms of this Agreement until such time as the Government in its discretion determines that the Borrower is again in a position to operate the Project in accordance with the terms of this Agreement and in compliance with the terms of the Note and Mortgage.

(4) Apply to any court, State or Federal, for specific performance of this Agreement, for an injunction against any violation of the Agreement, for a receiver to take over and operate the property in accordance with the terms of this Agreement, or for such other relief as may be appropriate since the injury to the Government arising from a default under any of the terms of this Agreement would be irreparable and the amount of damage would be difficult to ascertain.

16. As security for the performance of Borrower's obligations under this Agreement and under the Loan Agreement, the Borrower assigns to the Government its right to the rents, profits, income and charges of whatever sort which it may receive or be entitled to receive from the operation of the Mortgaged Property. Until a default is declared under this Agreement, however, permission is granted to the Borrower to collect such rents, profits, income and charges, but upon default this permission is terminated.

17. As used in this Agreement the term "Government" shall include the Secretary of Housing and Urban Development his successors, officials, employees, and agents; "Mortgage" shall include "Deed of Trust"; "Mortgaged Property" shall include all property, real or personal, covered by the Mortgage, and all personal property belonging to the Project and used in connection with the furnishing of a project constructed under Section 202 of the Housing Act of 1959, as amended; and "Borrower" shall include the Mortgagor, its successors and assigns.

18. The Government shall not be liable for any of its acts hereunder except for flagrant misfeasance.

19. The invalidity of any clause, part, or provision of this Agreement shall not affect the validity of the remaining portions thereof.

IN WITNESS WHEREOF, the United States of America, acting by and through the Secretary of Housing and Urban Development has caused this Agreement to be executed in its name and on its behalf, by the Regional Administrator, Region IV, and the Borrower has caused this instrument to be executed in its name and on its behalf by its President and attested by its Secretary, all as of the day and year first above written.

UNITED STATES OF AMERICA acting by and through the Secretary of Housing and Urban Development

By _____
Regional Administrator, REGION IV

(SEAL)

CATHEDRAL APARTMENTS, INC.

ATTEST:

By _____
President

Secretary

INDEXED

460409

Cathedral Apts. Inc

to

U.S.A. Housing & Urban Dev.

RECEIVED FOR RECORD
MAR 13 1987
At 1:47 o'clock P M
Recorded MAR 14 1987
Vol. 4655 Page 70-97
Ronald P. Ruff
Recorder,
Summit County, Ohio
$28.00

Prepared by Chris Flew

EXHIBIT 5

This exhibit addresses these components as presented in this project's Logic Model:

- *Case Management- Frail elderly persons in need of units and services*
- *HUD Priority- Promoting Assistance to Veterans*

EXHIBIT 5 *A market analysis of the need for the proposed ALF units, including information from both the project and the housing market, containing:*

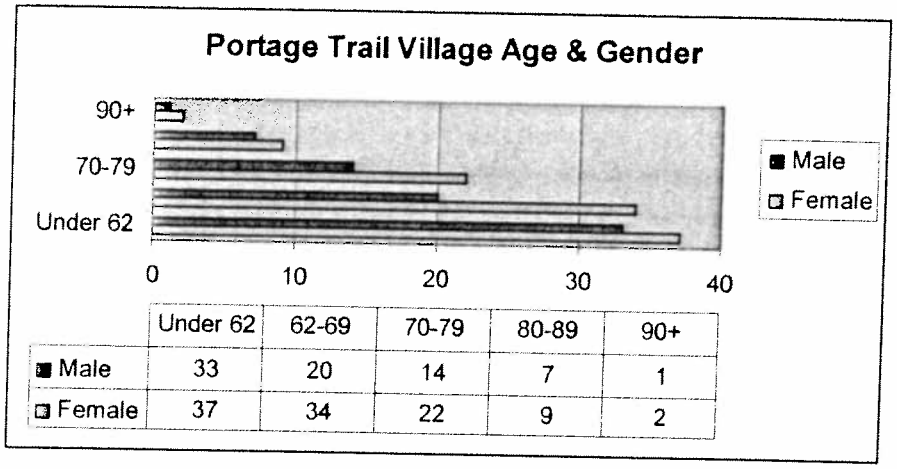
(a) Evidence of need for the ALF by current project residents:

1. *A description of the demographic characteristics of the elderly residents currently living in the project, including the current number of residents, distribution of residents by age and sex, an estimate of the number of residents with frailties/limitations in activities of daily living and an estimate of the number of residents in need of assisted living services*
2. *A description of the services currently available to the residents and/or provided on or off-site and what services are lacking*

(1) Description of demographic characteristics of current elderly residents

Portage Trail Village (PTV) is a 13 story, HUD Section 202, elderly housing development located in Cuyahoga Falls, Ohio. This 192 unit building is 100% occupied with a lengthy waiting list (see attached). Elderly individuals that were independent, not requiring supportive services, originally occupied the project built specifically for low-income seniors. These were traditional apartments. While adequate for the majority of low-income older residents, this housing does not provide the flexibility to allow residents to age in place, nor does it necessarily provide the range of housing options needed to serve the increasing share of frail seniors. As the residents have aged, their independence has decreased and their need for supportive services has increased. These once independent elderly residents now need assistance with several Activities of Daily Living (ADLs). In 2006, the Institute for the Future of Aging Services (IFAS) accomplished a study for the American Association of Homes & Services (AAHSA) entitled, Creating New Long-Term Care Choices for Older Adults: A Synthesis of Findings from a Study of Affordable Housing Plus Service Linkages.[attached] Research from that study

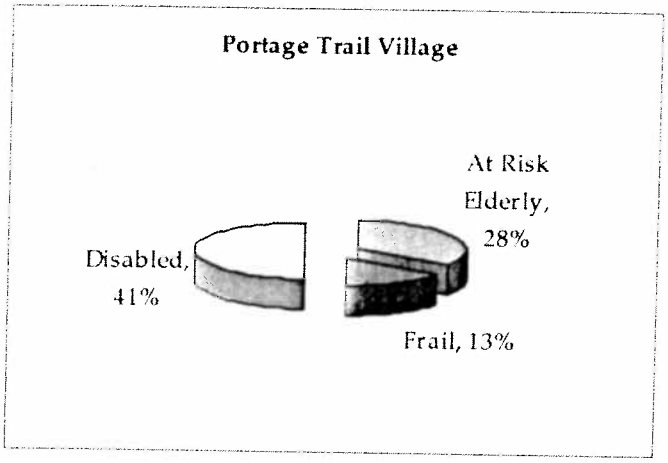
found "about 1.8 million older adults-mostly poor, single women in their mid 70s to early 80s-live in federally subsidized housing –". At least 58% of the current PTV residents are females and 11% of all PTV residents are in the over 80 range as shown in the following chart.



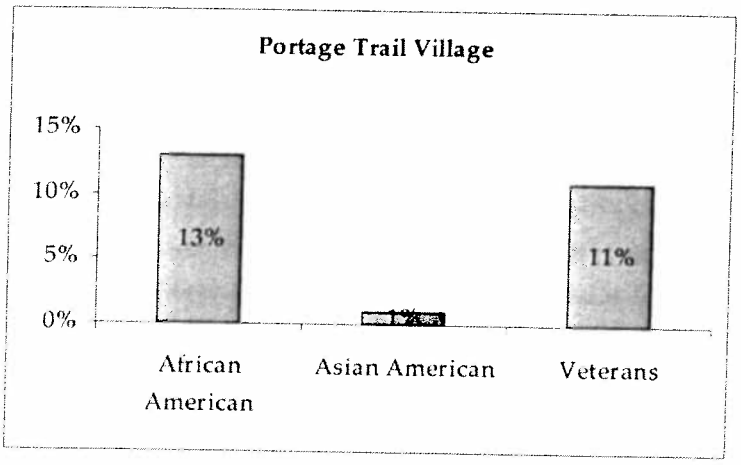
	Under 62	62-69	70-79	80-89	90+
Male	33	20	14	7	1
Female	37	34	22	9	2

The country's elderly resident population is changing radically, bringing new challenges to supportive housing projects. Their residents are not only poorer than the general senior population, they are also older, disproportionately minority and female, and more likely to be alone. A recent article which appeared in The Columbus Dispatch stated that "Ohioans are getting old and expensive." The article further explained that by 2040 the number of residents needing long term care will double unless the system is altered and more services are provided to allow those growing older in the state to have access to in home services or assisted living.

The demographic characteristics of the elderly residents of PTV indicate an aging population which becomes frailer each year. The following chart shows that 82% of the PTV residents are categorized as frail, at risk or disabled.



Finally, the following chart shows that 14% of the resident base at PTV is categorized as minority and another 11% of the residents housed at PTV are veterans.



(2) Description of services currently available to residents

Aging in place requires the coordination of health and housing programs to deliver a customized level of care in an individual's current environment. According to Robert Applebaum, a professor and director of The Scripps Gerontology Center at Miami University at Oxford, unless the system is altered, Medicaid could consume half of the state budget of Ohio by 2020. His recommendation, as outlined in ***The Columbus Dispatch***, is to increase the number in low-cost services available to Ohioans in need of

long term care. These services should include assisted living and the result would be that the state will save money by reducing the use of higher-cost nursing homes. The following services are currently available to residents through various organizations including the sponsor organization, National Church Residences (NCR). NCR employs approximately 154 service coordinators, serving 194 of its senior housing properties.

Service Coordination

PTV has had a HUD funded service coordinator through the HUD budget to assist our frail residents. The role of the service coordinator is determined by the HUD service coordinator guidelines and the State of Ohio's Assisted Living Regulations, which requires that an ALF have a service coordinator on site. The service coordinator works as a "gatekeeper" in identifying and assisting residents in securing community based services as well as in determining if residents are eligible for the Assisted Living Medicaid Waiver Program (ALMWP) or in need of assisted living services to remain at PTV. Furthermore, the Service Coordinator works closely with the registered nurse, case manager and the social worker as part of the interdisciplinary team to review and revise the service plan.

Personal Care

Personal Care consists of supervision of and assistance with Activities of Daily Living (ADL) such as bathing, dressing, and ambulation and Instrumental Activities of Daily Living (IADL) such as laundry, housekeeping, and socialization. These services will be available 7 days a week.

Medication Management

As specified by individual plans of care and on-going assessment, each resident will be provided with a Self-Administered Medication Management plan. This plan will include reminding residents to take medication, opening containers for residents, opening prepackaged medication for residents, reading the medication label to residents, observing residents while they take medication, checking the self-administered dosage against the label of the container, reassuring residents that they have obtained and are taking the dosage as prescribed and documenting in writing an observation of each resident's actions regarding the medication.

Emergency Response

Provision of the following emergency response plans:

- 24 hour a day on-site staff to respond to the needs of the ALF residents.

- For each individual receiving assisted living services there will be a personal emergency response system that will be maintained by the private organization specializing in this product.
- Emergency monitoring system centralized to the assisted living staff offices.
- Wandering alarm bracelet (or similar system such as a door monitoring) system for cognitively impaired residents.
- Emergency pull cords in all bedrooms and bathrooms.

Meals

PTV will have available on-site, 3 meals a day including: continental breakfast and full hot lunch served in our community dining room. The service plan for those paying privately includes one main meal daily with an option to purchase the continental breakfast.

Transportation

Transportation will be available for a broad range of purposes to the residents of PTV. Arrangements will be coordinated with the Area Agency on Aging van, and their local vender, and other local providers. The fees for personal and medical transportation will be set forth by the individual provider.

Optional Services

Personal Care

Personal Care consists of supervision of and assistance with Activities of Daily Living (ADL) such as bathing, dressing, and ambulation and Instrumental Activities of Daily Living (IADL) such as laundry, housekeeping, and socialization. These services will be available 7 days a week.

Transportation

Transportation Service is provided through the Area Agency on Aging as well as through the City program.

Meals

The ALF will have available on-site, 3 meals a day including: continental breakfast served in our country kitchen, and lunch and supper served in our spacious dining room.

Housekeeping

The housekeeping service includes cleaning the apartments, doing laundry, and shopping. This service can be purchased on an hourly basis.

The above referenced program stands today as an exemplary model of supportive housing. The Sponsor, NCR, is considered a state of the art model and has been featured in numerous reports and publications. One such example is the report issued by the American Association of Homes and Services for the Aging in which NCR is highlighted as a successful model. Attached is a copy of the relevant pages of that report.

The above services will be included in the ALF.

Manual Waiting List : Portage Trail Village

Application Received		Head of Household		Annual Income Level			Need for Accessible	Preference	Unit	Removal from List		
Date	Time	Last	First	Low	Very Low	ELI	Unit?	Status?	Size	Date	Time	Reason for Removal
09/14/04	2:55 p.m.	[redacted]				X	Yes	No	1 bd			
05/15/06	3:00 p.m.					X	No	No	1 Bd			
07/19/06	2:10 p.m.					X	No	No	1 Bd			
09/08/06	4:25 p.m.					X	Yes	No	1 Bd			
10/19/06	2:35 p.m.					X	No	No	1 Bd			
10/01/07	3:24 p.m.					X	No	No	1 Bd			
12/28/07	10:06 a.m.					X	Yes	No	1Bd			
02/29/08	10:53 a.m.					X	No	No	1 Bd			
03/05/08	10:48 a.m.				X		No	No	1 Bd			
08/18/08	1:28 PM				X		No	No	1Bd			
Current Residents												
12/18/07	11:32 AM	[redacted]				X	No	Yes	1 Bd.	12/08/08	11:30a.m.	Got 1 bedroom unit 403
01/08/08	1:00 PM				X		No	Yes	1 Bd.	12/15/08	11:00am	Got 1 Bedroom Unit 414
05/01/08	9:30 AM					X	Yes	Yes	1 Bd.	12/19/08	3:00 PM	Got 1 Bedroom Unit 203
05/05/08	3:30 PM				X		No	Yes	1Bd	08/04/09	3:00 PM	Moved Out 8/4/09
06/03/08	11:35 AM				X		No	Yes	1 Bd.			
07/29/08	2:00 PM				X		No	Yes	1 Bd.			
07/31/08	3:00 PM					X	No	Yes	1 Bd.			
08/05/08	1:15 PM				X		No	Yes	1 Bd.			
10/17/08	1:00 PM					X	No	Yes	1 Bd.			
11/19/08	04:02pm				X		No	Yes	1 Bd.			
11/25/08	9:25 AM					X	No	Yes	1 Bd.			
12/10/08	10:57 AM				X		No	Yes	1 Bd.			
05/22/09	3:22 PM				X		No	Yes	1Bd			
	Studio List	**Units for Disabled**										
04/30/08	11:57 AM	[redacted]				X	Yes	No	Studio			Moved In 1/9/09
05/28/08	3:09 PM					X	Yes	No	Studio			Moved in 4/16/09
07/08/08	3:12 PM					X	Yes	No	Studio			
07/10/08	3:30 PM					X	Yes	No	Studio			
07/11/08	10:39 AM					X	Yes	No	Studio			330-808-9078
07/11/08	2:49 PM					X	Yes	No	Studio			
08/08/08	2:56 PM					X	Yes	No	Studio			
08/15/08	3:20 PM					X	yes	No	Studio			
09/22/08	9:23 AM					X	Yes	No	Studio			

12/22/08	1:13 PM	[redacted]	X	Yes	No	Studio
12/29/08	9:00 AM		X	Yes	No	Studio
02/24/09	3:35pm		X	Yes	No	Studio
04/28/09	2:29pm		X	Yes	No	Studio
05/08/09	1:36 PM		X	Yes	No	Studio

Creating New Long-Term Care Choices for Older Adults

A Synthesis of Findings from a Study of Affordable Housing Plus Services Linkages

Mary F. Harahan • Alisha Sanders • Robyn Stone, Dr. P.H.

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Creating New Long-Term Care Choices for Older Adults: A Synthesis of Findings from a Study of Affordable Housing Plus Services Linkages

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The Institute for the Future of Aging Services is a policy research institute whose mission is to create a bridge between the practice, policy and research communities to advance the development of high-quality health, housing and supportive services for America's aging population. IFAS is the applied research arm of the American Association of Homes and Services for the Aging (AAHSA). AAHSA members serve two million people every day through mission-driven, not-for-profit organizations dedicated to providing the services people need, when they need them, in the place they call home. AAHSA's commitment is to create the future of aging services through quality people can trust.

Creating New Long-Term Care Choices for Older Adults

A Synthesis of Findings from a Study of Affordable Housing Plus Services Linkages

Introduction

The aging of the baby boomers will profoundly influence the delivery of health and long-term care services in this country. By 2030, older adults will comprise 20 percent of the population—doubling from 35 to 70 million people. As they age and face chronic illness and disability, the boomers will demand greater and more innovative long-term care choices. Of particular concern to lower-income seniors and their families will be finding affordable long-term care solutions.

Over the past several decades consumer advocates, policy makers and service providers have supported the development of new models of organizing and delivering health and supportive services to meet these new demands. In recent years, for example, substantial attention has been paid to developing licensed assisted living as a potentially less expensive and more attractive alternative to nursing homes.

The purpose of this study is to examine long-term care strategies that integrate affordable independent housing with health and supportive services so that low- and modest-income older adults who are frail and/or disabled are able to remain in the community. In this report, these strategies are called Affordable Housing Plus Services (AHPS).

Definition

The Institute for the Future of Aging Services (IFAS) the applied research arm of the American Association of Homes and Services for the Aging (AAHSA), defines AHPS as having three elements:

- Independent, unlicensed, largely subsidized multi-unit housing where large numbers of low- and modest-income older adults live in close proximity.
- Health-related and supportive services, funded separately from the housing, and available to at least some older residents (e.g., personal care, housekeeping, meals, transportation, health and wellness services, etc.).
- A purposeful linkage connecting residents to these services supporting their ability to "age in place" despite declining health and increasing disability.

About 1.8 million older adults—mostly poor, single women in their mid 70s to early 80s—live in federally subsidized housing—more than the number who live in nursing homes.

Methods

Findings from this study were generated through several methods:

1. A review of the research and evaluation literature.
2. Two informal workgroups held with AAHSA members and staff and other experts to develop definitions and identify policy and practice issues to be addressed in invitational workshops.
3. Telephone and in-person discussions with AAHSA members, other housing providers and aging and housing experts to identify exemplary programs.
4. Four invitational workshops attended by housing and aging services stakeholders to discuss the merits of, challenges to and opportunities for AHPS.

Findings from the Literature

About 1.8 million older adults—mostly poor, single women in their mid 70s to early 80s—live in federally subsidized housing—more than the number who live in nursing homes (Wilden and Redfoot, 2002). The majority live in public housing, Section 202 Supportive Housing for the Elderly, Low Income Housing Tax Credit (LIHTC) and Section 515 Rural Rental Housing properties. Unknown numbers of low-income seniors also live in rental properties subsidized through state and municipal programs and in privately financed unsubsidized housing rented or sold at market rates without regard to income.

Research shows that many of these older residents need assistance with routine activities. The 2002 American Community Survey found that subsidized older renters were twice as likely to be disabled as were older homeowners (Redfoot and Kochera, 2004). Over half reported limitations in activities like walking and climbing stairs, compared to one quarter of older homeowners. A third reported difficulty with shopping or going to the doctor, twice that of older homeowners. Likewise, surveys of Section 202 property managers indicate the proportion of residents having difficulty preparing meals or performing personal care tasks increased almost fourfold between 1988 and 1999. Managers in the 1999 survey also reported that 30 percent of vacancies are due to residents transferring to nursing homes (Heuman, Winter-Nelson and Anderson, 2001).

Connecting residents to needed assistance is not straightforward. Discontinuities between housing and long-term care agencies are well documented (Pynoos, Liebig, Alley and Nishita, 2004; Golant, 2003; Wilden and Redfoot, 2002; Redfoot and Kochera, 2004; Lawler, 2001). For example, housing policy is largely about "bricks and mortar" and, with few exceptions, housing funds cannot pay for services. Conversely, health and supportive services financing cannot be used to pay rent unless an individual is willing to enter a nursing home or, in some states, an assisted living facility (ALF). Diverting a resident's transfer to a nursing home is rarely the goal of housing policy. Nor is the availability of AHPS typically considered in developing long-term care policy.

Older residents themselves face barriers to getting the support they need (Pynoos, Liebig, Alley and Nishita, 2004; Golant, 2003; Wilden and Redfoot, 2002; Lawler, 2001). They are less likely than older homeowners to have family members to rely on. Community providers may incorrectly believe the housing provider is responsible for providing services. Other tenants may pressure management to evict residents who look too old and frail. Families may face difficulty in locating service providers. Housing managers may worry about their liability if confused residents leave the stove on or disturb other residents. Most often, housing providers and community services agencies simply view their missions through different lenses and lack experience working together.

The impact of AHPS is largely untested. In the 1990s, the U.S. Department of Housing and Urban Development (HUD) evaluated two of its programs designed to help seniors age in place through case management and supportive services—the Congregate Housing Services Program (CHSP) and the Hope for Elderly Independence Demonstration Program (HOPE IV). Researchers found participants were satisfied with both programs, but observed no significant impact on their nursing home use or length of residence in independent housing. These findings are not surprising given participants were found to be less disabled than those eligible for nursing homes (Ficke and Berkowitz, 2000).

The lack of research leaves policy makers and providers with little guidance on whether and which AHPS strategies are wise investments. Fortunately, however, a variety of existing programs can serve as natural laboratories in conducting impact evaluations.

Research shows that many of these older residents need assistance with routine activities. The 2002 American Community Survey found that subsidized older renters were twice as likely to be disabled as were older homeowners.

Inventory of Affordable Housing Plus Services Strategies

FAS has developed an inventory of AHPS programs across the country. These programs have been largely pieced together through the initiative and persistence of individual housing providers, community services agencies and, in a few cases, committed state leaders. Although not formally evaluated, they provide a rich set of examples for others.

The inventory could have been categorized in several ways. However, given the fact that a third of AAHSA's members sponsor housing that is largely publicly subsidized, we chose to divide our examples by how the housing is financed. We created further subcategories to help organize the examples. Unfortunately, it is difficult to neatly define the varying strategies and we acknowledge that some of the programs could fall under several subcategories. Also note that the examples identified here and the details included about them are not exhaustive, but are merely used for illustrative purposes.

A more detailed inventory can be found at www.futureofaging.org.

A. **Privately Financed Housing** refers to multi-unit owner and rental housing that receives no public subsidies, but is still affordable to low- and moderate-income older adults. It may include neighborhoods of single-family homes with large concentrations of senior households. Strategies include:

1. **Housing Cooperatives** allow residents to own and control their apartments through a cooperative arrangement in which they own stock and are involved in management and programming of the property. Maintaining affordability is difficult and is typically achieved by capping the resale price (limited-equity cooperatives). Services can be informal or formal, involving joint purchasing and/or scheduling or a coordinated program staffed by community agencies or the cooperative itself. **Penn South Cooperative, New York, NY**, is a limited-equity cooperative built in 1961 with 6,200 residents. As residents began to age, the co-op established a collaborative program with community agencies to provide supportive services. Now a separate nonprofit agency, the program offers cultural and educational activities, case management, day care, home care services, primary health care, wellness services, personal care and a variety of other supportive services to residents of the cooperative. **7500 York Cooperative, Edina, MN**, is a limited-equity cooperative with 330 units developed in 1978. As residents aged, the co-op offered office space to a home health agency, through which residents can arrange for services. With an onsite office, the agency can offer services in 15-minute intervals rather than the customary two-hour blocks—allowing residents to better target services to their needs. The agency also may serve seniors in surrounding apartment buildings out of this office.

2. **Shared Housing** involves two or more unrelated individuals living together in a private single-family home. Some programs match elderly homeowners with individuals willing to help with household chores in return for reduced rent. Others involve small numbers of older people living together and providing mutual support. Accessory housing is another type of shared housing where a trailer or portable manufactured home is placed next to a main home, enabling a frail senior to maintain independence and still be close to a family member or caregiver. **HomeShare Vermont, Burlington, VT**, helps seniors and persons with disabilities live independently by linking them with individuals seeking affordable housing or caregiving opportunities. Typically, a student or working-age adult is matched with an elderly homeowner for whom they carry out household chores in exchange for free or reduced rent.

3. **Mobile Home Parks/Manufactured Home Communities** provide homeownership opportunities to some lower-income seniors. Usually the housing unit is owned, the lot is leased and upkeep and maintenance are included in the lot fee. Social and recreational amenities are often shared. While many mobile home parks have been disappearing as land values increase, some are being converted to cooperative ownership to maintain their existence and affordability. Formal programs to link residents to services are hard to find, although aging in place is an issue. **Millennium Housing, Newport Beach, CA**, operates several senior parks in California. Residents receive a monthly magazine with information on where to get help with meals, bills, etc. A partnership with a community program provides homebound residents with home repairs and emergency response systems.

4. Single Room Occupancy Hotels (SROs) rent small private rooms, usually in depressed downtown areas, to low-income individuals on a weekly or monthly basis. Some space—like bathrooms, living rooms and kitchens—is typically shared. Urban renewal has eliminated many SROs; however, several cities have converted run-down hotels into SROs with supportive services. **Project Hotel Alert, Los Angeles, CA**, is funded by the city aging department to provide older adults living in SROs a wide range of services, including case management, information and referral, transportation, meals and medical screening. One SRO has been retrofitted with wheelchair-accessible bathrooms to accommodate disabled elderly residents.

B. **Publicly Subsidized Housing** refers to multi-unit rental housing owned or subsidized by federal, state or municipal governments. Strategies for integrating services include:

1. **Co-Location and Volunteerism** is a low-cost approach in which the housing manager encourages local providers to locate health and/or supportive services programs on or near the property and recruits volunteers to fill service gaps. Commonly co-located services include a Title III meals site, senior center or health and wellness programs. **Golden West Senior Residence, Boulder, CO**, a 255-unit refinanced Section 202 property, provides space to Medically Based Fitness (MBF) for operation of a wellness center. MBF staffs the center with a physical therapist and an exercise physiologist. Golden West also partners with several other programs or individuals who provide services at the property on a regular basis, such as footcare, massage, reflexology, hearing aid maintenance and banking services.

2. **Service Coordination** entails a full- or part-time staff person employed by the housing property to help residents identify and arrange for needed services, advocate on their behalf and provide

educational programs. About 37 percent of Section 202 housing properties have onsite service coordinators (Heuman, Winter-Nelson and Anderson, 2001). National Church Residences (NCR), headquartered in Columbus, OH, employs 154 service coordinators serving 194 of its senior housing properties. Service coordinators typically conduct an intake evaluation of residents requesting assistance; assess behavior, functioning and needs; develop a case management plan; and refer residents to community agencies. Schwenkfeld Manor, Lansdale, PA, employs nurses as service coordinators. In addition to traditional information and referral and case management, they informally observe changes in residents' status, provide health education and advise residents when they should call their doctor.

3. **Enriched Services and Formal Service Coordination** are strategies offering residents formal assessment, case management and a range of personal care and supportive services provided by onsite staff and/or a service agency owned by or under contract to the housing provider. Although the amount and intensity of services varies, 24-hour oversight, personal care, medication management, homemaking and transportation are likely to be available. With HUD approval, Peter Sanborn Place, Reading, MA, gives priority to prospective residents with high levels of need. Frail residents receive a comprehensive assessment and detailed care plan, and their status is monitored. A Section 202 loan refinance freed up resources that were reinvested in building renovations and resident services. The property operates its own home care agency, which provides case management, personal care, medication monitoring, homemaker services and transportation to eligible residents and the surrounding community. The local Visiting

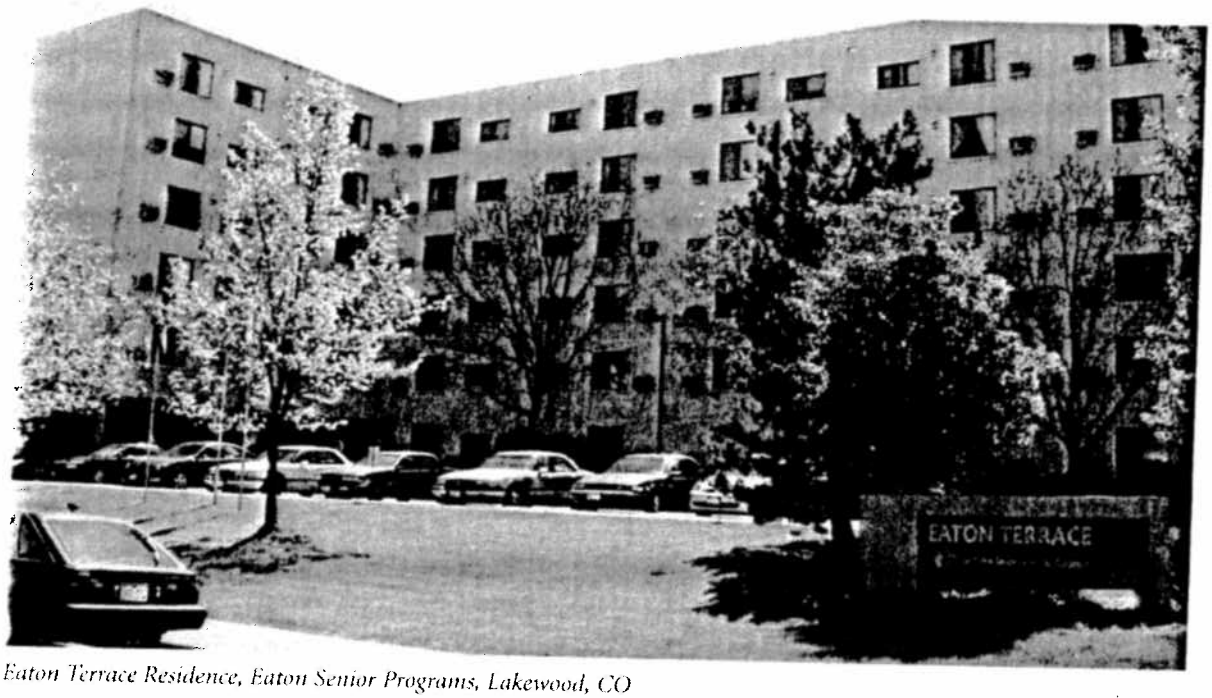
Peter Sanborn Place, Reading, MA

Nurses Association provides care and rehabilitation services under contract.

4. **NORC Service Programs** target naturally occurring retirement communities (NORCs), defined as a geographic area, neighborhood or building originally populated by people of all ages that has evolved to contain a high proportion of older adults. In some NORCs, property managers, residents and service providers have collaborated to develop programs to address elderly residents' changing needs. Services are available to all NORC residents, regardless of income, health or functional status. **Vladeck Cares/NORC Supportive Services Program, New York, NY**, serves seniors living in Vladeck House, a public housing project with 27 buildings and 3,000 residents, 860 of whom are elderly. Funded by the city, the state aging departments and private sources, it provides preventative health and social services, medical and health services, case management, mental health counseling and educational and cultural opportunities.

5. **State Supportive Housing Partnerships** are generally aimed at reducing Medicaid costs by delaying institutionalization. Partnerships among state housing agencies, subsidized housing properties and state aging and health agencies expand services to state-subsidized housing residents. State-designated providers are licensed to deliver personal care and supportive services to residents. **The Marvin, Norwalk, CT**, is a senior congregate housing community funded through LIHTC and low-interest loans from the state. All residents have access to supportive services through Connecticut's Congregate Housing for the Frail Elderly program, including a daily meal, weekly housekeeping and access to a service coordinator. Onsite, 24-hour oversight, an on-call nurse, health and wellness servic-

The Marvin, Norwalk, CT



Eaton Terrace Residence, Eaton Senior Programs, Lakewood, CO

es and emergency transportation also are subsidized. Residents pay a monthly congregate services fee based on their income. Those eligible for assisted living services under the state's Medicaid waiver receive nursing and personal care assistance.

6. **Assisted Living as a Service Program** is a state strategy to provide licensed assisted living as a package of services rather than as facility-based care. In **Minnesota**, most assisted living services are provided in facilities registered with the state health department as "housing with services establishments." These facilities offer, for a fee, one or more regularly scheduled health-related services or two or more regularly scheduled supportive services. If the property provides the services directly, it must have the appropriate license from the health department. Otherwise, it must contract with a licensed home care provider.

7. **A Campus Network Strategy** takes advantage of independent senior housing and licensed assisted living on the same campus to provide low- and modest-income residents some of the benefits of a continuing care retirement community. There is no entrance fee, and residents pay separately for different levels of care. **Eaton Senior Programs (ESP), Lakewood, CO**, operates Eaton Terrace Residence (ETR), a 162-unit subsidized senior housing property and Eaton Terrace II (ET II), an adjacent assisted living facility. ESP is able to leverage resources across both residential properties. ET II has an assisted living and home care license, which allows staff to provide services anywhere in the community. ETR residents may purchase personal care, housekeeping and medication monitoring services at whatever level they need. Residents pay out-of-pocket, unless Medicaid covers their costs. ESP also has created a "care consultation team" to support resident needs, which includes a nurse, social workers, activities coordinators, pastoral counselors, resident assistants and other staff.

Although each property has staff that focuses specifically on their residents, they are able to leverage expertise and resources across the team. Staff from the assisted living property are also able to provide after hours emergency response to ETR.

8. **Integrated Housing, Health Care and Supportive Services** enable residents to age in place by offering access to medical, health and long-term care services. They involve a formal collaboration between one or more affordable housing providers, neighborhood health care providers and aging services agencies. **Lifelong Medical Care, Oakland, CA,** anchors a collaboration between a housing developer, a federally qualified health center and a PACE (Programs of All-Inclusive Care for the Elderly) program to provide an assisted living level of care without special licensing or funding. The health center serves healthy and moderately disabled seniors, providing primary care, mental health services, adult day care, podiatry, dental care and other services. PACE serves residents eligible for skilled nursing facilities with a full spectrum of primary, acute and long-term care services. **The Sixty Plus Program,** Atlanta, GA, run by Piedmont Hospital, partners with four affordable housing properties to send a nurse to each weekly. Residents can schedule appointments, and the nurse follows up with patients discharged from the hospital. Piedmont physicians can also ask the nurse to check on their patients.

9. **Housing/Health Partnerships** are collaborations between one or more health providers and low-income housing sponsors to increase the supply of affordable housing. The potential exists for the two partners to create programs providing residents access to medical and health-related services. **Mercy Housing's** Strategic Health Partnerships is an initiative between Mercy Housing and seven Catholic health care systems to increase the supply of affordable housing for low-income seniors and poor families by leveraging health system resources.

The Ravine at Central College, National Church Residences, Westerville, OH

Lessons from the Regional Workshops

In 2005, IFAS held four invitational workshops, bringing together 230 stakeholders from 14 states to examine the merits of, challenges to and opportunities for the development of AHPS strategies. Participants represented housing, health care and aging services providers; federal and state policy makers; architects; investment bankers; insurers; and consumer advocates. The first workshop, targeting the Cleveland area, was hosted by the A.M. McGregor Home. The other three, hosted by AAHSA state affiliates in California, Rhode Island and Georgia, facilitated statewide and regional participation. The following summarizes lessons learned.

A complete workshop report can be found a www.futureofaging.org.

Do AHPS strategies work? Although most participants understood that the benefits of linkages between independent affordable housing and services had not been carefully evaluated, several apparent strengths were noted:

- **The product is attractive. Vast majorities of seniors want to stay in their home, even as their health declines.**
- **Co-location of services such as adult day care and health services, particularly in larger housing communities, helps seniors with significant disabilities, including dementia, stay in their apartments.**
- **AHPS programs allow health professionals and aging service providers to more efficiently target services because potential consumers are clustered.**
- Exploiting economies of scale through bulk purchasing of services and supplies and/or coordinated scheduling saves money.
- **Since many communities already have a rich array of services, purposefully linking residents to these services helps meet residents' needs at very low marginal costs.**

Several apparent strengths of affordable housing plus services strategies were noted

. . .meets resident desire to remain in their own home.

. . .capitalizes on existing community resources and strengths.

. . .exploits economies of scale in purchasing and scheduling.

- Much of the burden of caring for aging residents is transferred from the housing provider to community services agencies, which typically have greater capacity.

However, there was some disagreement about whether AHPS can or should support all residents regardless of their health condition and/or level of disability. Several housing providers believed all residents should be able to live out their lives in the property, maintaining that services comparable to a nursing home can be provided effectively. Others said keeping residents with significant disabilities who may need access to services 24/7—especially those with severe cognitive and/or mental health problems—is not possible or even appropriate. There was widespread agreement on the importance of evaluating and comparing the outcomes of alternative AHPS approaches for different populations.

What does an effective strategy look like? No one strategy was endorsed as appropriate for all environments. Some participants said caregiving staff should be employees of the property. Others thought housing providers should not deliver services directly, except for service coordination. Most agreed that a wide range of models could work, as long as they are anchored by a case management mechanism. Attendees felt that a particular AHPS approach should emerge from the state regulatory environment, the housing providers' capacity and service availability in the community. AHPS models also should be responsive to the changing characteristics of residents, such as the growing prevalence of new residents with cognitive impairments, mental health conditions or pre-existing disabilities. Some participants also said attention should be paid to the differences in the demand for and the availability of services in rural areas.

Which services are critical? Discussants emphasized the need for AHPS strategies to provide residents access to a full range of health-related and supportive services. Transportation ranked highly although questions were raised about the capacity of some housing communities to organize access to transportation services. Much less agreement was expressed about the desirability of incorporating primary health care and chronic care management. Some thought these services were too complex and risky for many housing providers and were only feasible as part of a PACE program. Others noted the growing experience with "house call" programs, where physicians and nurses offer primary care, preventative services and chronic care management to residents in their own apartments by using technology and a team approach. These programs seem ideally suited to affordable housing arrangements with large numbers of seniors.

What are the prerequisites of a successful strategy? Participants identified three fundamentals for AHPS strategies:

- **Informed housing providers who understand the need for services**—Housing providers must see themselves as more than property managers who collect rent and maintain the physical plant. They must understand residents' need for

No one affordable housing plus services strategy was endorsed as appropriate for all environments. Attendees felt that a particular approach should emerge from the state regulatory environment, the housing providers' capacity and services availability in the community.

Participants identified three fundamentals for successful affordable housing plus services strategies:

- *Informed housing providers who understand the need for services.*
- *Persistence and creativity.*
- *A person of a group to act as a catalyst.*

services, accept at least some of the responsibility for meeting these needs and ensure that service coordinators and onsite managers share this understanding. In addition to employing a service coordinator, they must be prepared to make financial and human resource investments to fill gaps in community services and be flexible enough to allow residents to refuse services and make some bad choices. Learning how to support aging residents to take risks was perceived to be part of maintaining an independent living environment.

- **Persistence and creativity**—Successful organizations are proactive—seeking out community partners, networking with policy and practice stakeholders, staying on top of new funding opportunities and working around policy and regulatory barriers. Knowing how to "work the system" was deemed essential.
- **A catalyst**—Some individual or organization must take ownership of the goal, identify and convene stakeholders, facilitate information gathering, mobilize resources and coordinate ongoing activities.

What are the obstacles? A number of barriers were acknowledged:

- **Licensing/regulation**—Licensing and regulation was identified as an impediment to the ability of independent housing providers to support residents' aging in place. For example, Internal Revenue Service rulings appear to limit the level of health and medical services that can be provided in properties financed through low-income housing tax credits (LIHTC). LIHTC properties also may not pay for health services with rent proceeds. Some states prohibit independent housing providers from providing direct services. In most states, assisted living services can only be provided to eligible residents in a licensed facility. Many housing providers expressed strong opposition to becoming licensed caregiving facilities to obtain services for residents. Providers said licensing requirements often result in increased costs, forcing them to rely on Medicaid, for which all residents may not be eligible. Participants pointed to assisted living regulations as an example of what they wished to avoid. Publicly reimbursed assisted living services were judged too rigid, serving only a narrowly defined population. A number of participants urged HUD and the Department of Health and Human Services to review federal and state regulations governing Section 202 and LIHTC properties, the assisted living conversion program, service coordinators and fair housing to identify and remove regulatory barriers to AHPS programs
- **Liability**—Housing providers expressed concerns about how to balance resident choice, including freedom to reject services, with their perception that they would be liable for poor choices that compromised resident health or safety.

- **Fair housing laws**—These laws were regarded as confusing. They prohibit housing providers from giving preference to frail and disabled residents unless a special waiver is obtained. Many participants also believed the unattended consequences of these laws discourage providers from determining a prospective resident's physical and mental health needs, even though such information is crucial to their ability to meet new residents' needs. Fair housing rules also seem unclear about when a tenant can be evicted when decision making is impaired. Several attendees suggested HUD needs to clearly spell out the implications of fair housing rules for AHPS.

- **Difficulty of bridging housing and aging services**—There was widespread agreement that housing and aging services providers know little about each other's programs or policies. Several said the workshop was the first time they had even been together in the same room. Housing providers rarely participate in long-term care policy forums and vice versa. According to several workshop attendees, both the housing and aging services communities need to be educated about their mutual interests.

- **Resources**—Finding funding was regarded as the major challenge facing AHPS program development. Relying on a single funding source, such as the Section 202 program or Medicaid, is shortsighted, several participants said. In their view, future needs cannot be accommodated without putting together a mix of funding. Several pointed out that AHPS strategies also must be designed around resident needs rather than allowing a funding source to determine who is served and how.

- **Limited understanding/capacity of certain housing providers to meet resident service needs**—Housing representatives were more likely than others to observe that a number of their colleagues saw their roles in traditional terms—leasing, collecting rents and maintaining the physical plant—rather than as architects of a housing environment that must adapt to changing needs of increasingly frail residents. They said it's not unusual for housing managers to interpret "independent housing" literally—if a resident needs help, she must move or find it herself. Housing providers also may lack sufficient knowledge about community resources and have limited skills in developing partnerships.

- **Resident opposition**—Several housing providers said residents themselves often oppose aging-in-place strategies. Many don't want to be reminded that they may lose independence as they age. To overcome this challenge, residents must be educated about and have sustained involvement in planning AHPS programs.

- **Affordability**—Participants said AHPS programs must minimize costs to residents, the housing sponsor and public entities. One suggested approach was to work with a home health agency or other community provider to break down the amount of services that can be purchased into short increments. Residents do not always need, nor can they afford, the two- or four-hours blocks of time typically available.

The workshops demonstrated that linking affordable senior housing and services is doable, and is widely perceived to be beneficial. Participants also identified a variety of obstacles to achieving wider implementation of promising strategies.

- **Nursing home influence**—Attendees had differing perspectives on the role of nursing home providers. Some thought nursing homes would oppose AHPS strategies. Others thought they could be valuable partners, given their interest in managing beds to keep acuity levels high for reimbursement.

What are funding opportunities? The workshops clearly demonstrated that funding is a primary challenge in developing new AHPS programs. Having concluded that neither Medicaid nor the Section 202 program are likely to be reliable funding sources on their own, participants identified other potential ideas that include:

- **New public initiatives**
  - Creating a state tax credit or bond program to fund resident services as well as affordable housing.
  - Developing health-related and supportive services "savings accounts" where pretax contributions of housing providers and residents could accumulate over time.
- **Housing provider strategies**
  - Developing mixed-income properties where the costs of services for lower-income residents are cross subsidized by wealthier ones, as in nursing homes.
  - Developing "win-win" partnerships between housing communities and health care entities. These partnerships can enhance resident access to primary care and chronic care management and increase referrals to providers and improve their ability to monitor and manage the resident's care.
- **Changes to HUD programs**
  - Increasing the limit on the proportion of savings from refinancing HUD loans (currently 15 percent) that can be spent on services.
  - Allowing federally subsidized housing providers to add the costs of some services, in addition to service coordination, to their operating budgets.
  - Capitalizing the cost of services in publicly subsidized housing up front in the debt service.
  - Charging higher-income residents extra fees for service coordination.
- **Expanding existing opportunities**
  - Documenting and disseminating to affordable housing providers the probable "return on investment" if they contribute their own resources to resident services.
  - Educating service coordinators on how to reduce service costs (e.g., capitalizing on economies of scale, working with community providers to deliver services in smaller increments, etc.).
  - Documenting the benefits of renting out commercial space for resident services to housing communities .
  - Encouraging wider participation in the HUD-funded service coordinator program.
  - Educating Section 202 providers about the potential of refinancing old loans to invest in services.

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Exhibit 5
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Next Steps

The workshops brought together a variety of stakeholders to identify common interests and seek common ground. For that alone, most participants judged them a success. Several additional initiatives were proposed to move an AHPS agenda forward:

- **Resident and Family Education Programs**—Residents and their families often aren't aware of the services available in their community. As one participant put it, many residents see services as a light switch—either "on" or "off." This participant thought the concept of a "dimmer switch" was more appropriate with residents and families learning how to seek services as needed, rather than waiting for a crisis. Service coordinators, AAHSA state affiliates, area agencies on aging, AARP chapters, the Red Cross and Alzheimer's Association chapters could develop and disseminate educational materials describing a community's resources and how to use them.

- **Provider Education and Technical Assistance**—Participants stressed the value of educating affordable housing providers about aging residents' service needs, available community resources and how to access them, promising AHPS strategies and how to overcome regulatory barriers. Some participants suggested AAHSA develop and operate a clearinghouse for members to provide technical assistance.

- **National Awareness Campaign**—There was significant support for raising the visibility of AHPS as a potential vehicle for meeting the long-term care needs of at least some low- and modest-income seniors. Participants spoke of subsidized elderly housing residents being "off the radar screen" of advocates and policy officials seeking long-term care solutions. Some observed that while funding has significantly grown for home and community-based services over the past several decades, little is known about the extent to which seniors in subsidized housing have benefited. One suggestion was to move AHPS onto the agenda of the Conference of Mayors since municipalities are now dealing with the problem of poor seniors who are unable to remain independent. It was also noted that advocates for the homeless have been effective in educating government about the importance of linking housing options with services to sustain independent living. Affordable housing providers might develop a similar platform for aging seniors in affordable housing.

- **Replication of Workshops in Rural Areas**—All workshops were held in urban areas, primarily for an urban or suburban audience. AHPS strategies that work in rural communities may be different. Holding one or more workshops in rural areas was suggested, possibly in partnership with the U.S. Department of Agriculture.

- **Developing AHPS in Market-Rate Housing**—The experience of subsidized housing providers dominated the workshops. IFAS was unable to identify more than a handful of AHPS programs in privately financed housing arrangements that are affordable to modest-income seniors. Future work should be directed at identifying and supporting housing cooperatives, mobile home parks, neighborhood-based NORCs, SROs and other market-rate housing arrangements to develop AHPS programs.

Applied Research and Evaluation Agenda

The information base on AHPS is extremely weak. The functional and cognitive characteristics of seniors in affordable housing, the services they receive and what difference they make and where these seniors go when they leave independent housing are simply not known. There is almost no evidence regarding the impact of AHPS programs on residents, families, housing providers, the larger community and funding sources such as Medicaid. IFAS has developed a policy, applied research and evaluation agenda to address these questions. It includes:

- Studies of the supply and demand for AHPS.
- A comparative evaluation of the outcomes of AHPS strategies.
- A comparison of the outcomes of AHPS programs and licensed ALFs.
- A review of state and federal regulations that impede AHPS development and implementation.
- The costs and benefits of options for organizing service coordination within AHPS programs.
- Practice-oriented studies investigating effective approaches within AHPS programs to organize after-hours care and unscheduled services, support cognitively/mentally impaired seniors, improve risk management and increase insurability and integrate primary care and chronic care management.

IFAS has developed an applied research and evaluation agenda to build the evidence base on the impact and cost effectiveness off affordable housing plus services strategies.

Conclusion

This was the first time such wide-ranging groups of stakeholders came together to examine the potential of replicating AHPS models. Across all workshops, a great deal of interest and enthusiasm was evident. Anecdotally, these providers believed linking affordable housing properties with supportive and health-related services could support lower-income seniors' desire to age in place despite declining health and increasing frailty—all while using public resources cost-efficiently. Current models can serve as natural laboratories to evaluate the efficacy of meeting these goals. They also offer a shared learning opportunity for other communities and housing and service providers to ignite or expand their own housing with services programs. Stakeholders at all levels should look at the lessons learned from these workshops to see what they can do to ease the challenges to expanding affordable housing with services options.

Participants at the workshop in Decatur, GA, one of four held across the country.

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The Columbus Dispatch

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WEDNESDAY, MAY 20, 2009

Aging could cripple budget

Half the state's revenue will go to Medicaid by 2020, research shows

By Catherine Candisky
THE COLUMBUS DISPATCH

Ohioans are getting old and expensive. By 2040, the number of residents needing long-term care will double, and the added cost to the Medicaid program, which pays for many of these services with state and federal money, threatens to crush Ohio's budget.

Unless the system is altered, Medicaid could consume half the state budget by 2020, according to researchers at the Scripps Gerontology Center at Miami University in Oxford.

"The only way to serve more people is to increase the number in lower-cost services," said Robert Applebaum, a professor and director of the center's long-term care research project.

In testimony before the Senate Finance Committee yesterday, Applebaum said Ohio has made progress, but has a long way to go to create an efficient and effective system of long-term care.

The Republican-controlled Senate is expected to slash $1 billion from a $54 billion two-year budget passed by the House to help deal with a projected shortfall that could reach $3 billion. Democratic leaders in the House will assist in making the rest of the cuts when the budget goes to a joint conference committee for a final review.

The looming long-term care crisis presents another fiscal challenge for lawmakers.

A new Gerontology Center report recommends expanding the services available to Ohioans in need of long-term care. They should include in-home services, in which individuals hire and supervise their own care providers, and assisted living.

The array of services would allow more elderly people to continue living in their homes, which is generally preferred. It's also cheaper and will save the state money by reducing the use of higher-cost nursing homes.

Medicaid pays $150 a day for a nursing-home stay and $38 a day to provide home care under Ohio's popular PASSPORT program.

But Ohio's elderly aren't the only ones running up the state's long-term care bills. The number of Ohioans younger than 60 in nursing homes is growing.

Over the past decade, there has been a 9 percent reduction in the number of Medicaid recipients older than 60 in nursing homes. But during the same time span, there has been a 17 percent increase in the Medicaid recipients younger than 60 who use nursing homes, the report found.

Between April and June of 2008, nearly 15 percent of the 54,045 Medicaid patients in nursing homes were younger than 60.

Applebaum said many of those younger nursing-home residents, some with mild impairments and others suffering from mental illness, apparently have nowhere else to turn.

State officials have pushed for years to expand the long-term care options under Medicaid, with some success.

Currently, 72 percent of Ohio's long-term care budget is spent on institutional care and 28 percent on community-based services. That ranks it 43rd in the nation for margin of institutional versus community care; however, it's an improvement from 47th place in 2004.

Applebaum said Ohio's goal should be a 50-50 split.

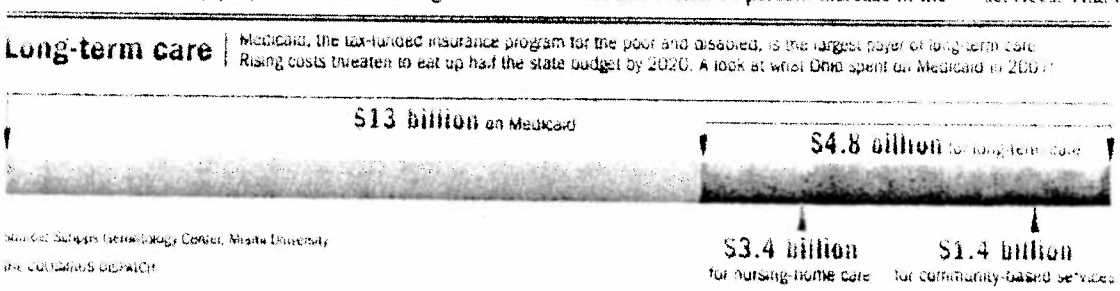

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EXHIBIT 5 *A market analysis of the need for the proposed ALF units, including information from both the project and the housing market, containing:*

(b) Evidence of the need for ALF units by very low income elderly and disabled households in the market area; a description of the trend in elderly and disabled population and household change; data on the demographic characteristics of the very low-income elderly in need of assisted living services (age, race, sex, household size, and tenure) and extent of residents with frailty/limitations in existing federally assisted housing for the elderly (HUD and Rural Housing Service); and an estimate of the very low-income elderly and disabled in need of assisted living taking into consideration any available state or local data.

When an individual is allowed to age in his or her community with social support networks intact, costs are minimized and care is delivered in response not to a rigid service-delivery model, but to actual need. Communities save needed resources by reducing the amount of unnecessary service to individuals who could and would prefer to be more independent. At present there are **few affordable** assisted living facilities in the State of Ohio. In testimony before the Senate Finance Committee on Tuesday, May 19, 2009, Robert Applebaum, a professor and director of the Scripps Gerontology Center at Miami University in Oxford stated "Ohio has made progress but has a long way to go to create an efficient and effective system of long-term care." The only assisted living options available for elders are for those who are in the upper middle and upper income categories. Despite the benefits and cost savings which can be achieved by avoiding overcare and undercare, historical, structural and regulatory barriers keep health and housing services separate. This separation affects the quality of life for most aging Americans including those residing in the Cuyahoga area. Elders who live in units that are inadequate for their needs are faced with hard choices. For most Ross County elders, assisted living is not a housing option due to the high cost of rent and related fees. The array of services offered through the HV assisted living program will allow more people to "age in place", which is generally preferred. It is also cheaper and will save the state of Ohio significant money by reducing the use of higher-cost nursing homes.

Additionally, extreme need is evidenced by the number of residents that have had no alternative but to move from their apartments at Portage Trail Village (PTV) to seek living arrangements with more resources for specialized care.

The following chart shows that at least 83% of PTV residents that left over the past 24 months went for housing that could give them living assistance and a higher level of care . As market studies show, the need for affordable assisted living for the frail elderly is far outpacing the supply. Further improvements in architectural features and service delivery are needed in existing affordable elderly housing units in order to enable existing residents to "age in place". As the elderly population continues to grow at a rapid pace, and in particular the frail elderly segment of the population (those over 75) triples in size, the current systems of elderly health and housing services will be heavily taxed. Better coordination of services and more efficient use of funds are essential to meet the growing demand.

Chart of Residents Leaving PTV In the Last 24 Months

Month	Year	To Higher Level of Care	Death	Other Services
Oct. – Dec.	2007	3	3	6
Sub Total		**3**	**3**	**6**
Jan.- March	2008	7	4	6
April - June	2008	1	1	5
July - Sept.	2008	1	1	8
Oct. – Dec.	2008	1	1	5
Sub Total		**10**	**7**	**24**
Jan. - March	2009	1	0	6
April - June	2009	1	1	3
July – Sept.	2009	1	1	5
SubTotal		**3**	**2**	**14**
TOTAL		**16**	**12**	**44**
% of Total		22%	17%	61%

The proportion of older persons in the population varies considerably by state with some states experiencing much greater growth in their older populations. According to a study prepared by the United States Department of Health and Human Services, Administration on Aging entitled "A Profile of Older Americans: 2008", Ohio has

approximately 1,545,085 persons aged 65 and older living in the state – an increase of 3.4% from 1997. That number makes up 13.5% of Ohio's total population and 8.1% of those elders are living below poverty level. Along with the chart from this profile, listed below is an independent market study along with various reports that clearly indicate the need for this Assisted Living Conversion Project of affordable elderly rental units in the Cuyahoga Falls and the surrounding communities within Summit County.

The Market Support Study prepared in June, 2008 by VWB Research (a complete copy is provided as an attachment to this exhibit) projects a strong and sustained market of the proposed project. VWB concluded in its study:

> ***"it is our opinion that the Cuyahoga Falls Site PMA can support up to 100 assisted-living beds as part of the Portage Trail Village conversion. These units would be affordable at a maximum monthly fee of $1,440. We acknowledge that there is good senior household growth in the market."***

The principal findings and conclusions with respect to market demand and sustainability for the Portage Trail Village are as follows:

1. Age 65+ renter households increased by 91 (7.6%) between 2000 and 2007, and are projected to increase by an additional 86, or 6.7%, between 2007 and 2012.
2. The age 75+ population for the Site PMA represented 8.7% of the 2007 area population compared to 9.4% within the city of Cuyahoga Falls. People age 55 to74 represent 17.7% and 20.4% of the 2007 and 2012 population, respectively. This age 55 to 74 group, a potential user of assisted-living services as the segment ages, is projected to increase 15.6% over the next few years.
3. Between 2007 and 2012 the greatest growth among household age groups was among households between the ages of 55 and 74. Household growth is also occurring at a rapid rate among households age 85+, indicating a growing need for senior housing alternatives within the Cuyahoga Falls market. The distribution of households by persons per household for the Site PMA is similar to other suburban markets.
4. There are three assisted living facilities located within the Cuyahoga Falls Site PMA, Traditions of Bath Road (a NCR facility), Cardinal Retirement Village, and Falls Village. These projects represent a variety of ages, quality, locations, amenities, price points and services. These facilities are market rate and represent different levels of competition for the proposed subject

development. It is our opinion that there is no competitive impact on the potential for a subsidized assisted living facility at the subject Portage Trail Village.

2000 Census Data

The formula used to allocate ALCP funds to the various HUD Hubs was based on the 2000 decennial census demographic characteristics of age and incidence of frailty that would be expected for program participants as stated in the NOFA.

The following data is taken from the 2000 US census data for the Cuyahoga Falls City:

1. There are **1,451** people with one type of disability in our primary market area
2. There are **1,536** people with two or more types of disabilities in our primary market area

Based on the census data illustrated above, there is a great need for assisted living services for frail/disabled seniors in the primary market area. Please see the chart from the U.S. Census Bureau's website which is attached to this exhibit and shows the number of 65 years or older people with disabilities in the targeted market area

State and Local Reports

- In its Final Report of the Unified Long Term Care Budget Workgroup, dated May 30, 2008, the Ohio Department of Aging made the recommendation to the State Legislature that the State of Ohio should begin the process of providing consumers with a choice of services designed to meet their needs and improve their quality of life. The Workgroup also recognized that a special "gap" exists in housing and supportive services and accordingly asked a group of stakeholders to develop recommendations designed to remedy this gap.
- In his July 17, 2001 testimony before the House Financial Services Sub-Committee on Housing and Opportunity, Thomas Slemmer, President of NCR said "there is a critical need to assist and preserve existing non-profit sponsored elderly housing facilities, as well as to expand the supply of suitable and affordable housing for low and moderate income older persons." Slemmer went on to say "Unfortunately, low income elderly people seeking housing are faced with multi-year waiting lists exacerbated by the shrinking supply of suitable, affordable housing.

National Reports

- AAHSA (American Association of Homes and Services for the Aging) on its website: AAHSA.org, stresses the growing need for supportive elderly housing. General facts listed include:
  - By 2026 the population of Americans ages 65 and older will double to 71.5 million
  - Between 2007 and 2015 , the number of Americans ages 85 and older is expected to increase by 40 percent
  - Among people turning 65 today, 69 percent will need some form of long-term care, whether in the community or a residential care facility
  - In 2020, 12 million older Americans will need long-term care
- Elinor Ginzler, director for livable communities at AARP, Washington, D.C., told the ***Chicago Tribune***, in an article dated January 28, 2007: "There's a real lack of subsidized apartments for seniors." Compounding the problem, Ginzler added, is the fact that seniors who need subsidized housing are not just poor but also increasingly frail and in need of services.
- The Retirement Project, a 2007 report that addresses the long term needs of the baby boomers, predicts that because the overall size of the older population will expand rapidly, the number of older Americans will soar in coming decades.
- In 2006, an AARP study revealed that on average, there were 50 applicants waiting for a unit to become available. This is a dramatic increase from the 1999 study that stated there were 9 people waiting for every unit.
- According to the attached article from the July 9, 2000 issue of the ***New York Times***, the average cost of assisted living was $2,500 or more at that time.
- Report published by the Robert Wood Johnson Foundation states that the monthly fees in assisted living can range from $1,800 to $5,000.
- AARP's report: Assisted Living in the United States confirmed that "the median basic rate ranges from $1,800 to $2,200 a month, or from $21,600 to $26,300 a year."
- Report published by the Joint Center for Housing Studies at Harvard University reveals, "Fees at most private pay assisted living facilities range from $2,000 - $4,000 per month, with a national average of $2,159." Furthermore, this report illustrates that "Assuming that seniors are willing to pay around 80% of their income for a combination of housing and services, a post tax annual income of $32,385 would be needed to afford the average private-pay facility." According to this report approximately 77% of the senior population has an income of less than $25,000 per year. In addition, this report highlights that low income seniors

tend to have higher physical needs. **The report specifies that in year 2000 an estimated 1.4 million seniors received assistance with two or more activities of daily living, and that this number is expected to increase to 2.7 million by 2030.**

- According to the Bureau of the Census Statistical Brief, "among those who were not institutionalized in 1900-91, 9 percent aged 65 to 69 years, but 50 percent aged 85 or older, needed assistance performing everyday activities such as bathing, getting around inside the home, and preparing meals."

Attached to this exhibit please find:

- VWB Research Market Support Study, 2008
- May 20, 2009, news article from ***The Columbus Dispatch***
- A Profile of Older Americans : 2008 – State of Ohio data
- January 28, 2007, news article from the ***Chicago Tribune***
- The Retirement Project: Meeting the Long-Term Care Needs of the Baby Boomers
- AARP Report: Developing Appropriate Rental Housing for Low Income Older Persons
- Testimony before the House Financial Services Subcommittee on Housing and Community Opportunity, by Thomas Slemmer, President of National Church Residences
- Ohio State Office for the Aging, Testimony Submitted by Michael J. Burgess, Director
- AASHA webpage- Aging Services: The Facts
- July 9, 2000 news article from ***The New York Times***
- Robert Wood Johnson Foundation National Program Report: The Coming Home Program: Affordable Assisted Living
- Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century
- AARP Report - Assisted Living In The United States
- Affordable Assisted Living: Surveying the Possibilities, Joint Center for Housing Studies of Harvard University - Executive Summary
- Bureau of the Census Statistical Brief

The various reports included in this exhibit overwhelmingly indicate the significant need for affordable assisted living facilities for low and very low income elders who are frail and at-risk in the City of Cuyahoga Falls and the immediate surrounding market area.

In addition, various community organizations and community leaders have indicated, in their support letters, the shortage and need of affordable, assisted living in the Summit County area. These letters have also been attached to this exhibit as further evidence of the great need for this ALCP project.

Portagell2009-HUD ALCP
Exhibit 5
DUNS: 602418803
FAXID: 1252097519-2061

The Columbus Dispatch

WWW.DISPATCH.COM

WEDNESDAY, MAY 20, 2009

Aging could cripple budget

Half the state's revenue will go to Medicaid by 2020, research shows

By Catherine Candisky
The COLUMBUS DISPATCH

Ohioans are getting old and expensive. By 2040, the number of residents needing long-term care will double, and the added cost to the Medicaid program, which pays for many of those services with state and federal money, threatens to crush Ohio's budget.

Unless the system is altered, Medicaid could consume half the state budget by 2020, according to researchers at the Scripps Gerontology Center at Miami University in Oxford.

"The only way to serve more people is to increase the number in lower-cost services," said Robert Applebaum, a professor and director of the center's long-term care research project.

In testimony before the Senate Finance Committee yesterday, Applebaum said Ohio has made progress but has a long way to go to create an efficient and effective system of long-term care.

The Republican-controlled Senate is expected to slash $1 billion from a $54 billion two-year budget passed by the House to help deal with a projected shortfall that could reach $3 billion. Democratic leaders in the House will assist in making the rest of the cuts when the budget goes to a joint conference committee for a final review.

The looming long-term care crisis presents another fiscal challenge for lawmakers.

A new Gerontology Center report recommends expanding the services available to Ohioans in need of long-term care. They should include in-home services, in which individuals hire and supervise their own care providers, and assisted living.

The array of services would allow more elderly people to continue living in their homes, which is generally preferred. It's also cheaper and will save the state money by reducing the use of higher-cost nursing homes.

Medicaid pays $156 a day for a nursing-home stay and $38 a day to provide home care under Ohio's popular PASSPORT program.

But Ohio's elderly aren't the only ones running up the state's long-term care bills. The number of Ohioans younger than 60 in nursing homes is growing.

Over the past decade, there has been a 9 percent reduction in the number of Medicaid recipients older than 60 in nursing homes. But during the same time span, there has been a 17 percent increase in the Medicaid recipients younger than 60 who use nursing homes, the report found.

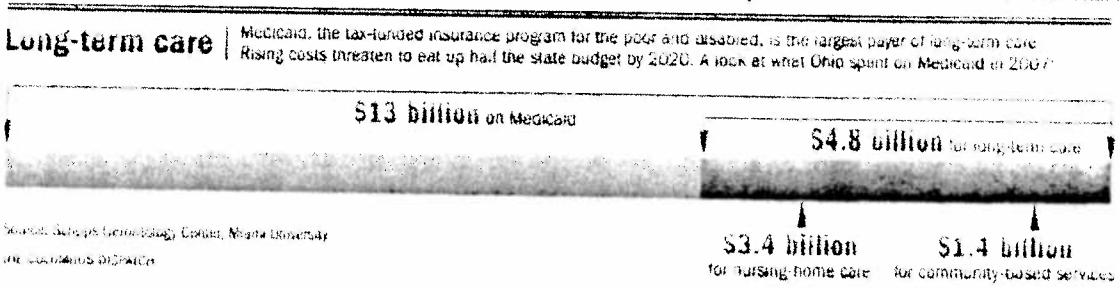
Between April and June of 2008, nearly 13 percent of the 54,045 Medicaid patients in nursing homes were younger than 60.

Applebaum said many of those younger nursing-home residents, some with mild impairments and others suffering from mental illness, apparently have nowhere else to turn.

State officials have pushed for years to expand the long-term care options under Medicaid, with some success.

Currently, 72 percent of Ohio's long-term care budget is spent on institutional care and 28 percent on community-based services. That ranks it 43rd in the nation for margin of institutional versus community care; however, it's an improvement from 47th place in 2004.

Applebaum said Ohio's goal should be a 50-50 split.



A Profile of Older Americans: 2008

Administration on Aging
U.S. Department of Health and Human Services

Table of Contents

Highlights *

- The older population (65+) numbered 37.9 million in 2007, an increase of 3.8 million or 11.2% since 1997.
- The number of Americans aged 45-64 – who will reach 65 over the next two decades – increased by 38% during this decade.
- Over one in every eight, or 12.6 percent, of the population is an older American.
- Persons reaching age 65 have an average life expectancy of an additional 19.0 years (20.3 years for females and 17.4 years for males).
- Older women outnumber older men at 21.9 million older women to 16.0 million older men.
- In 2007, 19.3% of persons 65+ were minorities--8.3% were African-Americans.** Persons of Hispanic origin (who may be of any race) represented 6.6% of the older population. About 3.2% were Asian or Pacific Islander,** and less than 1% were American Indian or Native Alaskan.** In addition, 0.6% of persons 65+ identified themselves as being of two or more races.
- Older men were much more likely to be married than older women--73% of men vs. 42% of women (Figure 2). 42% older women in 2007 were widows.
- About 30 percent (10.9 million) of noninstitutionalized older persons live alone (7.9 million women, 2.9 million men).
- Half of older women (49%) age 75+ live alone.
- About 450,000 grandparents aged 65 or more had the primary responsibility for their grandchildren who lived with them.
- The population 65 and over will increase from 35 million in 2000 to 40 million in 2010 (a 15% increase) and then to 55 million in 2020 (a 36% increase for that decade).
- The 85+ population is projected to increase from 4.2 million in 2000 to 5.7 million in 2010 (a 36% increase) and then to 6.6 million in 2020 (a 15% increase for that decade).
- Minority populations are projected to increase from 5.7 million in 2000 (16.3% of the elderly population) to 8.0 million in 2010 (20.1% of the elderly) and then to 12.9 million in 2020 (23.6% of the elderly).
- The median income of older persons in 2007 was $24,323 for males and $14,021 for females. Median money income (after adjusting for inflation) of all households headed by older people did not change in a statistically different amount from 2006 to 2007. Households containing families headed by persons 65+ reported a median income in 2007 of $41,851.
- Major sources of income for older people in 2006 were: Social Security (reported by 89 percent of older persons), income from assets (reported by 55 percent), private pensions (reported by 29 percent), government employee pensions (reported by 14 percent), and earnings (reported by 25 percent).
- Social Security constituted 90% or more of the income received by 32% of all Social Security beneficiaries (20% of married couples and 41% of non-married beneficiaries).
- About 3.6 million elderly persons (9.7%) were below the poverty level in 2007 which is a statistically significant increase from the poverty rate in 2006 (9.4%).
- About 11% (3.7 million) of older Medicare enrollees received personal care from a paid or unpaid source in 1999.

**Principal sources of data for the Profile are the U.S. Bureau of the Census, the National Center on Health Statistics, and the Bureau of Labor Statistics. The Profile incorporates the latest data available but not all items are updated on an annual basis.*

The Older Population

The older population--persons 65 years or older--numbered 37.9 million in 2007 (the most recent year for which data are available). They represented 12.6% of the U.S. population, over one in every eight Americans. The number of older Americans increased by 3.8 million or 11.2% since 1997, compared to an increase of 12.9% for the under-65 population. However, the number of Americans aged 45-64 – who will reach 65 over the next two decades – increased by 38% during this period.

In 2007, there were 21.9 million older women and 16.0 million older men, or a sex ratio of 137 women for every 100 men. The female to male sex ratio increases with age, ranging from 114 for the 65-69 age group to a high of 210 for persons 85 and over.

Since 1900, the percentage of Americans 65+ has tripled (from 4.1% in 1900 to 12.6% in 2007), and the number has increased twelve times (from 3.1 million to 37.9 million). The older population itself is getting older. In 2007, the 65-74 age group (19.4 million) was over 8.8 times larger than in 1900, but the 75-84 group (13.0 million) was 17 times larger and the 85+ group (5.5 million) was 45 times larger.

In 2006, persons reaching age 65 had an average life expectancy of an additional 19.0 years (20.3 years for females and 17.4 years for males). A child born in 2006 could expect to live 78.1 years, about 30 years longer than a child born in 1900. Much of this increase occurred because of reduced death rates for children and young adults. However, the period of 1985-2005 also has seen reduced death rates for the population aged 65-84, especially for men – by 32.3% for men aged 65-74 and by 23.5% for men aged 75-84. Life expectancy at age 65 increased by only 2.5 years between 1900 and 1960, but has increased by 4.7 years from 1960 to 2006.

About 2.4 million persons celebrated their 65th birthday in 2007. In the same year, about 1.8 million persons 65 or older died. Census estimates showed an annual net increase of 634,893 in the number of persons 65 and over.

There were 80,771 persons aged 100 or more in 2007 (0.21% of the total 65+ population). This is a 117% increase from the 1990 figure of 37,306.

(Data for this section were compiled primarily from Internet releases of the U.S. Bureau of the Census and the National Center for Health Statistics/Trends in Health and Aging Data Warehouse).

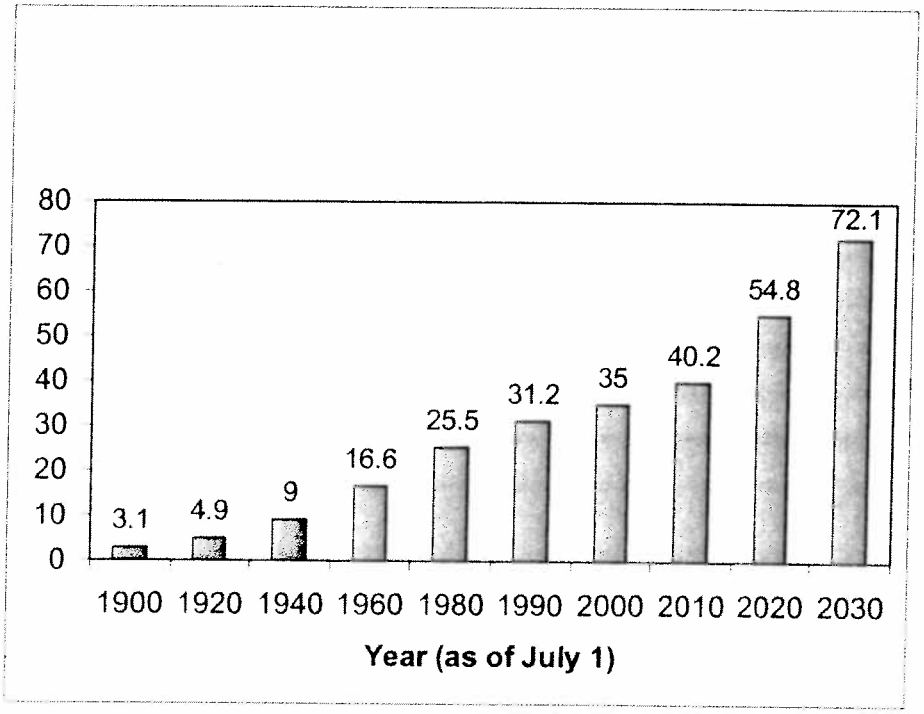
Future Growth

The older population will continue to grow significantly in the future (see Figure 1). This growth slowed somewhat during the 1990's because of the relatively small number of babies born during the Great Depression of the 1930's. But the older population will burgeon between the years 2010 and 2030 when the "baby boom" generation reaches age 65.

The population 65 and over will increase from 35 million in 2000 to 40 million in 2010 (a 15% increase) and then to 55 million in 2020 (a 36% increase for that decade). By 2030, there will be about 72.1 million older persons, almost twice their number in 2007. People 65+ represented 12.6% of the population in the year 2007 but are expected to grow to be 19.3% of the population by 2030. The 85+ population is projected to increase from 5.5 million in 2007 to 5.8 million in 2010 and then to 6.6 million in 2020 (15%) for that decade.

Minority populations are projected to increase from 5.7 million in 2000 (16.3% of the elderly population) to 8.0 million in 2010 (20.1% of the elderly) and then to 12.9 million in 2020 (23.6% of the elderly). Between 2007 and 2030, the white** population 65+ is projected to increase by 68% compared with 184% for older minorities, including Hispanics (244%), African-Americans** (126%), American Indians, Eskimos, and Aleuts** (167%), and Asians and Pacific Islanders** (213%).

Figure 1: Number of Persons 65+, 1900 – 2030 (number in millions)



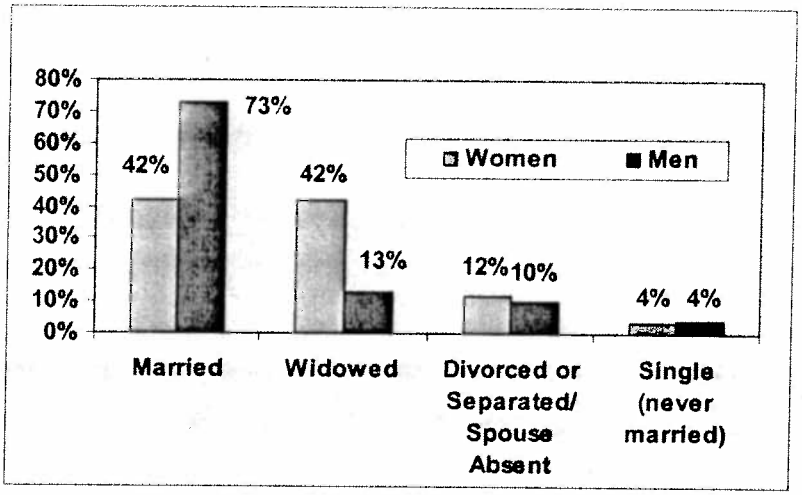
Note: Increments in years are uneven.
(Sources: Projections for 2010 through 2050 are from: Table 12. Projections of the Population by Age and Sex for the United States: 2010 to 2050 (NP2008-T12), Population Division, U.S. Census Bureau; Release Date: August 14, 2008. The source of the data for 1900 to 2000 is Table 5. Population by Age and Sex for the United States: 1900 to 2000, Part A. Number, Hobbs, Frank and Nicole Stoops, U.S. Census Bureau, Census 2000 Special Reports, Series CENSR-4, Demographic Trends in the 20th Century. The figures for 2007 are from the Census Bureau 2007 population estimates.)

Marital Status

In 2007, older men were much more likely to be married than older women--73% of men, 42% of women (Figure 2). Widows accounted for 42% of all older women in 2007. There were over four times as many widows (8.7 million) as widowers (2.0 million).

Divorced and separated (including married/spouse absent) older persons represented only 11.1% of all older persons in 2007. However, this percentage has increased since 1980, when approximately 5.3% of the older population were divorced or separated/spouse absent.

Figure 2: Marital Status of Persons 65+, 2007



(Based on Internet releases of data from the 2007 Current Population Survey, Annual Social and Economic Supplement of the U.S. Bureau of the Census)

Living Arrangements

Over half of (55.3%) the older non-institutionalized persons lived with their spouse in 2007. Approximately 11.2 million or 72.8% of older men, and 8.7 million or 42.2% of older women, lived with their spouse (Figure 3). The proportion living with their spouse decreased with age, especially for women. Only 30.1% of women 75+ years old lived with a spouse.

About 30.2% (10.9 million) of all non-institutionalized older persons in 2007 lived alone (7.9 million women, 2.9 million men). They represented 38.6 of older women and 19.0% of older men. The proportion living alone increases with advanced age. Among women aged 75 and over, for example, half (49%) lived alone.

More than 670,000 grandparents aged 65 or over maintained households in which grandchildren were present in 2007. (Another 234,000 elderly were spouses of such people.) In addition, almost 857,000 grandparents over 65 years lived in parent-maintained households in which their grandchildren were present. A total of about 1.83 million older people lived in household with a grandchild present in the house. About 450,000 of these grandparents over 65 years old were the persons with primary responsibility for their grandchildren who lived with them.

While a relatively small number (1.57 million) and percentage (4.4%) of the 65+ population in 2007 lived in institutional settings such as nursing homes, the percentage increases dramatically with age, ranging from 1.3% for persons 65-74 years to 4.1% for persons 75-84 years and 15.1% for persons 85+. In addition, approximately 2%-5% (depending on the definition) of the elderly lived in senior housing with at least one supportive service available to their residents.

Figure 3A: Living Arrangements of Persons 65+, 2007 (Men)

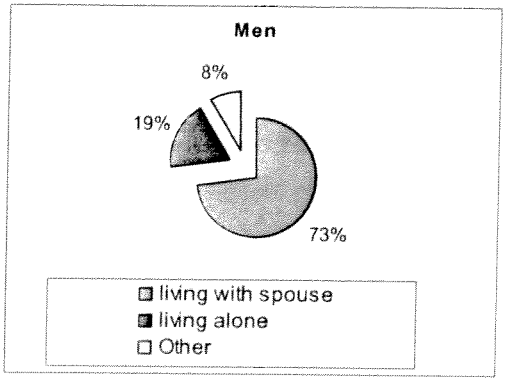
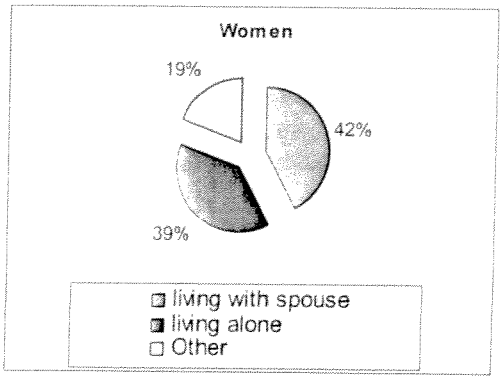


Figure 3B: Living Arrangements of Persons 65+, 2007 (Women)



(Based on data from U.S. Bureau of the Census including the 2007 Current Population Survey, Annual Social and Economic Supplement and the 2007 American Community Survey. See: March 2008 Current Population Survey Internet releases, Detailed Tables and unpublished data from the Centers for Medicare and Medicaid Services.)

Racial and Ethnic Composition

In 2007, 19.3% of persons 65+ were minorities--8.3% were African-Americans.** Persons of Hispanic origin (who may be of any race) represented 6.6% of the older population. About 3.2% were Asian or Pacific Islander,** and less than 1% were American Indian or Native Alaskan.** In addition, 0.6% of persons 65+ identified themselves as being of two or more races.

Only 7.1% of all the people who were minority race or of Hispanic ethnicity were 65+ in 2007 (8.5% of African-Americans,** 5.5% of Hispanics, 9.3% of Asians and Pacific Islanders,** 8.1% of American Indians and Native Alaskans,**), compared with 15.4% of non-Hispanic whites.**

(Data for this section were compiled from Internet releases of the Census 2007 Population Estimates).

Geographic Distribution

The proportion of older persons in the population varies considerably by state with some states experiencing much greater growth in their older populations (Figures 4 and 5). In 2007, about half (52.4%) of persons 65+ lived in nine states. California had 4.0 million; Florida 3.1 million; New York 2.5 million; Texas 2.4 million; and Pennsylvania 1.9 million, Illinois, Ohio, Michigan, and New Jersey each had well over 1 million (Figure 6).

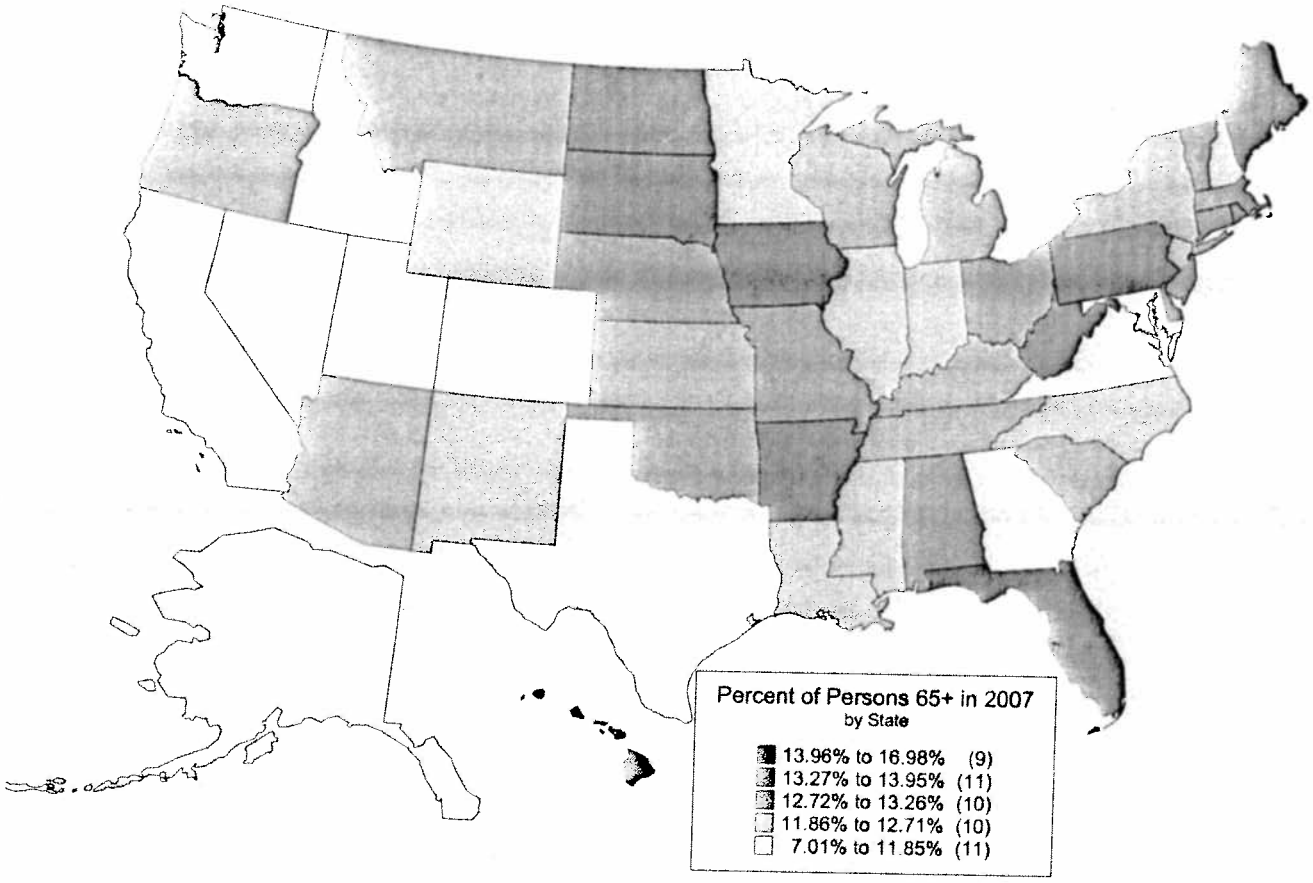
Person 65+ constituted approximately 14% or more of the total population in 10 states in 2007 (Figure 6): Florida (18.5%); Pennsylvania (15.8%); Rhode Island (15.8%) West Virginia (15.1%); Iowa (15.0%); North Dakota (14.4%); Connecticut (14.4); Arkansas (14.3%); South Dakota (14.3%); and Massachusetts (14.1%). In ten states, the 65+ population increased by 20% or more between 1997 and 2007 (Figure 6): Alaska (49.6%); Nevada (48.3%); Arizona (36.2%); Utah (30.0%); New Mexico (29.7%); Idaho (27.8%); Georgia (27.7%); South Carolina (26.3%) ; Colorado (25.2%); and Delaware (24.7%). The ten jurisdictions with the highest poverty rates for elderly during 2007 were the District of Columbia (14.6%), Mississippi (14.5%), North Dakota (14.4%), Kentucky (13.1%), Louisiana (13.1%), New Mexico (13.0%), Georgia (12.2%), South Carolina (12.1%), Texas (12.0%), and Alabama (11.9%).

Most persons 65+ lived in metropolitan areas in 2007 (80.5%). About 63.3% of these older persons lived outside the principal cities and 36.7% lived in principal cities. Also, 19.5% of older persons lived in nonmetropolitan areas.

The elderly are less likely to change residence than other age groups. From 2006 to 2007, only 4.2% of older persons moved as opposed to 17.0% of the under 65 population. Most older movers (57.9%) stayed in the same county and 78.9% remained in the same state. Only 21.1% of the movers moved out-of-state.

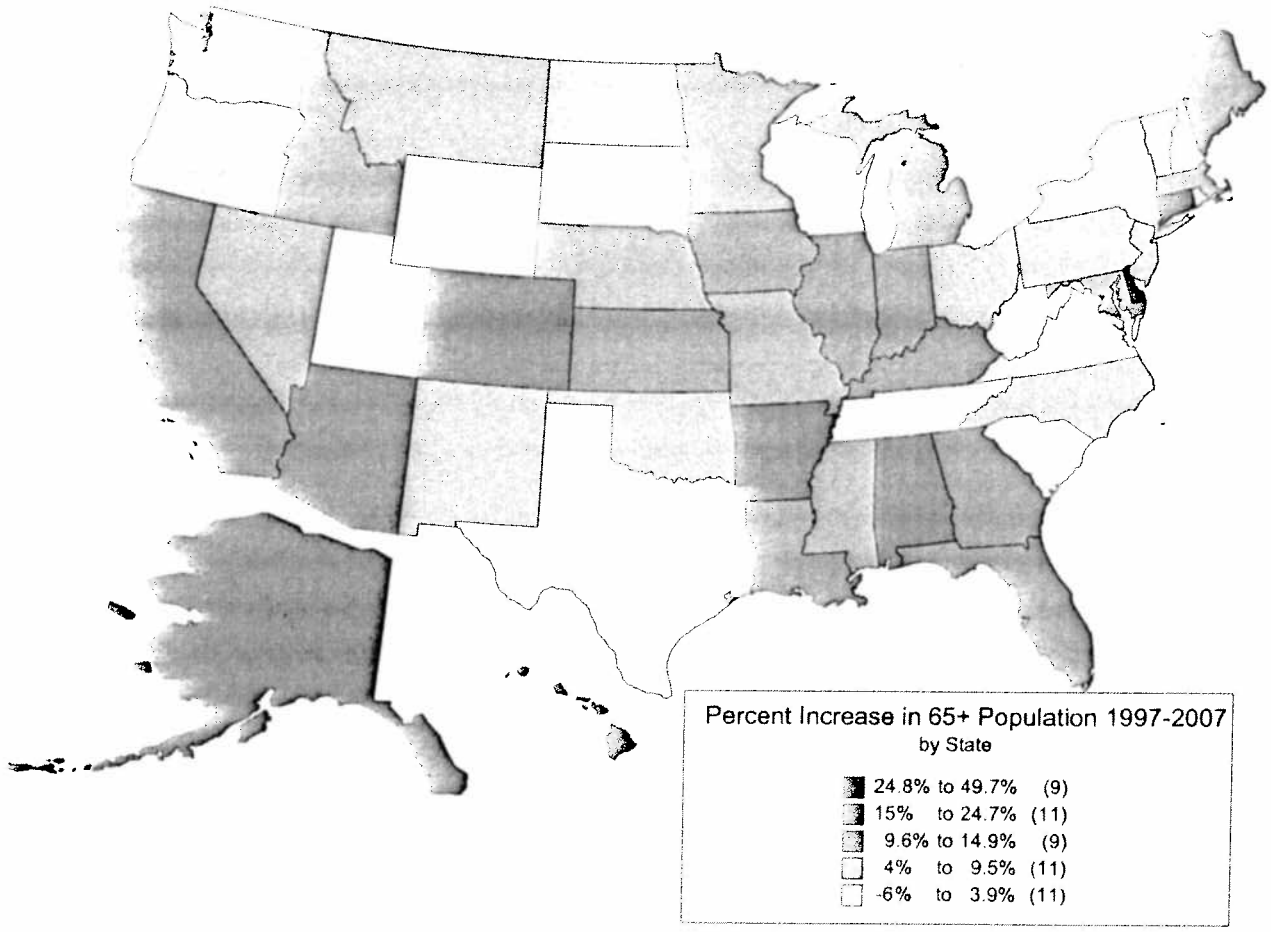
(Data for this section and for Figures 4-6 were compiled primarily from the Census Population Estimates for 2007 as well as other Internet releases of the U.S. Bureau of the Census including tables from the March 2008 Current Population Survey, Annual Social and Economic Supplement and the 2007 American Community survey)

Figure 4: Persons 65+ as a Percentage of Total Population, 2007



(Source: 2007 Population Estimates from the U.S. Bureau of the Census)

Figure 5: Percentage Increase in Population 65+, 1997 to 2007



(Source: 1997 and 2007 Population Estimates from the U.S. Bureau of the Census)

Figure 6: The 65+ Population by State 2007

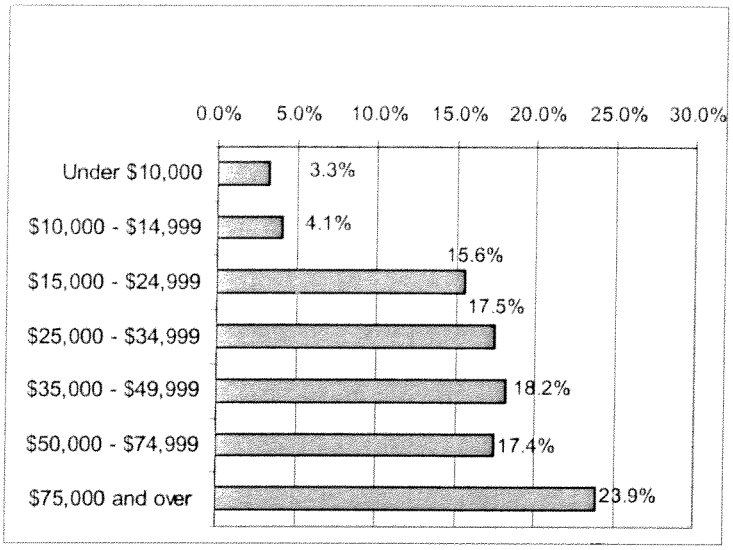
Numbers	Number of Persons 65 and Older	Percent of All Ages	Percent Increase from 1997 to 2007	Percent Below Poverty 2007
US Total (50 States + DC)	37,887,958	12.6%	11.2%	9.7%
Alabama	625,756	13.5%	11.5%	11.9%
Alaska	47,935	7.0%	49.6%	5.0%
Arizona	820,391	12.9%	36.2%	8.6%
Arkansas	397,108	14.0%	10.3%	11.9%
California	4,003,593	11.0%	12.1%	8.1%
Colorado	492,685	10.1%	25.2%	8.9%
Connecticut	472,284	13.5%	0.6%	6.2%
Delaware	117,678	13.6%	24.7%	8.6%
District of Columbia	69,741	11.9%	-5.0%	14.6%
Florida	3,098,364	17.0%	14.4%	9.5%
Georgia	942,832	9.9%	27.7%	12.2%
Hawaii	183,994	14.3%	17.4%	6.5%
Idaho	174,946	11.7%	27.8%	8.6%
Illinois	1,548,781	12.1%	4.6%	8.6%
Indiana	795,441	12.5%	8.4%	7.8%
Iowa	438,448	14.7%	2.1%	8.1%
Kansas	360,216	13.0%	2.5%	8.7%
Kentucky	549,504	13.0%	12.4%	13.1%
Louisiana	522,334	12.2%	5.1%	13.1%
Maine	194,986	14.8%	12.5%	8.2%
Maryland	661,809	11.8%	13.4%	7.8%
Massachusetts	858,939	13.3%	-0.4%	9.2%
Michigan	1,280,152	12.7%	5.4%	8.1%
Minnesota	636,216	12.2%	10.1%	8.1%
Mississippi	364,614	12.5%	9.5%	14.5%
Missouri	788,371	13.4%	6.5%	9.4%
Montana	133,578	13.9%	15.0%	8.9%
Nebraska	236,648	13.3%	4.0%	8.4%
Nevada	285,654	11.1%	48.3%	6.6%
New Hampshire	165,742	12.6%	17.2%	6.2%
New Jersey	1,134,636	13.1%	2.6%	8.5%
New Mexico	250,235	12.7%	29.7%	13.0%
New York	2,546,405	13.2%	4.9%	11.8%
North Carolina	1,103,413	12.2%	18.9%	11.0%
North Dakota	93,285	14.6%	0.8%	14.4%
Ohio	1,545,085	13.5%	3.4%	8.1%
Oklahoma	480,140	13.3%	8.0%	10.3%
Oregon	488,936	13.0%	13.6%	8.6%
Pennsylvania	1,889,660	15.2%	-0.8%	8.8%
Rhode Island	146,847	13.9%	-5.9%	9.1%
South Carolina	573,098	13.0%	26.3%	12.1%
South Dakota	113,555	14.3%	7.9%	10.9%
Tennessee	793,117	12.9%	18.4%	11.8%
Texas	2,394,157	10.0%	22.2%	12.0%
Utah	233,982	8.8%	30.0%	5.3%
Vermont	84,425	13.6%	16.9%	7.3%
Virginia	909,522	11.8%	20.4%	9.3%
Washington	757,852	11.7%	17.1%	7.5%
West Virginia	280,666	15.5%	2.3%	10.4%
Wisconsin	736,301	13.1%	7.7%	8.3%
Wyoming	63,901	12.2%	17.7%	4.6%
Puerto Rico	521,983	13.2%	--	43.7%

(Source: Population data is from Census Bureau 2007 Population Estimates. State level poverty data is from the Census 2007 American Community Survey. National level poverty data is from the 2007 Current Population Survey/American Social and Economic Survey.)

Income

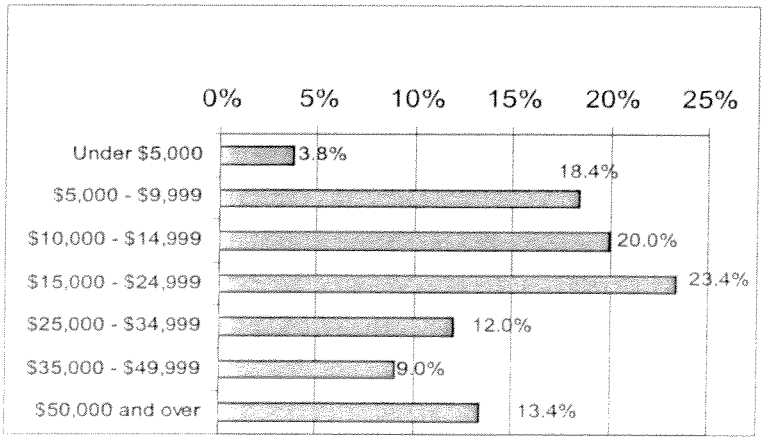
The median income of older persons in 2007 was $24,323 for males and $14,021 for females. Median money income (after adjusting for inflation) of all households headed by older people did not change in a statistically different amount from 2006 to 2007. Households containing families headed by persons 65+ reported a median income in 2007 of $41,851 ($43,654 for non-Hispanic Whites, $31,544 for Hispanics, $32,025 for African-Americans, and $47,135 for Asians). About one of every fourteen (7.4%) family households with an elderly householder had incomes less than $15,000 and 59.5% had incomes of $35,000 or more (Figure 7A/7B).

Figure 7A: Percent Distribution by Income: 2007 (Family Households 65+)



$41,851 median for 12.5 million family households 65+

Figure 7B: Percent Distribution by Income: 2007 (Person 65+ Reporting Income)



$17,424 median for 35.5 million persons 65+ reporting income

For all older persons reporting income in 2007 (35.5 million), 22.3% reported less than $10,000 and 34.4% reported $25,000 or more. The median income reported was $17,424.

The major sources of income as reported by older persons in 2006 were Social Security (reported by 89% of older persons), income from assets (reported by 55%), private pensions (reported by 29%), government employee pensions (reported by 14%), and earnings (reported by 25%). In 2006, Social Security benefits accounted for 37% of the aggregate income of the older population. The bulk of the remainder consisted of earnings (28%), asset income (15%), and pensions (18%). Social Security constituted 90% or more of the income received by 32% of beneficiaries (20% of married couples and 41% of non-married beneficiaries).

(Based on data from Current Population Survey, Annual Social and Economic Supplement, "Income, Poverty, and Health Insurance Coverage in the United States: 2007" P60-235, issued August, 2008 by the U.S. Bureau of the Census, related Census detailed tables on the Census Bureau web site, and from Fast Facts and Figures About Social Security, 2008 Social Security Administration)

Poverty

About 3.6 million elderly persons (9.7%) were below the poverty level in 2007. This poverty rate is a statistically significant increase from the poverty rate in 2006 (9.4%). Another 2.4 million or 6.4% of the elderly were classified as "near-poor" (income between the poverty level and 125% of this level).

One of every fourteen (7.4%) elderly Whites** was poor in 2007, compared to 23.2% of elderly African-Americans, 11.3% of Asians, and 17.1% of elderly Hispanics. Higher than average poverty rates were found in 2006 for older persons were found among those who lived in principal cities (12.2%), outside metropolitan areas (i.e. rural areas and small towns) (10.8%), and in the South (10.8%).

Older women had a higher poverty rate (12.0%) than older men (6.6%) in 2007. Older persons living alone were much more likely to be poor (17.8%) than were older persons living with families (5.6%). The highest poverty rates were experienced among Hispanic women (39.5%) who lived alone and also by older Black women (39.0%) who lived alone.

(Based on data from Current Population Survey, Annual Social and Economic Supplement, "Income, Poverty, and Health Insurance Coverage in the United States: 2007," P60-235, issued August, 2008, by the U.S. Bureau of the Census and related Census detailed tables on the Census Bureau web site)

Housing

Of the 2.9 million households headed by older persons in 2007, 80% were owners and 20% were renters. The median family income of older homeowners was $29,899. The median family income of older renters was $15,130. In 2007, 46% of older householders spent more than one-fourth of their income on housing costs - 39% for owners and 73% for renters - as compared to 46% of all householders.

For homes of older householders in 2007, the median construction year was 1969 (it was 1973 for all householders) and 4.4% of the homes had physical problems. In 2007, the median value of homes owned by older persons was $168,654 (with a median purchase price of $45,191) compared to a median home value of $191,471 for all homeowners. About 68% of older homeowners in 2007 owned their homes free and clear.

(Source: "Amer. Housing Survey for the United States: 2007, Current Housing Reports" H150/07)

Employment

In 2007, 5.8 million (16.0 %) Americans age 65 and over were in the labor force (working or actively seeking work), including 3.2 million men (20.5%) and 2.6 million women (12.6%). They constituted 3.8% of the U.S. labor force. About 3.3% were unemployed. Labor force participation of men 65+ decreased steadily from 2 of 3 in 1900 to 15.8% in 1985; then stayed at 16%-18% until 2002; and has been increasing since then to over 20%. The participation rate for women 65+ rose slightly from 1 of 12 in 1900 to 10.8% in 1956, fell to 7.3% in 1985, was around 7%-9% from 1986 – 2002. However, beginning in 2000, labor force participation of older women has been gradually rising to the 2007 level. This increase is especially noticeable among the population aged 65-69.

(Source: Current Population Survey, labor force statistics. See: Bureau of Labor Statistics web-site: http://www.bls.gov/cps/home.htm)

Education

The educational level of the older population is increasing. Between 1970 and 2007, the percentage who had completed high school rose from 28% to 76.1%. About 19.2% in 2007 had a bachelor's degree or more. The percentage who had completed high school varied considerably by race and ethnic origin in 2007: 81.1% of Whites**, 71.7% of Asians and Pacific Islanders, 57.4% of African-Americans, and 42.2% of Hispanics. The increase in educational levels is also evident within these groups. In 1970, only 30% of older Whites and 9% of older African-Americans were high school graduates.

(Source: Current Population Survey, Annual Social and Economic Supplement, 2007 and related tables on the Census Bureau web site)

Health and Health Care

In 2007, 39.0% of non-institutionalized older persons assessed their heath as excellent or very good (compared to 64.8% for persons aged 18-64). There was little difference between the sexes on this measure, but African-Americans** (23.7%), older American Indians/Alaska Natives (24.3%) and older Hispanics (28.9%) were less likely to rate their health as excellent or very good than were older Whites** (40.4%) or older Asians (34.1%)†. Most older persons have at least one chronic condition and many have multiple conditions. Among the most frequently occurring conditions older persons in 2004-2005 were: hypertension (48%), diagnosed arthritis (47%), all types of heart disease (32%), any cancer (20%), diabetes (16%), and sinusitis (14%).

Almost 67% reported in 2007 that they received an influenza vaccination during the past 12 months and 58% reported that they had ever received a pneumococcal vaccination. About 25% (of persons 60+) report height/weight combinations that place them among the obese. Almost 25% of persons aged 65-74 and 18% of persons 75+ report that they engage in regular leisure-time physical activity. Only 8% reported that they are current smokers and only 5% reported excessive alcohol consumption. Only 2% reported that they had experienced psychological distress during the past 30 days.

In 2006, over 13.1 million persons aged 65 and older were discharged from short stay hospitals. This is a rate of 3,508 for every 10,000 persons aged 65+ which is over three times the comparable rate for persons of all ages (which was 1,169 per 10,000). The average length of stay for persons aged 65+ was 5.5 days;

† *These figures are from 2004-2006 data.*

the comparable rate for persons of all ages was 4.8 days. The average length of stay for older people has decreased by 5 days since 1980. Older persons averaged more office visits with doctors in 2005: 6.5 office visits for those aged 65-74 and 7.7 office visits for persons over 75 while persons aged 45-65 averaged only 3.9 office visits during that year. In 2007, over 96% of older persons reported that they did have a usual place to go for medical care and only 2.5% said that they failed to obtain needed medical care during the previous 12 months due to financial barriers.

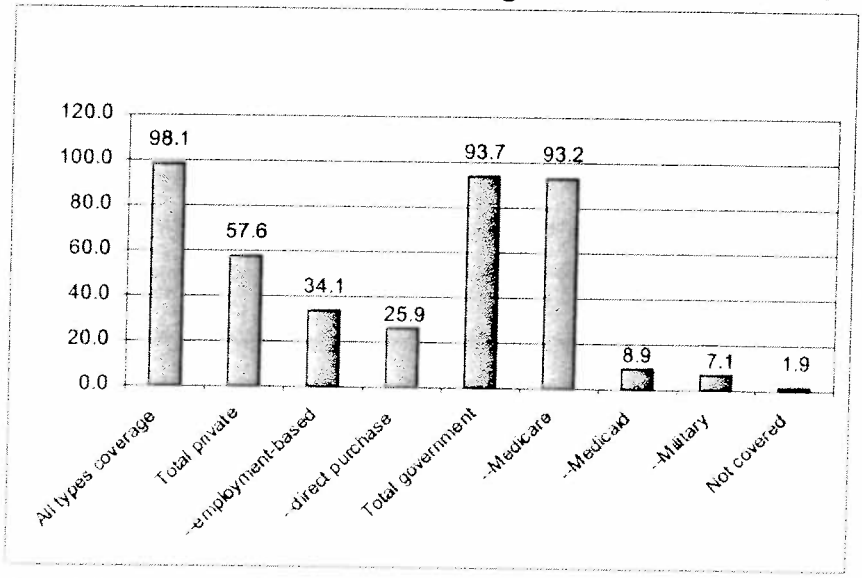
In 2006 older consumers averaged out-of-pocket health care expenditures of $4,631, an increase of 62% since 1996. In contrast, the total population spent considerably less, averaging $2,853 in out-of-pocket costs. Older Americans spent 12.7% of their total expenditures on health, more than twice the proportion spent by all consumers (5.7%). Health costs incurred on average by older consumers in 2006 consisted of $2,770 (60%) for insurance, $859 (18%) for drugs, $844 (18.5%) for medical services, and $159 (3%) for medical supplies.

(Sources: Data releases from the web sites of the National Center for Health Statistics (including the Health Data Interactive data warehouse, accessed 12/30/2008); from the Agency for Healthcare Research and Quality and from the Bureau of Labor Statistics web site)

Health Insurance Coverage

In 2007, almost all (93%) non-institutionalized persons 65+ were covered by Medicare. Medicare covers mostly acute care services and requires beneficiaries to pay part of the cost, leaving about half of health spending to be covered by other sources. About 58% had some type of private health insurance. Over 7% had military-based health insurance and 9% of the non-institutionalized elderly were covered by Medicaid. Only 1% did not have coverage of some kind. About 89% of non-institutionalized Medicare beneficiaries in 2006 had some type of supplementary coverage. Among Medicare beneficiaries residing in nursing homes, about half (52%) were covered by Medicaid.

Figure 8: Health Insurance Coverage of Persons 65+: 2007 (%)



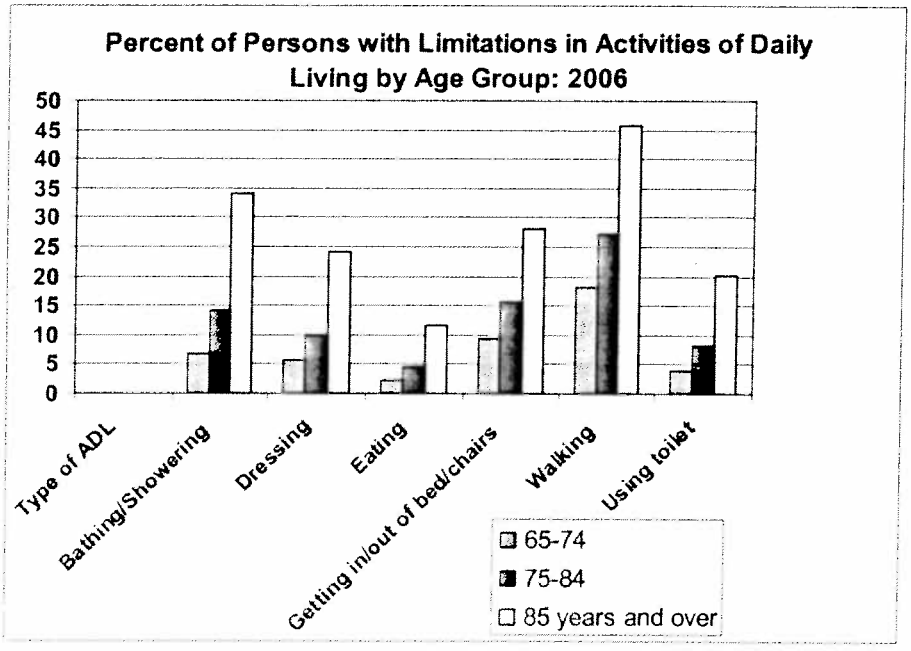
Note: Figure 8 data is for the non-institutionalized elderly. A person can be represented in more than one category. (Source:, "Income, Poverty, and Health Insurance Coverage in the United States: 2007," P60-235, issued August, 2008, by the U.S. Bureau of the Census. Medicare beneficiary data is from the Medicare Current Beneficiary Survey)

Disability and Activity Limitations

Some type of disability (sensory disability, physical disability, or mental disability) was reported by 52% of older persons in 2007. Some of these disabilities may be relatively minor but others cause people to require assistance to meet important personal needs. Almost 37% of older persons reported in 2005 a severe disability and 16% reported that they needed some type of assistance as a result. Reported disability increases with age. 56% of persons over 80 reported a severe disability and 29% of the over 80 population reported that they needed assistance. There is a strong relationship between disability status and reported health status. Among those 65+ with a severe disability, 64% reported their health as fair or poor. Among the 65+ persons who reported no disability, only 10 % reported their health as fair or poor. Presence of a severe disability is also associated with lower income levels and educational attainment.

In another study which focused on the ability to perform specific activities of daily living (ADLs), over 27% of community-resident Medicare beneficiaries over age 65 in 2006 had difficulty in performing one or more ADLs and an additional 12.5% reported difficulties with instrumental activities of daily living (IADLs). By contrast, 91% of institutionalized Medicare beneficiaries had difficulties with one or more ADLs and 73.4% of them had difficulty with three or more ADLs. [ADLs include bathing, dressing, eating, and getting around the house. IADLs include preparing meals, shopping, managing money, using the telephone, doing housework, and taking medication.] Limitations on activities because of chronic conditions increase with age. As shown in Figure 9, the rate of limitations on activities among persons 85 and older are much higher than those for persons 65-74.

Figure 9: Percent of Persons with Limitations in Activities of Daily Living by Age Group: 2006



It should be noted that (except where noted) the figures above are taken from surveys of the noninstitutionalized elderly. Although nursing homes are being increasingly used for short-stay postacute care, about 1.3 million elderly are in nursing homes (about half are age 85 and over). These individuals often have high needs for care with their ADLs and/or have severe cognitive impairment, due to Alzheimer's disease or other dementias.

(Sources: Americans with Disabilities: 2005, December 2008, P70-117 and other Internet releases of the Census Bureau, the Centers for Medicare and Medicaid, and the National Center on Health Statistics, including the NCHS Health Data Interactive data warehouse)

Caregiving

About 11% (3.7 million) of older Medicare enrollees received personal care from a paid or unpaid source in 1999. Almost all community resident older persons with chronic disabilities receive either informal care (from family or friends) or formal care (from service provider agencies). Over 90% of these older persons with chronic disabilities received informal care and/or formal care; and about two thirds received only informal care. About 9 % of this chronically disabled group received only formal services.

(Source: National Long Term Care Survey, 1999)

Notes

*Principal sources of data for the Profile are the U.S. Bureau of the Census, the National Center on Health Statistics, and the Bureau of Labor Statistics. The Profile incorporates the latest data available but not all items are updated on an annual basis.
**Excludes persons of Hispanic origin.

A Profile of Older Americans: 2008 was developed by the Administration on Aging (AoA), U.S. Department of Health and Human Services. The annual Profile of Older Americans was originally developed and researched by Donald G. Fowles, AoA. Saadia Greenberg, AoA, developed the 2008 edition.

AoA serves as an advocate for the elderly within the federal government and is working to encourage and coordinate a responsive system of family and community based services throughout the nation. AoA helps states develop comprehensive service systems which are administered by 56 State and Territorial Units on Aging, 632 Area Agencies on Aging, 244 Native American and Hawaiian organizations, and more than 18,000 local service providers.

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A MARKET EVALUATION

OF THE PROPOSED

PORTAGE TRAIL VILLAGE ASSISTED-LIVING CONVERSION

IN

CUYAHOGA FALLS, OHIO

FOR

MR. DANIEL SAGEN
NATIONAL CHURCH RESIDENCES
2335 NORTH BANK DRIVE
COLUMBUS, OHIO 43220-5499

EFFECTIVE DATE

JUNE 26, 2008

JOB REFERENCE NUMBER

4756JB

vogtwilliamsbowen
RESEARCH

June 26, 2008

Mr. Daniel Sagen
National Church Residences (NCR)
2335 North Bank Drive
Columbus, Ohio 43220-5499

Re: Market Evaluation, Senior Age 62+ – CUYAHOGA FALLS, OHIO
Proposed Portage Trail Village Assisted-Living Conversion

Dear Mr. Sagen:

The purpose of this letter is to address the demographic support for the conversion of some or the entire existing Portage Trail Village apartment project into an Assisted-Living Facility (ALF) under HUD's Assisted-Living Conversion Program (ALCP).

Portage Trail Village is a 199-unit HUD Section 202 apartment building for age 62+ seniors in Cuyahoga Falls, Ohio. The 13-story mid-rise building, originally built in 1968 and located at 45 Cathedral Lane in the far northwest area of the city, is nearly 100% occupied with a lengthy wait list for one-bedroom units. Cuyahoga Falls, currently the second largest city in Summit County behind Akron, is considered a suburb of both Akron and Cleveland.

According to HUD requirements, the facility must be licensed and regulated by the state (or if there is no state law providing such licensing and regulation, by the municipality or other subdivision in which the facility is located).

Assisted-Living Facilities are designed to accommodate frail elderly and people with disabilities who can live independently, but need assistance with Activities of Daily Living (ADL) (e.g., assistance with eating, bathing, grooming, dressing, and home management activities.) ALFs provide support services such as personal care, transportation, meals, housekeeping, and laundry. In Ohio, assisted-living communities housing 17 or more individuals are licensed by the Ohio Department of Health as Residential Care Facilities (RCFs).

To determine market support, VWB Research considered the city of Cuyahoga Falls and nearby residential areas as the primary source of support and analyzed the demographic trends for the city and Summit County. The Site PMA demographics are detailed later in this letter. We have concluded this analysis by providing a demand analysis for the market.

AREA DEMOGRAPHICS

The city of Cuyahoga Falls experienced a slight increase in area population while households increased by 8.3% between 1990 and 2000. Population for the county increased 5.4% during this same period, and households increased 8.9%. Increases in households are expected through 2012, when there will be a total of 48,814 people and 21,833 households within Cuyahoga Falls, and 550,038 people within 223,925 households in Summit County.

The following table reflects trends for area population and households projected to 2012:

	AREA POPULATION		
	CUYAHOGA FALLS	SUMMIT COUNTY	CUYAHOGA FALLS AS PERCENTAGE OF SUMMIT COUNTY
1990 CENSUS	48,009	514,990	9.3%
2000 CENSUS	49,374	542,899	9.1%
CHANGE, 1990-2000	1,365	27,909	4.9%
PERCENT CHANGE, 1990-2000	2.8%	5.4%	-
2007 ESTIMATED	48,971	547,763	8.9%
PERCENT CHANGE, 2000-2007	-0.8%	0.9%	-
2008 ESTIMATED	48,940	548,218	8.9%
2012 PROJECTED	48,814	550,038	8.9%
CHANGE, 2007-2012	-158	2,275	-6.5%
PERCENT CHANGE, 2007-2012	-0.3%	0.4%	-

Source: VWB Research; ESRI; 1990 and 2000 Census

	AREA HOUSEHOLDS		
	CUYAHOGA FALLS	SUMMIT COUNTY	CUYAHOGA FALLS AS PERCENTAGE OF SUMMIT COUNTY
1990 CENSUS	19,996	199,998	10.0%
2000 CENSUS	21,655	217,788	9.9%
CHANGE, 1990-2000	1,659	17,790	9.3%
PERCENT CHANGE, 1990-2000	8.3%	8.9%	-
2007 ESTIMATED	21,767	221,870	9.8%
PERCENT CHANGE, 2000-2007	0.5%	1.9%	-
2008 ESTIMATED	21,781	222,281	9.8%
2012 PROJECTED	21,833	223,925	9.8%
CHANGE, 2007-2012	66	2,055	3.2%
PERCENT CHANGE, 2007-2012	0.3%	0.9%	-

Source: VWB Research; ESRI; 1990 and 2000 Census

According to the 2000 Census, there were 21,655 households in Cuyahoga Falls, an increase of 8.3% from 1990. By 2007, the number of households increased 0.5% to 21,767, which represented 9.8% of the Summit County households. Projections indicate that there will be a total of 21,833 households in Cuyahoga Falls in 2012. This also represents 9.8% of the Summit County projection.

The distribution of households by tenure and age for the city of Cuyahoga Falls area follows:

TENURE	2000 (CENSUS)		2007 (ESTIMATED)		2012 (PROJECTED)	
	HOUSEHOLDS	PERCENT	HOUSEHOLDS	PERCENT	HOUSEHOLDS	PERCENT
OWNER-OCCUPIED	14,244	65.8%	14,856	68.3%	14,834	67.9%
AGE 55+	6,161	28.4%	6,499	29.9%	6,918	31.7%
AGE 65+	4,232	19.5%	3,958	18.2%	3,720	17.0%
AGE 75+	2,064	9.5%	2,485	11.4%	2,180	10.0%
RENTER-OCCUPIED	7,411	34.2%	6,911	31.7%	7,000	32.1%
AGE 55+	1,654	7.6%	1,812	8.3%	1,985	9.1%
AGE 65+	1,202	5.5%	1,293	5.9%	1,379	6.3%
AGE 75+	762	3.5%	771	3.5%	768	3.5%
TOTAL	21,655	100.0%	21,767	100.0%	21,833	100.0%

Source: ESRI; 2000 Census

Renter households age 75+ comprised 3.5% of all area households in 2007. This is a low share of renters for a market of the size and characteristics similar to Cuyahoga Falls, but reflective of the number of homeowners in the area. Clearly, conversion of homeowners is an important support segment for senior assisted-living housing in the Cuyahoga Falls area.

The following tables detail the demographic characteristics for the age 75+ group:

	AGE 75+ POPULATION AND HOUSEHOLDS					
	POPULATION			HOUSEHOLDS		
	CUYAHOGA FALLS	SUMMIT COUNTY	% OF SUMMIT COUNTY	CUYAHOGA FALLS	SUMMIT COUNTY	% OF SUMMIT COUNTY
2000 CENSUS	3,855	36,978	10.4%	2,826	24,611	11.5%
2007 ESTIMATED	4,616	42,613	10.8%	3,256	27,729	11.7%
CHANGE, 2000-2007	761	5,635	13.5%	430	3,118	13.8%
PERCENT CHANGE, 2000-2007	1.9%	15.2%	-	15.2%	12.7%	-
2008 ESTIMATED	4,529	42,365	10.7%	3,194	27,527	11.6%
2012 PROJECTED	4,180	41,375	10.1%	2,948	26,717	11.0%
CHANGE, 2007-2012	436	-1,238	35.2%	-308	-1,012	30.4%
PERCENT CHANGE, 2007-2012	-9.4%	-2.9%	-	-9.5%	-3.6%	-

Source: ESRI; 2000 Census

The age 75+ population base experienced a significant increase within Summit County and the Cuyahoga Falls area between 2000 and 2007. Recent trends however, indicate a decreasing support base of potential age 75+ households in both areas.

INCOME TRENDS

The distribution of households by income within the city of Cuyahoga Falls is summarized as follows:

HOUSEHOLD INCOME	2000 (CENSUS)		2007 (ESTIMATED)		2012 (PROJECTED)	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
LESS THAN $10,000	1,567	7.2%	1,295	5.9%	1,206	5.5%
$10,000 - $19,999	2,630	12.1%	1,944	8.9%	1,419	6.5%
$20,000 - $29,999	2,694	12.4%	2,236	10.3%	1,793	8.2%
$30,000 - $39,999	3,072	14.2%	2,380	10.9%	2,108	9.7%
$40,000 - $49,999	2,746	12.7%	2,434	11.2%	2,250	10.3%
$50,000 - $59,999	2,388	11.0%	2,311	10.6%	2,108	9.7%
$60,000 - $74,999	2,671	12.3%	2,797	12.8%	2,616	12.0%
$75,000 - $99,999	2,214	10.2%	2,911	13.4%	3,235	14.8%
$100,000 & HIGHER	1,673	7.7%	3,459	15.9%	5,098	23.3%
TOTAL	21,655	100.0%	21,767	100.0%	21,833	100.0%
MEDIAN INCOME	$42,896		$52,202		$60,141	

Source: 2000 Census; ESRI; VWB Research

In 2000, the median household income was $42,896. This increased 21.7% to $52,202 in 2007. By 2012, it is estimated the median household income will be $60,141, an increase of 15.2% over 2007.

The following tables illustrate household income for renter households age 65 and older for 2000, 2007 (estimated), and 2012 (projected) for Cuyahoga Falls in greater detail:

AGE 65+ RENTERS	2000 CENSUS					
	1-PERSON	2-PERSON	3-PERSON	4-PERSON	5+-PERSON	TOTAL
$0-$10,000	301	0	0	0	0	301
$10,000-$20,000	457	49	0	0	0	506
$20,000-$30,000	124	42	0	0	0	166
$30,000-$40,000	57	55	17	0	0	129
$40,000-$50,000	16	16	3	0	9	44
$50,000-$60,000	11	4	0	0	0	15
$60,000+	0	30	0	0	11	41
TOTAL	967	196	20	0	20	1,202

Source: Ribbon Demographics; ESRI

AGE 65+ RENTERS	2007 ESTIMATE					
	1-PERSON	2-PERSON	3-PERSON	4-PERSON	5+-PERSON	TOTAL
$0-$10,000	292	0	0	0	0	292
$10,000-$20,000	446	39	0	0	0	485
$20,000-$30,000	173	39	0	0	0	212
$30,000-$40,000	84	61	19	0	0	163
$40,000-$50,000	26	23	5	0	11	65
$50,000-$60,000	15	4	0	0	0	19
$60,000+	0	47	0	0	11	57
TOTAL	1,036	212	24	0	22	1,293

Source: Ribbon Demographics; ESRI

AGE 65+ RENTERS	2012 PROJECTED					
	1-PERSON	2-PERSON	3-PERSON	4-PERSON	5+-PERSON	TOTAL
$0-$10,000	283	0	0	0	0	283
$10,000-$20,000	423	35	0	0	0	458
$20,000-$30,000	204	40	0	0	0	244
$30,000-$40,000	100	63	24	0	0	186
$40,000-$50,000	44	27	5	0	15	92
$50,000-$60,000	19	4	0	0	0	22
$60,000+	0	76	0	0	17	93
TOTAL	1,073	244	29	0	32	1,379

Source: Ribbon Demographics; ESRI

Age 65+ renter households increased by 91 (7.6%) between 2000 and 2007, and are projected to continue to increase by an additional 86, or 6.7%, between 2007 and 2012.

The following tables illustrate household income for homeowner households age 65 and older for 2000, 2007 (estimated), and 2012 (projected) for Cuyahoga Falls in greater detail:

AGE 65+ HOMEOWNERS	2000 CENSUS					
	1-PERSON	2-PERSON	3-PERSON	4-PERSON	5+-PERSON	TOTAL
$0-$10,000	205	25	0	5	0	235
$10,000-$20,000	718	178	12	0	0	908
$20,000-$30,000	370	381	27	0	9	788
$30,000-$40,000	124	500	12	12	0	648
$40,000-$50,000	88	367	41	4	8	507
$50,000-$60,000	69	260	66	12	0	408
$60,000+	48	388	242	34	27	739
TOTAL	1,621	2,100	399	68	44	4,232

Source: Ribbon Demographics; ESRI

AGE 65+ HOMEOWNERS	2007 ESTIMATE					
	1-PERSON	2-PERSON	3-PERSON	4-PERSON	5+-PERSON	TOTAL
$0-$10,000	178	18	0	3	0	198
$10,000-$20,000	591	116	7	0	0	714
$20,000-$30,000	401	304	23	0	10	738
$30,000-$40,000	138	428	11	11	0	587
$40,000-$50,000	102	345	37	3	5	492
$50,000-$60,000	82	251	59	8	0	401
$60,000+	58	424	278	33	33	827
TOTAL	1,551	1,887	415	58	47	3,958

Source: Ribbon Demographics; ESRI

AGE 65+ HOMEOWNERS	2012 PROJECTED					
	1-PERSON	2-PERSON	3-PERSON	4-PERSON	5+-PERSON	TOTAL
$0-$10,000	151	13	0	3	0	167
$10,000-$20,000	438	75	5	0	0	518
$20,000-$30,000	381	250	18	0	9	658
$30,000-$40,000	131	349	11	10	0	501
$40,000-$50,000	105	339	35	4	5	488
$50,000-$60,000	76	241	61	8	0	386
$60,000+	75	505	343	39	41	1,003
TOTAL	1,358	1,771	472	64	56	3,721

Source: Ribbon Demographics; ESRI

Age 65+ homeowner households decreased by 274 (6.5%) between 2000 and 2007, and are projected to continue to decrease by an additional 237, or 6.0%, between 2007 and 2012.

The following tables illustrate household income for renter households age 75 and older for 2000, 2007 (estimated), and 2012 (projected) for Cuyahoga Falls:

AGE 75+ RENTERS	2000 CENSUS					
	1-PERSON	2-PERSON	3-PERSON	4-PERSON	5+-PERSON	TOTAL
$0-$10,000	191	0	0	0	0	191
$10,000-$20,000	289	31	0	0	0	321
$20,000-$30,000	79	27	0	0	0	105
$30,000-$40,000	36	35	11	0	0	82
$40,000-$50,000	10	10	2	0	6	28
$50,000-$60,000	7	2	0	0	0	10
$60,000+	0	19	0	0	7	26
TOTAL	613	124	13	0	13	762

Source: Ribbon Demographics; ESRI

AGE 75+ RENTERS	2007 ESTIMATE					
	1-PERSON	2-PERSON	3-PERSON	4-PERSON	5+-PERSON	TOTAL
$0-$10,000	190	0	0	0	0	190
$10,000-$20,000	288	30	0	0	0	319
$20,000-$30,000	84	26	0	0	0	110
$30,000-$40,000	39	35	11	0	0	85
$40,000-$50,000	11	11	2	0	6	30
$50,000-$60,000	8	2	0	0	0	10
$60,000+	0	21	0	0	7	28
TOTAL	619	126	13	0	13	771

Source: Ribbon Demographics; ESRI

AGE 75+ RENTERS	2012 PROJECTED					
	1-PERSON	2-PERSON	3-PERSON	4-PERSON	5+-PERSON	TOTAL
$0-$10,000	190	0	0	0	0	190
$10,000-$20,000	290	31	0	0	0	320
$20,000-$30,000	82	26	0	0	0	108
$30,000-$40,000	38	35	11	0	0	84
$40,000-$50,000	10	11	2	0	6	29
$50,000-$60,000	7	2	0	0	0	10
$60,000+	0	20	0	0	6	26
TOTAL	618	124	13	0	12	768

Source: Ribbon Demographics; ESRI

Age 75+ renter households were unchanged between 2000 and 2007 and are projected to remain relatively unchanged between 2007 and 2012, decreasing only slightly from 771 in 2007 to 768 in 2012. This is a 0.4% decrease between 2007 and 2012.

The following tables illustrate household income for homeowner households age 75 and older for 2000, 2007 (estimated), and 2012 (projected) for the city of Cuyahoga Falls:

AGE 75+ HOMEOWNERS	2000 CENSUS					
	1-PERSON	2-PERSON	3-PERSON	4-PERSON	5+-PERSON	TOTAL
$0-$10,000	100	12	0	3	0	115
$10,000-$20,000	350	87	6	0	0	443
$20,000-$30,000	180	186	13	0	5	384
$30,000-$40,000	60	244	6	6	0	316
$40,000-$50,000	43	179	20	2	4	247
$50,000-$60,000	34	127	32	6	0	199
$60,000+	23	189	118	17	13	360
TOTAL	791	1,024	195	33	21	2,064

Source: Ribbon Demographics; ESRI

AGE 75+ HOMEOWNERS	2007 ESTIMATE					
	1-PERSON	2-PERSON	3-PERSON	4-PERSON	5+-PERSON	TOTAL
$0-$10,000	112	11	0	2	0	125
$10,000-$20,000	371	73	4	0	0	448
$20,000-$30,000	252	191	15	0	6	464
$30,000-$40,000	87	269	7	7	0	369
$40,000-$50,000	64	217	23	2	3	309
$50,000-$60,000	52	158	37	5	0	252
$60,000+	37	266	175	21	21	519
TOTAL	974	1,185	260	36	30	2,485

Source: Ribbon Demographics; ESRI

AGE 75+ HOMEOWNERS	2012 PROJECTED					
	1-PERSON	2-PERSON	3-PERSON	4-PERSON	5+-PERSON	TOTAL
$0-$10,000	88	8	0	2	0	98
$10,000-$20,000	257	44	3	0	0	304
$20,000-$30,000	223	147	10	0	5	386
$30,000-$40,000	77	204	6	6	0	293
$40,000-$50,000	62	198	20	3	3	286
$50,000-$60,000	45	141	36	5	0	226
$60,000+	44	296	201	23	24	588
TOTAL	796	1,038	277	37	33	2,181

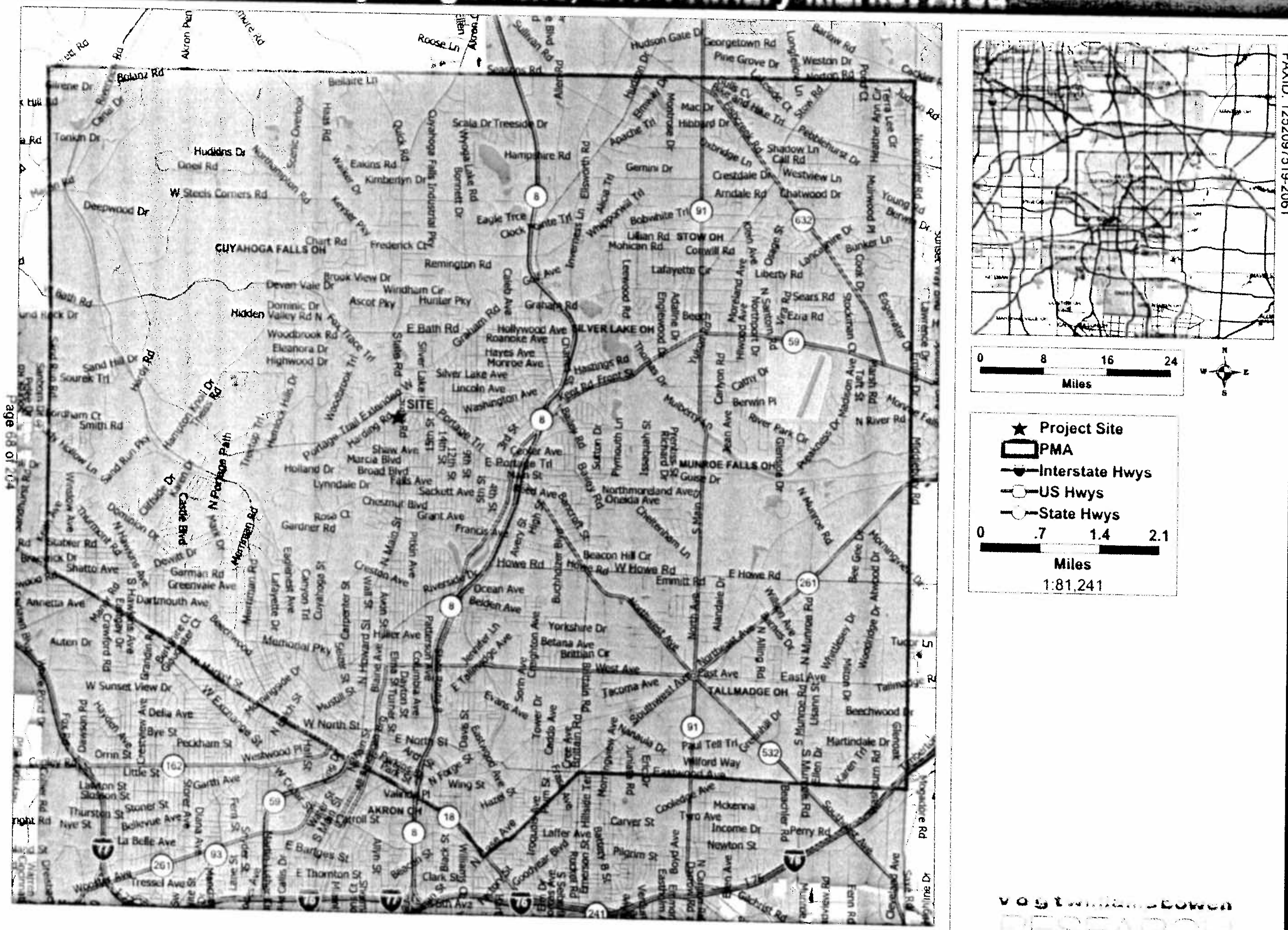
Source: Ribbon Demographics; ESRI

Age 75+ homeowner households increased by 421 between 2000 and 2007, a 20.4% increase, but are projected to decrease by 304 homeowners, or 12.2%, between 2007 and 2012. Notably, the 2012 projection represents a 5.7% increase from the 2000 age 75+ homeowner base.

The Cuyahoga Falls Site Primary Market Area (PMA) was determined through interviews with management of Portage Trail Village, senior housing specialists and social workers, area real estate agents, government officials, and economic development representatives familiar with the Cuyahoga Falls area. In general, the subject Site PMA includes the cities of Cuyahoga Falls, Stow, and Tallmadge as well as the northern portion of the city of Akron. A map of the Cuyahoga Falls Site PMA is included on the next page.

PortageII2009-HUD ALCP
Exhibit 5
DUNS: 602418803
FAXID: 1252097519-2061

Cuyahoga Falls, OH: Primary Market Area



Following is a summary of demographic and economic characteristics for the subject Cuyahoga Falls Site PMA:

The Cuyahoga Falls Site PMA population base increased by 5,622 between 1990 and 2000; this represents a 3.5% increase from the 1990 total population and an annual increase of 3.0%. The Site PMA population bases for 1990, 2000, 2007 (estimated), and 2012 (projected) are summarized as follows:

	YEAR			
	1990 (CENSUS)	2000 (CENSUS)	2007 (ESTIMATED)	2012 (PROJECTED)
POPULATION	159,037	164,659	166,010	166,697
POPULATION CHANGE	-	5,622	1,351	686
PERCENT CHANGE	-	3.5%	0.8%	0.4%

Source: 2000 Census; ESRI; VWB Research

Between 2000 and 2007, area population increased 0.8%. It is projected that the area population will increase by 686 people, or 0.4%, between 2007 and 2012.

The Site PMA population bases by age are summarized as follows:

POPULATION BY AGE	2000 (CENSUS)		2007 (ESTIMATED)		2012 (PROJECTED)		CHANGE 2007-2012	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
17 & UNDER	42,392	25.7%	41,278	24.9%	40,269	24.2%	-1,010	-2.4%
18 TO 24	9,545	5.8%	9,463	5.7%	10,419	6.3%	956	10.1%
25 TO 34	23,968	14.6%	22,080	13.3%	20,333	12.2%	-1,747	-7.9%
35 TO 44	26,388	16.0%	23,672	14.3%	22,832	13.7%	-840	-3.5%
45 TO 54	23,148	14.1%	25,726	15.5%	25,204	15.1%	-522	-2.0%
55 TO 64	14,039	8.5%	18,395	11.1%	22,446	13.5%	4,051	22.0%
65 TO 74	12,788	7.8%	10,884	6.6%	11,398	6.8%	514	4.7%
75 & HIGHER	12,391	7.5%	14,512	8.7%	13,796	8.3%	-716	-4.9%
TOTAL	164,659	100.0%	166,010	100.0%	166,697	100.0%	686	0.4%

Source: 2000 Census; ESRI; VWB Research

The age 75+ population for the Site PMA represented 8.7% of the 2007 area population compared to 9.4% within the city of Cuyahoga Falls. People age 55 to 74 represent 17.7% and 20.4% of the 2007 and 2012 population, respectively. This age 55 to 74 group, a potential user of assisted-living services as the segment ages, is projected to increase 15.6% over the next few years.

The Site PMA household bases by age are summarized as follows:

HOUSEHOLDS BY AGE	2007 (ESTIMATED)		2012 (PROJECTED)		CHANGE 2007-2012	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
UNDER 25	3,226	4.6%	3,344	4.7%	118	3.7%
25 - 34	11,644	16.5%	10,740	15.1%	-904	-7.8%
35 - 44	13,398	19.0%	13,011	18.3%	-387	-2.9%
45 - 54	15,061	21.3%	14,584	20.5%	-477	-3.2%
55 - 64	11,018	15.6%	13,464	18.9%	2,446	22.2%
65 - 74	6,808	9.6%	7,203	10.1%	395	5.8%
75 - 84	6,839	9.7%	5,809	8.1%	-1,030	-15.1%
85 & HIGHER	2,608	3.7%	3,133	4.4%	525	20.1%
TOTAL	70,602	100.0%	71,288	100.0%	686	1.0%

Source: 2000 Census; ESRI; VWB Research

Between 2007 and 2012 the greatest growth among household age groups was among households between the ages of 55 and 74. Household growth is also occurring at a rapid rate among households age 85+, indicating a growing need for senior housing alternatives within the Cuyahoga Falls market. The distribution of households by persons per household for the Site PMA is similar to other suburban markets.

INCOME TRENDS

The distribution of households by income within the Cuyahoga Falls Site PMA is summarized as follows:

HOUSEHOLD INCOME	2000 (CENSUS)		2007 (ESTIMATED)		2012 (PROJECTED)	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
LESS THAN $10,000	5,500	7.9%	4,534	6.4%	4,185	5.9%
$10,000 - $19,999	8,192	11.8%	5,982	8.5%	4,544	6.4%
$20,000 - $29,999	8,518	12.3%	7,298	10.3%	5,753	8.1%
$30,000 - $39,999	9,093	13.1%	7,509	10.6%	6,816	9.6%
$40,000 - $49,999	8,123	11.7%	7,104	10.1%	6,819	9.6%
$50,000 - $59,999	7,086	10.2%	6,989	9.9%	6,237	8.7%
$60,000 - $74,999	7,996	11.5%	8,662	12.3%	7,880	11.1%
$75,000 - $99,999	7,671	11.1%	9,044	12.8%	10,295	14.4%
$100,000 & HIGHER	7,087	10.2%	13,480	19.1%	18,759	26.3%
TOTAL	69,266	100.0%	70,602	100.0%	71,288	100.0%
MEDIAN INCOME	$44,049		$53,655		$62,015	

Source: 2000 Census; ESRI; VWB Research

In 2000, the median household income was $44,049. This increased 21.8% to $53,655 in 2007. By 2012, it is estimated the median household income will be $62,015, an increase of 15.6% over 2007. Between 2007 and 2012, the number of households with incomes above $50,000 is projected to increase by 13.1% and households with incomes above $100,000 are projected to increase by 39.2% over the same period. Income trends among older age households will be detailed for the proposed senior assisted-living project.

The following tables illustrate renter (age 75+) household income by household size for 2000, 2007 (estimated), and 2012 (projected) for the Site PMA:

AGE 75+ RENTERS	2000 CENSUS					
	1-PERSON	2-PERSON	3-PERSON	4-PERSON	5+-PERSON	TOTAL
$0 - $10,000	578	17	12	1	0	608
$10,000 - $20,000	739	95	4	0	0	839
$20,000 - $30,000	276	96	2	0	0	373
$30,000 - $40,000	108	82	11	0	0	201
$40,000 - $50,000	27	34	16	4	10	92
$50,000 - $60,000	10	20	0	1	0	31
$60,000+	54	71	0	2	7	134
TOTAL	1,792	415	47	8	17	2,278

Source: Ribbon Demographics; ESRI

AGE 75+ RENTERS	2007 ESTIMATED					
	1-PERSON	2-PERSON	3-PERSON	4-PERSON	5+-PERSON	TOTAL
$0 - $10,000	575	17	12	0	0	604
$10,000 - $20,000	739	93	4	0	0	837
$20,000 - $30,000	286	94	2	0	0	382
$30,000 - $40,000	114	83	11	0	0	209
$40,000 - $50,000	29	36	17	4	10	96
$50,000 - $60,000	11	20	0	1	0	32
$60,000+	58	73	0	2	7	141
TOTAL	1,813	416	47	8	17	2,301

Source: Ribbon Demographics; ESRI

AGE 75+ RENTERS	2012 PROJECTED					
	1-PERSON	2-PERSON	3-PERSON	4-PERSON	5+-PERSON	TOTAL
$0 - $10,000	575	17	12	0	0	604
$10,000 - $20,000	741	94	4	0	0	839
$20,000 - $30,000	284	93	2	0	0	379
$30,000 - $40,000	113	83	11	0	0	208
$40,000 - $50,000	29	35	17	4	10	95
$50,000 - $60,000	10	20	0	1	0	31
$60,000+	57	72	0	2	7	138
TOTAL	1,808	414	47	8	17	2,294

Source: Ribbon Demographics; ESRI

Age 75+ renter households within the Cuyahoga Falls Site PMA increased by one (1.0%) between 2000 and 2007. Most senior household growth is occurring among homeowners.

The following tables illustrate household income for homeowner households age 75 and older for 2000, 2007 (estimated), and 2012 (projected) for Cuyahoga Falls Site PMA in greater detail:

AGE 75+ HOMEOWNERS	2000 CENSUS					
	1-PERSON	2-PERSON	3-PERSON	4-PERSON	5+-PERSON	TOTAL
$0-$10,000	331	47	0	2	2	382
$10,000-$20,000	751	311	19	5	0	1,085
$20,000-$30,000	478	544	31	1	5	1,058
$30,000-$40,000	279	629	62	12	0	982
$40,000-$50,000	131	489	52	10	12	694
$50,000-$60,000	76	363	88	14	0	541
$60,000+	142	761	294	55	32	1,285
TOTAL	2,188	3,145	546	98	50	6,028

Source: Ribbon Demographics; ESRI

AGE 75+ HOMEOWNERS	2007 ESTIMATE					
	1-PERSON	2-PERSON	3-PERSON	4-PERSON	5+-PERSON	TOTAL
$0-$10,000	342	42	0	1	1	386
$10,000-$20,000	764	260	16	3	0	1,044
$20,000-$30,000	606	543	34	1	6	1,191
$30,000-$40,000	385	677	70	10	0	1,142
$40,000-$50,000	197	576	67	10	13	862
$50,000-$60,000	116	444	106	14	0	680
$60,000+	241	1,063	427	62	45	1,838
TOTAL	2,651	3,604	721	103	64	7,143

Source: Ribbon Demographics; ESRI

AGE 75+ HOMEOWNERS	2012 PROJECTED					
	1-PERSON	2-PERSON	3-PERSON	4-PERSON	5+-PERSON	TOTAL
$0-$10,000	277	31	0	2	0	310
$10,000-$20,000	577	170	11	2	0	759
$20,000-$30,000	548	442	32	1	5	1,028
$30,000-$40,000	346	542	59	8	0	954
$40,000-$50,000	207	539	72	10	12	840
$50,000-$60,000	119	433	111	17	0	680
$60,000+	278	1,158	512	72	54	2,074
TOTAL	2,350	3,314	796	111	72	6,644

Source: Ribbon Demographics; ESRI

Age 75+ homeowner households increased by 1,115 (18.5%) between 2000 and 2007. Notably however, between 2007 and 2012, the age 75+ homeowners are projected to decrease by 499, a 7.0% decline.

Data from the preceding tables is used in our Site PMA demand estimates.

INCOME AND RENT ELIGIBILITY

Residency at HUD Section 202 properties require residents to be at least 62 years of age and have very low incomes, or adjusted household income levels below 50% of Area Median Household Income, or AMHI. HUD establishes income limits annually. The Akron, Ohio Metropolitan Statistical Area (MSA) has a 2008 median household income of $61,700.

The following table summarizes the maximum allowable income by household size for the MSA:

HOUSEHOLD SIZE	MAXIMUM ALLOWABLE INCOME BY % AMHI	
	50%	60%
ONE-PERSON	$21,600	$25,920
TWO-PERSON	$24,700	$29,640
THREE-PERSON	$27,750	$33,300

The demand for specialized senior housing and supportive services is driven by a number of demographic factors, chiefly size of the senior population, marital status, living arrangements, and geographic distribution.

The largest unit offered at the subject senior development will likely be a one-bedroom unit, which could house up to a two-person household. However, research shows that the majority of assisted-living residents are one-person households. As such, the maximum allowable income permitted to live at the subject would be $21,600 per year based on current income characteristics of the 50% AMHI group.

Generally, the need for supportive services increases with age; an increase in the number of seniors in the 75 to 84 and 85+ age groups will result in more demand for housing with services.

In addition to age, demand for supportive housing is heavily influenced by a combination of marital status and living arrangements. Most of the seniors who move into assisted-living are not married and live alone. These percentages vary considerably by gender. Generally, nearly three-quarters of age 75+ men are married and living with a spouse, and 15% to 20% live alone. Among age 75+ women, 55% to 60% are single (widowed, divorced, or never married) and 40% live alone. Statistics show that the proportion of seniors living alone increases with age for both men and women. Currently the market for seniors supportive housing serves mostly single women living alone, but there may be increased demand in the future from single men and older married couples.

Based on our telephone survey of existing apartment alternatives in the Site PMA, there are over 1,300 existing subsidized units (including the subject Portage Trail Village project) for senior households age 62 and over. In addition, VWB Research identified three assisted-living facilities in the Cuyahoga Falls area.

Housing tenure also figures into seniors' demand for supportive housing. Seniors who own their homes are less likely to move, but if they do so, often have greater ability to pay, since home equity represents a significant portion of many seniors' assets.

One starting point for estimating the potential market for affordable assisted-living is the senior population defined as poor or near poor. Just over 10.0% of seniors had incomes below the federal poverty line ($10,400 for one person) and another 7.0% were classified as near poor, with incomes up to 125% of poverty ($13,000), according to the U.S. Department of Health and Human Services, HHS Poverty Guidelines 2008. Generally, poverty rates are higher for African-American (22.4%) and Hispanic seniors (18.8%) than for white seniors (8.9%). Women had a higher poverty rate (12.2%) than men (7.5%). Older persons living alone or with non-relatives had a poverty rate of 20.8%, compared to those living with families (5.1%). Elderly living in central cities and rural areas experienced higher poverty rates than those living in the suburbs, all according to a recent report from the U.S. Administration on Aging.

The presence of assets is an important determinant of seniors' ability to afford assisted-living, yet asset ownership comes with some complications. Seniors in private-pay assisted-living often liquidate assets, yet the high fees can consume a lifetime of savings quickly. The National Investment Center estimates that assets of $50,000 will enable a senior to pay fees for two to three years. For low-income seniors, holding assets other than a primary residence will generally result in loss of eligibility for government-assistance programs. For instance, assets over $2,000 preclude eligibility for Supplemental Security Income for a single person and $3,000 for a couple. Many seniors sell their homes prior to moving into assisted-living; although the proceeds from the sale of a home can allow a senior to pay for assisted-living, this is an emotionally difficult experience and is often delayed until health status is considerably deteriorated.

All of these factors highlight the difficulty of estimating demand for specialized senior housing, seniors are reluctant to leave an independent-living situation and the decision to do so is driven mostly by poor health, retirement, and the death of a spouse. Although the likelihood of ceasing independent-living clearly increases with age, it is difficult to predict exactly at what age any given senior will require a change in housing situation. Moreover, the typical economic variables – income, wealth, prices, and interest rates – that typically drive housing demand for younger households play, at best, a secondary role in seniors' housing choices.

According to Current Population Survey estimates, fewer than 5.0% of seniors move from their current residences each year, compared with about 16.0% of all households. Even assuming that moves are more frequent among seniors over age 75, an entry of 10.0% of the older senior population each year into assisted-living facilities is fairly generous. Second, 45.0% of the assisted-living units turn over every year, as seniors move into skilled nursing facilities or die, according to several sources.

According to our experience surveying assisted-living facilities, most residents need assistance with at least three Activities of Daily Living (ADLs) per day (this most commonly involves medication reminders, mobility assistance, meal monitoring, dressing and grooming assistance, and/or personal laundry). Fees for ADL assistance can be bundled into levels of care, offered as a-la-carte services based upon a point system, or included in the base monthly fee. Typically, assisted-living facilities conduct regular assessments of residents to ensure that their assistance needs are being met.

In 2009 (anticipated year of opening following conversion), we estimate there will be 1,360 renter households headed by a person age 75 and over with incomes below $21,600 (the income limit for one person at 50% AMHI). In addition, there are an estimated 1,098 age 75+ homeowners within the Cuyahoga Falls area with an income below $21,600. Combined, these two potential support segments total 2,458 households, an excellent support base. This number is projected to decrease to 2,303 in 2012, reflecting a decrease in the number of income-eligible homeowners.

Based on our experience in evaluating senior markets, a new project can capture up to 10.0% of the potential support base based on lower rental rates. Typically, for facilities at market-rate rental rates the capture rate ratio is no more than 7.0%. Applying the 10.0% capture rate to the 2,458 income-eligible age 75+ households in the market yields potential support for 245 units.

The total income- and asset-qualified households are summarized in the following table:

INCOME- AND ASSET-QUALIFIED 75+ HOUSEHOLDS (2010) CUYAHOGA FALLS, OHIO SITE PMA	
INCOME-QUALIFIED, LESS THAN $21,600	2,458
ACHIEVABLE CAPTURE RATE	10.0%
QUALIFIED HOUSEHOLDS X CAPTURE RATE	2,458 x 10.0% = 245
TOTAL POTENTIAL SUPPORT	**245**

Assisted-Living Support

To establish the universe of older adults who require assistance with Activities of Daily Living (ADL), we have applied affliction rates based upon a national survey conducted by the Medicare Current Beneficiary Survey (2003), as reported by the National Center for Health Statistics (2004). According to the survey report, 12.9% of the non-institutional population age 75 to 84, and 32.7% of the non-institutional population age 85 and over needed help with three to six ADLs.

The following table estimates the number of older adults age 75 and over requiring some assistance with ADLs within the preliminary market area in 2007.

CUYAHOGA FALLS PRELIMINARY PMA			
AGE CATEGORY	2007 (ESTIMATED) POPULATION	SHARE WITH 3 TO 6 ADLS	ESTIMATE OF SHARE WITH 3 TO 6 ADLS
75 TO 84	10,351	12.9%	1,335
85+	4,161	32.7%	1,361
TOTAL	14,512	18.6%	2,696

Source: Claritas; National Center for Health Statistics; Medicare Current Beneficiary Survey

Based upon this calculation, there are an estimated 2,969 persons age 75 and over within the market area who need assistance with at least three ADLs. Some receive care from family members and/or home healthcare providers, while others are neither income- nor asset-qualified to pay for ADL care. These individuals represent 18.6% (the overall affliction rate) of the total population age 75 and over. A 10.0% capture of these likely assisted-living appropriate households results in a potential for 269 units.

Combined, the two demand evaluations result in potential demand for up to 257 units, the average of the two support evaluations; 245 units under the income-appropriate evaluation and 269 units from the evaluation of the age 75+ population with deficiencies in Activities of Daily Living. It is our recommendation that no more than 100 units be renovated for assisted-living residents as a conservative market addition.

In calculating support for assisted-living units within the senior residential market area, we have made several assumptions:

- 80.0% of the resident's income would likely be paid toward monthly fees (with much of the remaining 20.0% going towards medications and personal items). As such, with an income of $21,600, a monthly fee of $1,440 is appropriate ($21,600/12 months = $1,800 X 80% = $1,440 per month). We have only considered income and limited assets in this estimate of support.

- We have assumed a 2.5-year stay within the assisted-living facility. There have been a number of studies conducted to identify the length of stay at an assisted-living facility, and according to a study prepared by ALFA/NIC entitled *National Survey of Assisted-living Residents: Who is the Customer?,* the median length of stay in 1998 was 19.6 months. Another study, *The State of Seniors Housing,* reports a median length of stay between 25.5 to 30.8 months.

- Individuals with three to six ADL needs are most likely to need residency within an assisted-living facility, as opposed to home healthcare.

- The National Alliance for Care Giving indicates that between 60.0% and 80.0% of all people requiring assistance with Activities of Daily Living currently receive assistance through home healthcare or family caregivers. Based upon our use of three to six ADL criteria, we assume a 60.0% ratio (or a 40.0% rate of institutionalization).

- Based on research at Boston's Brigham and Women's Hospital, 7.4% of people between the ages of 65 and 85, and 47.0% over age 85 suffer from probable Alzheimer's. *An estimated 30.0% of these individuals will require some level of institutionalization.*

We have concluded an estimated need for up to 257 beds/units as part of the proposed Portage Trail Village conversion under HUD's Assisted-Living Conversion Program. As noted earlier, it is our recommendation that no more than 100 units be converted to assisted-living. This is a conservative estimate, as the project currently has 199 senior apartment units. For the purposes of our analysis, we estimate that approximately 75 beds/units will be assisted-living units and the remaining 25 will target Alzheimer's/dementia care residents.

There are three assisted-living facilities located within the Cuyahoga Falls Site PMA, Traditions of Bath Road (a NCR facility), Cardinal Retirement Village, and Falls Village. These projects represent a variety of ages, quality, locations, amenities, price points, and services. These facilities are market-rate and represent different levels of competition for the proposed subject development. It is our opinion that there is no competitive impact on the potential for a subsidized assisted-living facility at the subject Portage Trail Village.

SUMMARY

As noted, it is our opinion that the Cuyahoga Falls Site PMA can support up to 100 assisted-living beds as part of the Portage Trail Village conversion. These units would be affordable at a maximum monthly fee of $1,440.

We acknowledge that there is good senior household growth in the market. However, only a portion of this support will respond to assisted-living. We do believe there may be some opportunity for the subject project to attract more than the fair share of support from existing assisted-living facilities in the market, particularly given the fact that it will be the "newest" project in the market by at least 10 years following renovation, and because it is anticipated to offer a comparable amenity package and design at significantly lower rates when compared with other alternatives in the market.

Assisted-living offers frail seniors a package of housing, personal care, and supportive services in between independent-living and skilled nursing facilities. The fees at private-pay assisted-living facilities are quite high, averaging $2,600 per month, so seniors with annual incomes less than $25,000 will require additional financial assistance to afford these fees. However, assisted-living facilities are considerably less expensive than skilled nursing facilities, although nursing homes traditionally receive much more public funding through Medicaid. Allowing frail seniors who do not need the level of care provided in skilled nursing facilities to choose assisted-living could provide a more desirable living environment to seniors and potential cost savings to the government.

Assisted-living can provide an appropriate package of housing, personal care, and supportive services appropriate for frail seniors for whom independent-living is difficult but who do not require the level of care provided by skilled nursing facilities. However, seniors are often reluctant to move out of independent-living situations. In choosing to move into assisted-living, poor health, retirement, and the death of a spouse are the most important factors.

It is important to note this is a preliminary report. We have not visited the subject site or the existing assisted-living alternatives in the area, or conducted an evaluation of the subject's location, surrounding land uses, visibility, access, or proximity to community services. Also, we did not review site or floor plans for the proposed subject project. Therefore, we have made assumptions that the project's design will be marketable. A superior or inferior design or location may alter our findings and conclusions. A full market feasibility analysis may provide additional information that would allow us to modify our analysis.

An important consideration is the competitive senior projects in the area. VWB Research identified but has not completed a detailed field survey of area assisted-living facilities for this preliminary demand assessment.

We hope this information is useful to you. Mr. Sagen, please contact Rob Vogt or myself if you need any additional information or have questions regarding this matter.

Respectfully,

Jim Beery
Project Director

Portage2009-HUD ALCF
Exhibit 5
DUNS: 602418803
FAXID: 1252097519-2061

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Promoting uniformity and consistency in the supervision of financial institutions

Geocoding System

Geocode Search Result for 2009 HMDA/CRA Reporting

Street Address	45 CATHEDRAL LN	**MSA/MD Code**	10420
City Name	CUYAHOGA FLS	**State Code**	39
State Abbreviation	OH	**County Code**	153
Zip Code	44223	**Tract Code**	5203.00

MSA/MD Name: AKRON, OH
State Name: OHIO
County Name: SUMMIT COUNTY

Get Census Demographic | Get Street Map

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Geocoding System

MSA Code: 10420	State Code: 39	County Code: 153	Tract Code: 5203.00

Summary Census Demographic Information

Tract Income Level	Middle	Tract Population	7058
Underserved or Distressed Tract	No	Tract Minority %	2.37
2009 HUD Estimated MSA/MD/non-MSA/MD Median Family Income	$65,000	Minority Population	167
2009 Est. Tract Median Family Income	$75,309	Owner-Occupied Units	2471
2000 Tract Median Family Income	$60,729	1- to 4-Family Units	2911
Tract Median Family Income %	115.86		

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Geocoding System

MSA Code: 10420	State Code: 39	County Code: 153	Tract Code: 5203.00

Census Income Information

Tract Income Level	Middle	Tract Median Family Income %	115.86
2004 MSA/MD/statewide non-MSA/MD Median Family Income	$52,418	2000 Tract Median Family Income	$60,729
2009 HUD Estimated MSA/MD/non-MSA/MD Median Family Income	$65,000	2009 Estimated Tract Median Family Income	$75,309
% below Poverty Line	5.23	2000 Tract Median Household Income	$45,283

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Geocoding System

MSA Code: 10420	State Code: 39	County Code: 153	Tract Code: 5203.00

Census Population Information

Tract Population	7058	**Tract Minority Population**	167
Tract Minority %	2.37	**American Indian Population**	5
Number of Families	2010	**Asian/Hawaiian/Pacific Islander Population**	35
Number of Households	3289	**Black Population**	58
Non-Hispanic White Population	6891	**Hispanic Population**	23
		Other/Two or More Races Population	46

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Geocoding System

MSA Code: 10420	State Code: 39	County Code: 153	Tract Code: 5203.00

Census Housing Information

Total Housing Units	3390	**Owner-Occupied Units**	2471
1- to 4- Family Units	2911	**Renter Occupied Units**	799
Median House Age (Years)	46	**Vacant Units**	120
Inside Principal City?	Yes	**Owner Occupied 1- to 4- Family Units**	2351

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Ohio | Department of Aging

Building a Cost-effective, Consumer-friendly Long-term Services and Supports System

Final Report of the Unified Long-Term Care Budget Workgroup

May 30, 2008

ODA0003

Ohio Department of Aging

50 West Broad Street/9th Floor, Columbus, Ohio 43215-3363
(614)466-5500 TTY (614)466-6191 FAX (614)466-5741

Ted Strickland, Governor
Barbara E. Riley, Director

Dear Governor Strickland, Speaker Husted, President Harris, House Minority Leader Beatty, Senate Minority Leader Miller, Chair Jones and Members of the Joint Legislative Committee on Medicaid Technology and Reform:

I am very pleased to submit to you the final report and recommendations of the Unified Long Term Care Budget workgroup, as required by Am. Sub. H.B. 119 of the 127th General Assembly. The report is the culmination of 10 months of work involving over 300 individuals representing consumers, providers, advocates, state agencies, local entities, and interested stakeholders who served on the workgroup itself and its five subcommittees. In addition to the committee work, in order to assure that all interested parties had an opportunity to be informed and to be heard, we hosted community forums, presented at numerous conferences, held webinars, and created an extensive unified long term care budget web site with over 700 "subscribers".

Because of the broad representation of interested parties I believe we have been able to assemble a comprehensive report that addresses the legislatively required elements, and recommends many systemic changes designed to:

- Create a more cost effective and consumer based system;
- Achieve a better balance between institutional and home and community based care;
- Provide consumers with a choice of services designed to meet their needs and improve their quality of life; and
- Consolidate agency authority and long term care budgets.

I want to thank each of the workgroup members, with special thanks to Representatives Shannon Jones and Armand Budish, and Senators Thomas Niehaus and Capri Cafaro all of whom served on the workgroup. The product being presented to you represents a consensus report, and I want to acknowledge the work of our facilitator Maggie Lewis from the Commission on Dispute Resolution and Conflict Management who ably assisted us in our efforts. In order to address any questions or concerns you might have, I would like to request an opportunity to present the report to the committee in the near future as our recommendations include an aggressive implementation plan beginning in SFY 2009.

Thank you for the opportunity to work with an outstanding group of individuals who came together to work to improve our long term care system and better serve our consumers and Ohio's taxpayers.

Sincerely,

Barbara E. Riley
Director

Executive Summary

Ohio is faced with a major challenge – one that only will continue to increase over time. How best to provide needed long-term services and supports to a growing population of Ohioans who need this support? A recent report from the Scripps Gerontology Center at Miami University estimates that the number of Ohioans of all ages that will need long-term services and supports will increase by 14% between now and 2020 (an increase of 43,600 consumers).

These demographic changes, in combination with continued growth in Ohio's Medicaid program, have serious implications for the state budget of 2020. Today, Ohio spends 24% of its General Revenue Fund (GRF) budget on Medicaid (the major funding source for long-term services and supports). If the state maintains the status quo – that is, its formal long-term supports are provided the same way, with the same programmatic structure, to the same proportion of Ohioans with disabilities, and Medicaid grows at a rate of 6% per year and overall state budget growth is 3.5% per year – then by 2020, Ohio will spend 32% of its *entire* GRF budget on Medicaid, according to Scripps. Between 2000 and 2006 Medicaid grew at a rate of 11.5% and if this higher rate of growth continued and the state budget continued to grow at 3.5%, by 2020 Medicaid would consume 68% of Ohio's entire GRF budget. It is clear that Ohio must change its current approach to delivering and funding long-term services and supports in order to meet the needs of our citizens and to manage our economic future.

It is important that a unified budget strategy not be perceived as a panacea for the challenge Ohio faces. Based on the experience of other states such as Oregon, Washington, Vermont and Wisconsin, a unified budget and budgeting process is a *tool* toward achieving policy goals. What Ohio lacks is a comprehensive *strategy* to address the future need of its citizens for long-term services and supports. In order to create an effective unified long-term care budget, it is essential simultaneously to build that strategy. This report of the Unified Long-Term Care Budget (ULTCB) workgroup sets forth an initial strategic framework upon which a comprehensive and cost effective system can be built.

Am. Sub. H.B. 119 created a unified budget workgroup chaired by the Director of the Department of Aging, Barbara E. Riley. The workgroup, consisting of consumer advocates, providers, and state policymakers, was to recommend a new budgeting process that:

- Provides consumers with a *choice* of services that meet the consumers needs and improve the consumer's quality of life;
- Provides an *array* of services that meet the consumer's needs throughout life;
- *Consolidates* policymaking authority and the associated budgets for long-term services and supports in a single entity (promotes *simplicity* ***and*** *flexibility)*; and

- Assures a system that is *cost effective* and links disparate services across agencies and jurisdictions.

The workgroup was required to submit an implementation plan by June 1, 2008 (i.e., this final report) that incorporates:

- Recommendations regarding the *structure* of the unified long-term care budget;
- A plan outlining how funds can be transferred among involved agencies in a fiscally neutral manner;
- Identification of the resources needed to implement the unified budget in a multiphase approach starting in SFY 2009; and
- Success criteria and tools to measure progress.

The plan is to consider the recommendations of the Medicaid Administrative Study Council and the Ohio Commission to Reform Medicaid.

In order to focus on the goals and purposes articulated in Am. Sub. H.B. 119, the ULTCB workgroup adopted the following mission statement:

> To create a budget for long-term care services and supports that unifies the budgeting process for facility-based and home-based services and that supports Ohio's ability to accurately forecast expenditures for these services in future years.

The workgroup also went on to adopt the following vision:

> Ohio's budget for long-term services and supports will be: flexible to permit consumers to choose from a wide array of quality services based on their preferences and needs; transparent to policymakers; and a cost-effective solution to budgeting for the future service needs for Ohioans in need of long-term care who may eventually need Medicaid-funded supports.

The key concepts embedded in the mission and vision statements are *consumer choice*, *flexibility* and *transparency*. Consumer choice allows consumers to make informed choices among appropriate services and service settings. Flexibility is the creation of a budget structure that allows consumers to move among service settings and programs in a seamless fashion without regard to funding source. Transparency is the creation of a budget structure that informs key policymakers in the General Assembly of the use of funds for programs and services encompassing Ohio's long-term services and supports delivery system.

affect both individual consumers and the delivery system for long term services and supports. Any changes to existing rules and regulations should be data driven to the extent possible and based on analysis of utilization and assessment data. In addition, care should be taken to ensure that existing rules and regulations are not changed more quickly than the capacity to meet consumer needs is developed. Therefore, the workgroup recommends that mechanisms be developed to explore and evaluate each of these reforms and report to the Executive Medicaid Management Administration (EMMA) on their findings.

Financial eligibility processes and policies with respect to Medicaid-covered services in the delivery system for long term services and supports are a critical element in a consumer's ability to exercise meaningful choice. The ability to determine the eligibility for Medicaid funds and the policies used to make those determinations have been identified as barriers to obtaining services and exercising consumer choice to remain in the community in today's environment.

The recommendations for change relating to financial eligibility focused on four specific areas. These areas include:

- The timely processing for eligibility determinations,
- The requirements for documentation and face-to face-meetings,
- The need for education and training, and
- Policies affecting the financial eligibility determinations.

Unmet needs in community settings

The ULTCB workgroup recognizes that an inherent weakness in balancing Ohio's system of long-term services and supports is that key supports promoting the ability for consumers to live in the community simply may be unavailable. A "gap analysis" of Ohio's existing community-based long-term services and supports system suggests that issues exist in four specific areas.

- What are the gaps in service delivery that may result in institutional placement when it is not the consumer's preference?
- What provider requirements result in difficulty in obtaining needed long term services and supports when a consumer prefers a community setting?
- How can the delivery system for long term services and supports use informal supports to support a community setting? and
- How to ensure transportation as a critical element to community placement?

The ULTCB workgroup also recognizes that a special "gap" exists in housing and supportive services and accordingly asked stakeholders to develop recommendations designed to remedy this gap. The stakeholder group addressed five housing-related areas:

- Home maintenance, repair, and accessibility;
- Adult care facilities and adult foster homes;
- Assisted living and other supported housing;
- Service coordination; and
- Affordability of housing.

Consumer-directed supports

Participation in consumer directed care opportunities must be voluntary, flexible enough to meet the consumer's needs, and contingent upon whether the consumer and/or authorized representative can adequately direct his/her own care. The concept of "dignity of risk" and the consumer's right to make bad decisions is inherent in the concept of consumer direction and will need to be embraced in any consumer-directed care endeavors implemented by the state. For the latter to be possible, and to assure ongoing consumer participation, a comprehensive set of tools and resources must be created at the state level, and provided to interested consumers and/or their authorized representatives for the purpose of developing the skills necessary to direct their own care and services. Moreover, for consumer direction to be effective, it must be designed as simply as possible.

Every consumer should be able to direct as much of his/her care as he/she has the desire and ability to direct. To do so, the consumer should:

- Be able to communicate his/her specific needs to the provider.
- Possess the judgment and skills necessary to manage his/her specific needs.
- Select his/her team members and participate in the development of service plans and plans of care.
- Successfully complete training about how to hire, supervise, dismiss and evaluate a worker, complete/approve timesheets, and resolve conflicts, etc.
- Direct his/her care while staying within a budget or under a cost cap established for the consumer as part of the specific program in which he/she is enrolled.