Dedicated to Health, Healing and Recovery

FY 14-16 LMCS MANAGEMENT REPORT

Lookout Mountain Community Service Board (LMCS) is a public corporation created by State law to provide Mental Health, Developmental Disabilities, and Addictive Disease services to persons residing within Catoosa, Chattooga, Dade and Walker Counties of Northwest Georgia. The agency is also allowed to provide services outside the four counties, but the primary service area comprises these four counties. The governing board of eight members is comprised of a majority of individuals who have or have had family members is behavioral health or intellectual disability services and is reflective of the social and demographic characteristics of the area.

In the 2014 legislative session Georgia legislators passed SB349 which made significant changes to Community Service Board membership. The legislation which was signed by the Governor in April 2014 requires that each Community Service Board add from one to four elected officials to the Board. These must be appointed by one to four counties based on county contributions or county size. Lookout Mountain Community Services Board gained two Board members. One from Walker County is the School Board Superintendent and one from Catoosa County is the County Coroner.

Personnel

As of June 30, 2016, LMCS had 258 full-time and part-time employees. The agency contracted with another 142 contracted provides that include nurses, foster home parents, and host home providers.

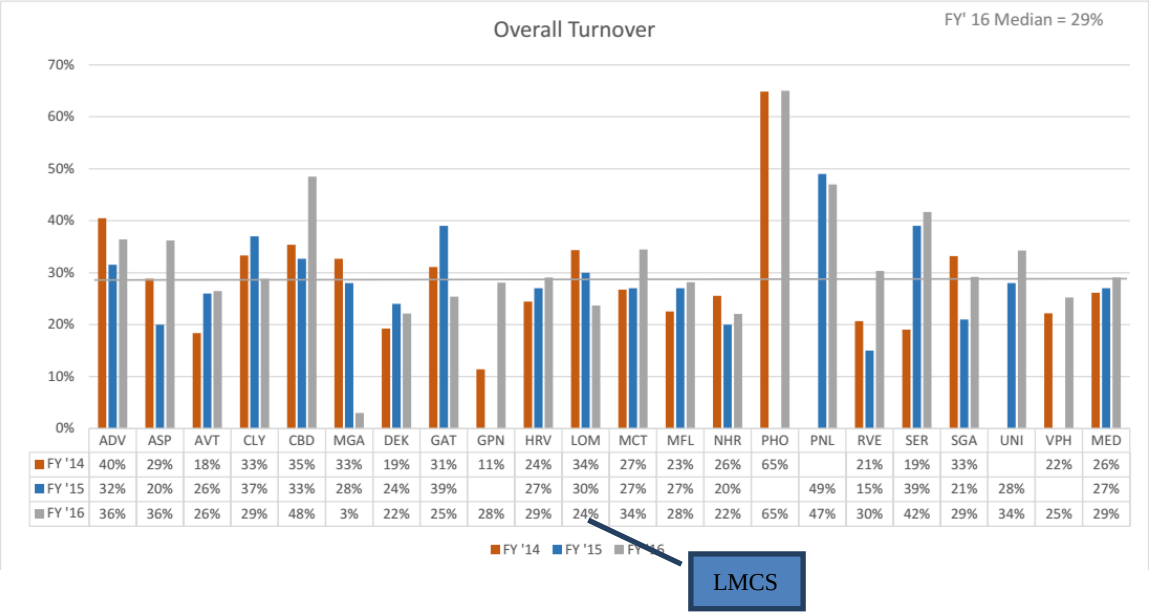
LMCS evaluated its turnover rates for the past three fiscal years. The results are represented in the following table.

LMCS Turnover Rates	
July 2013 – June 2014	29%
July 2014 – June 2015	30%
July 2015– June 2016	22%

In 2014 turnover of 29% is attributed to the downsizing of two programs: 21st program lost 11 staff and the Care Management Entity (CME) lost 9 staff. Overall, Kaleidoscope

DD has been the program with the highest turnover with 54% in 2014, 46% in 2015 and 37% in FY2016. Some of this turnover was related to a number of staff achieving State retirement goals, but the most significant underlying issue has been the change in management. In an 18 month period the director of the program changed four times. LMCS and Highland Rivers CSBs also attempted to share a director which resulted in significant turmoil in the program. Currently, the program has had the same director for the past eight months and the turnover has reduced as management has stabilized.

LMCS participates in a benchmarking initiative with over 20 other Community Service Boards (CSBs) across Georgia. As part of this initiative which began in 2008 the agencies submit quarterly and annual data on various measures to allow agencies to see how the agency compares to other CSBs in the state. One of the annual measures is turnover. The turnover figures for the past three fiscal years are presented below.



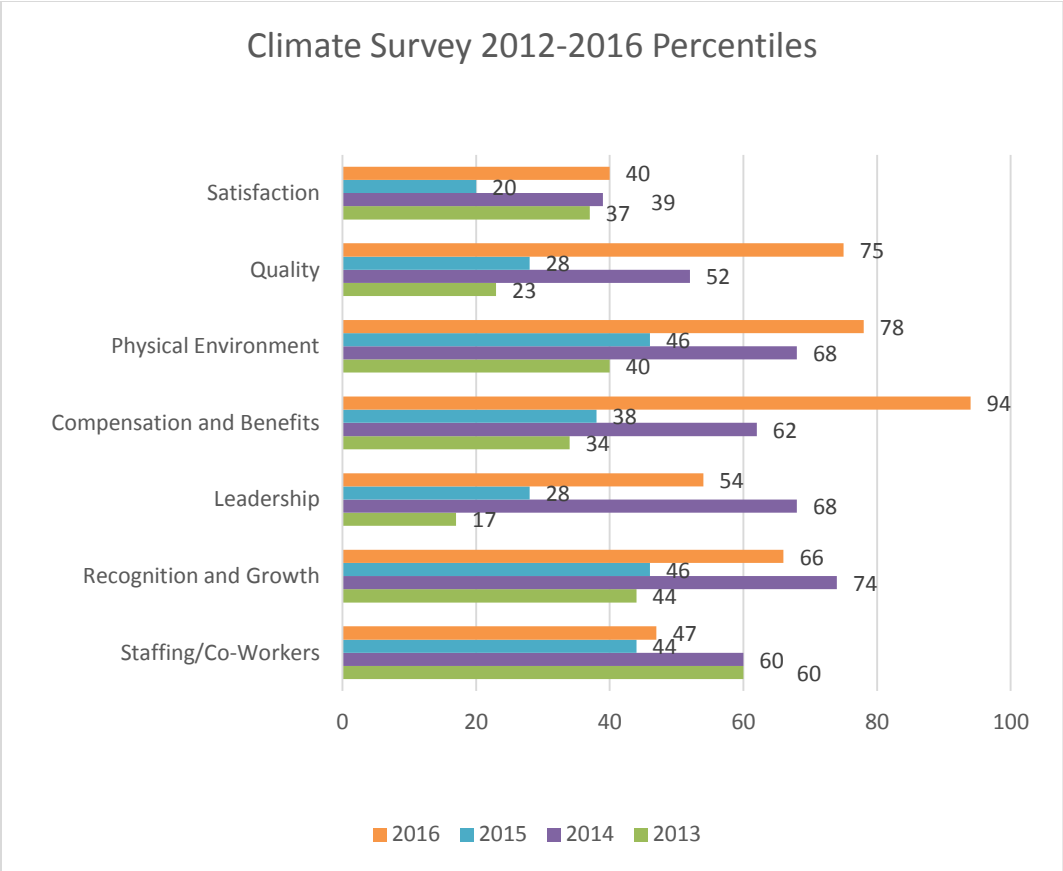
	ADV	ASP	AVT	CLY	CBD	MGA	DEK	GAT	GPN	HRV	LOM	MCT	MFL	NHR	PHO	PNL	RVE	SER	SGA	UNI	VPH	MED
FY '14	40%	29%	18%	33%	35%	33%	19%	31%	11%	24%	34%	27%	23%	26%	65%		21%	19%	33%		22%	26%
FY '15	32%	20%	26%	37%	33%	28%	24%	39%		27%	30%	27%	27%	20%		49%	15%	39%	21%	28%		27%
FY '16	36%	36%	26%	29%	48%	3%	22%	25%	28%	29%	24%	34%	28%	22%	65%	47%	30%	42%	29%	34%	25%	29%

Throughout this report other statewide comparisons will be shown. Lookout Mountain is designated as LOM on the charts. As one can see LMCS is below the median of 29% for FY16 for the CSBs.

Organizational Climate Improvement

Given that these turnover percentages are above a national average of 18% the Leadership Team decided to address the issue with a multi-prong approach. The first was to utilize feedback gathered from an Organizational Climate Survey administered as part of a benchmarking initiative conducted by the Georgia Association of Community Service Boards (GACSB). The survey is used nationwide which would allow us to receive benchmark comparisons with national and other Community Service Boards in the state. While the survey can be administered multiple times each year the GACSB, all CSBs agreed to administer at least one in the November-December timeframe so that

statewide benchmarks would include all participating (24) CSBs. The percentile scores are those compared to the other CSBs taking the survey during the same quarter. Each survey period usually involved over 2500 respondents across the CSBs. The following chart provides a graphic overview of the summary results for LMCS from the 2013 - 2016 surveys.



Based on feedback from the Climate Improvement Survey the Board approved two "holidays". One was tied to each employee's birthday; the other was a second day at Christmas which had been removed in 2010 as a cost-cutting measure.

The scores from the FY13 survey revealed a sense that management was not informing staff on events that were going on in the agency and in the State. Though there was a weekly managers' meeting it was apparent that information discussed in the managers' meetings did not make it back to the staff. To address this, quarterly meetings were begun led by the CEO. Attendance at these meetings included representative staff at all levels of the organization with the expectation that these staff would talk to their colleagues in a way different than the managers did. The meetings highlighted representative programs in the agency, recognized staff for outstanding accomplishments, discussed changes that may be coming due to mandates from the State, and presented a thorough overview of the year-to-date financials. Scores on the FY14 survey suggested that these attempts at improving information dissemination and staff recognition were successful.

Another major change that may have led to increased scores on the FY14 survey was a significant change in the staff incentive plan. The plan begun in early FY14 applied to all agency programs and focused on measurable data applicable to each program. Prior to that the incentive plan had primarily applied only to outpatient and some community programs. In addition to the incentive plan improvements each program was given $10 per FTE monthly to use as they wished to improve staff morale. Initially, many programs simply purchased lunch for staff one time per month. Later managers became more creative asking staff what they would like to purchase with the funds. This led to purchases such as umbrellas, and other items requested by the staff.

In FY15 scores dipped then increased again in FY16. While it is difficult to be certain what may have caused this dip, one major transition was the announcement by the State that State funded services would be moving to a fee-for-service model. This would impact a significant proportion of the services as over 50% of the individuals served would move to this payment model. With the significant uncertainty of funding processes especially with major changes in the authorization process transpiring, staff may have felt under increased pressure for productivity. However, after much education and training by State-contracted consultants and with several quarters of incentive payout, staff may have felt more positive in FY16 and early FY17 to report improved satisfaction in a number of areas as represented by improved scores on the FY16-17 survey.

The largest jump surprisingly was in Compensation and Benefits in 2016. Since over 170 staff responded to the survey online, this score was a large increase over the previous year. This may have been in large part a result of a couple of factors. One, all full-time staff were given a 3% salary increase in July 2016. Two, in the previous year the agency as a whole was included in the staff productivity plan and eligible staff received productivity incentives two of the four quarters of FY16. Productivity expectations are now in all clinical staff annual performance goals and are linked to incentives if the agency meets a target margin of 2% for the quarter. Complaints about productivity which had been continual in the past has now dwindled to almost nothing.

Expansion of programs and services

LMCS attempts to diversify its funding streams. Much of the funding comes through contracts with the Department of Behavioral Health and Developmental Disabilities (DBHDD). However, two other programs have contracts with the Department of Human Services (DHS). One contract provides funding on a fee-for-service basis for transportation of individuals to our programs and to healthcare providers as needed. A second contract with DHS encompasses the provision of foster care services through our TREK program. In this contract LMCS recruits, trains and contracts with foster parents to take youth who have been removed from their homes by child welfare staff. Over the past three years this program has expanded to other parts of the State. First, to the middle Georgia area in Forsyth, then to Cartersville in Northwest Georgia, and most recently to Athens. All of the other sites have foster parents serving youth. LMCS is the only Community Service Board (CSB) in the State that has a RBWO (foster parent) contract.

Another program that has gone through significant transition and expansion is our Developmental Disabilities Program, known as Kaleidoscope. In our previous CARF survey we were collaborating with another CSB, Highland Rivers, whereby we were sharing a program director. However, after the shared program director was terminated, the collaboration did not continue as both agency directors believed that the large geography – 16 counties – and the significant needs by both agencies to hire lower level managers and staff to replace many staff who had retired was too much to handle along with bringing in another "shared" director. Thus, each agency reverted to hiring directors for the agency with responsibilities for only the one agency. LMCS has struggled with significant changes within the program as many mid-level managers were not strong and had to be replaced and the director of the program had to leave after 18 months due to medical issues. Nevertheless, since August 2016, we have put managers in place who are improving the morale and to the focus of the program. We have continued to grow the residential side of the program. We have expanded the number of host homes by 12 with four more applications pending. The day programs are moving away from facility-based activities to more community integration. The prevocational activities have been almost completely stopped with plans to purchase training modules to prepare the individuals for community employment. During the past six months LMCS has contracted with the Department of Vocational Rehabilitation to put individuals into work settings. Currently, there are nine individuals on a newly hired case manager hired specifically for this contract. The supported employment continues to grow. The major limitation has been ensuring transportation for the individuals once they get a job; however, our Supported Employment staff have done an outstanding job of trying to use natural supports when possible.

Interagency collaborations

In 2008 LMCS collaborated with five other agencies who had an EHR that was not user-friendly. The six agencies brought in a consultant to develop forms and workflows to increase clinical efficiencies. While two of the agencies left the consortium for agency-specific reasons, the other four formed a 501-(c)-3 called Georgia Information Technology consortium, GAIT for short. In late 2008 they selected Qualifacts as their new EHR and all went live with the new software on July 1, 2009. The EHR has led to significant increases in performance by staff and the intra-consortium communication has resulted in improved problem solving in the billing and clinical domains. In 2012 two more agencies joined GAIT, in 2013 a seventh member joined with two more members going live as members of GAIT in the summer of 2014. In 2015 a tenth member joined. With ten active members the LMCS CEO is currently the Chair of the Consortium. While the Consortium has experienced some positive cross-agency information sharing vis a vis a GAIT Billing Committee and GAIT UM/Clinical Committee, the current EHR vendor has not always met up to expectations of the Consortium. Therefore, GAIT has begun a deliberate search process which will involve outside consultation to review the needs of the Consortium members, to determine whether the structure of the Consortium works well for all members, and inevitably, review whether or not the current EHR vendor is meeting the Consortium members' needs.

In 2011 Lookout Mountain CSB joined with four other Community Service Boards: Highland Rivers Health, Cobb-Douglas CSB, Avita Community Partners, and View Point Health CSB to create a 501-(c)-3, called North Georgia Partnership for Behavioral Health (NoGAP). In 2012 a sixth agency, Advantage Community Service Board, joined the 501-(c)-3. The non-profit was created to share knowledge, increase efficiencies, and contract with payers as one entity. The collaboration has led to several grant applications from NoGAP, two which have been successful. The CEOs continue to share information in monthly calls that help keep each agency aware of improvements or process changes that can lead to enhanced services to individuals served.

Clinical Services

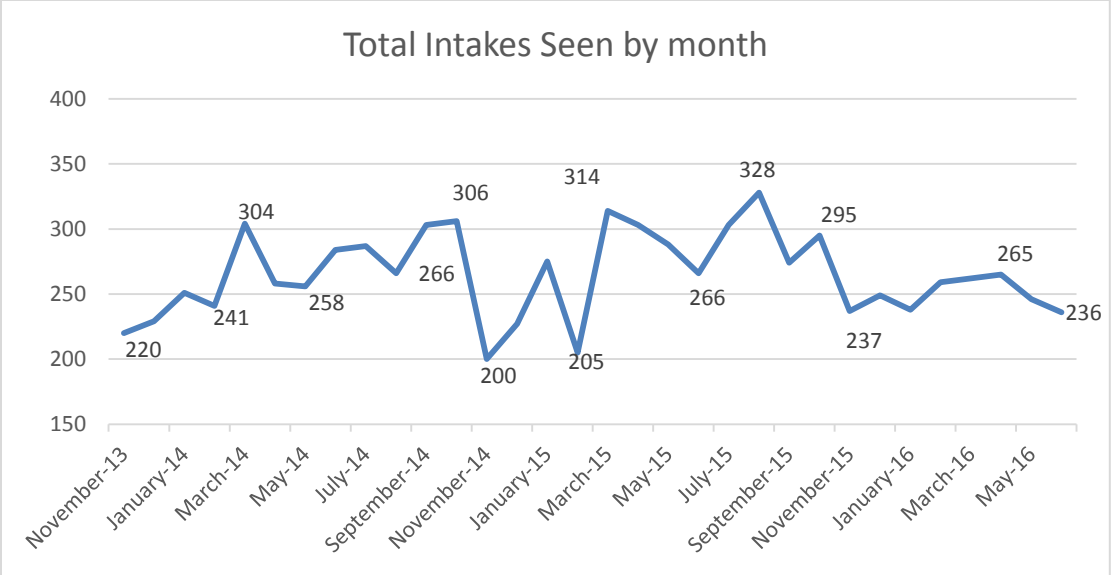
The following table presents an overview of the individuals seen during the past fiscal year. This data is for July 1, 2015 to June 30, 2016.

Ethnic Group	Total	Female	Male
Total Cases	5,705	3,267	2,348
Hispanic	46	21	25
African-American	235	116	119
Caucasian	5,236	3,038	2,198
Native American	6	3	3

The following table presents an overview of the number of individuals seen during the past five fiscal years.

Cases Seen				
Time Frame	**Female**	**Male**	**Total**	**Change**
7/1/2011 - 6/30/2012	3,400	2,457	5,857	+2.6%
7/1/2012 - 6/30/2013	3,409	2,509	5,918	1.04%
7/1/2013 - 6/30/2014	3,325	2,540	5,870	-0.81%
7/1/2014 - 6/30/2015	3,277	2,481	5,759	-1.89%
7/1/2015 - 6/30/2016	3,267	2,348	5,705	-0.94%

An analysis of the second table reveals a slight decline in individuals seen since FY13. Growth was minimal at around one percent for the fiscal year 2013. In FY14 the reduction may have been affected by weather as the agency closed for seven days due to extreme conditions. And for another seven to ten days conditions were so cold that many of our individuals served did not attend resulting in much higher no show rates even though the agency was open for services. An inspection of the intakes does not reveal any significant trend during the first two fiscal years, but since November 2015 the number of intakes seen has remained more stable between 240 – 260.



One factor that may be impacting the number of intakes is the Affordable Care Act. In Georgia individuals with insurance are not eligible for discounted services through the State defined sliding fee scale. Plus, contracts with insurers require that LMCS collect the deductible and copay for services provided. Since some of the insurances now have significantly high deductibles these individuals are essentially priced out of services that prior to the ACA would have been served under the sliding fee scale. As the primary competitor in the four counties does not serve individuals with private insurance, these individuals are now being priced out of services previously available to them.

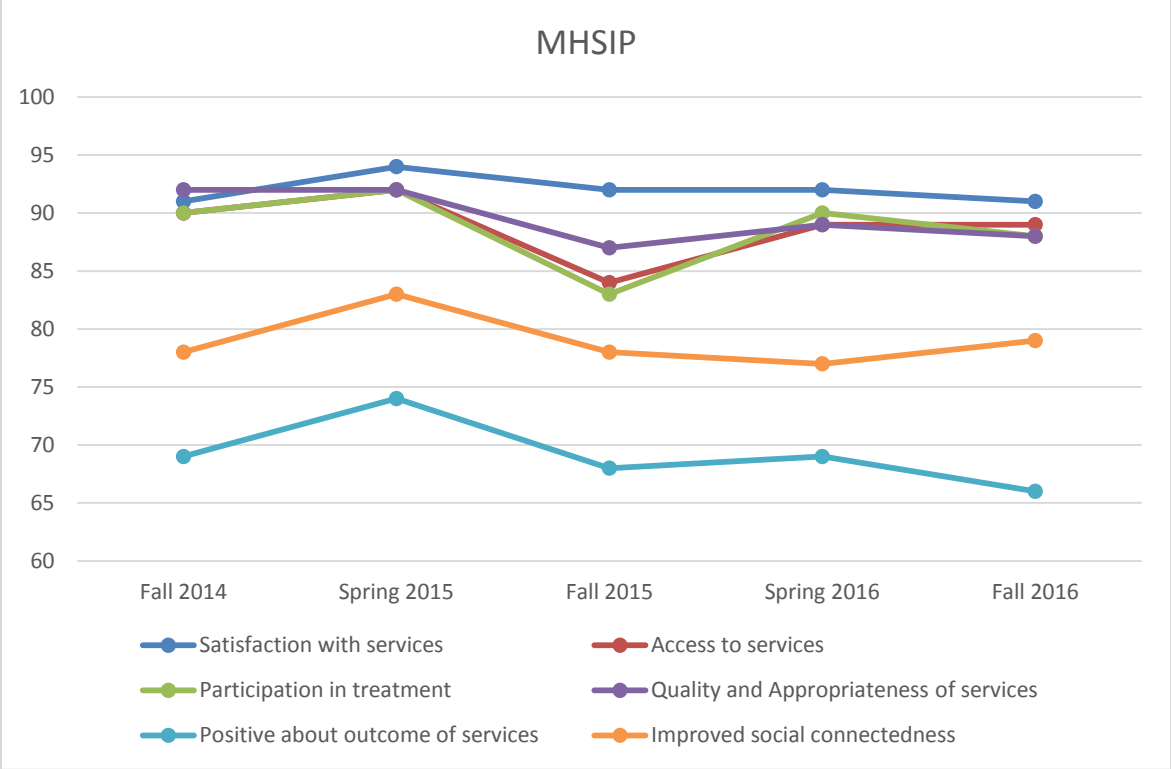
In analyzing the service data across the three fiscal years, a comparison of sessions per individual served reveals a more positive picture as shown below.

Fiscal Year	Measure	MH/AD	IDD
FY14	Service Days	270	365
FY14	Cases	5,632	217
FY14	Sessions	61,375	67,912
FY14	Sessions per case	11	313
FY15	Service Days	307	365
FY15	Cases	5,467	210
FY15	Sessions	64,547	70,777
FY15	Sessions per case	12	337
FY16	Service Days	342	366
FY16	Cases	5,397	208
FY16	Sessions	62,511	75,129
FY16	Sessions per case	12	361

The table reveals several points. First, the number of service days for the Mental Health and Addictive Disease Programs which includes Outpatient, Case Management, and Peer Support Services was significantly lower in FY14, the year with the severe weather. While there were some weather-related days in FY15, the number of days of service increased. Likewise, in FY16 the days of service increased for Mental Health and Addictive Disease Programs as there was very little severe weather. However, as one can see the number of cases seen decreases across the three fiscal years. The number of sessions increases from FY14 to FY15 for both groups of programs – MH/AD and IDD – but in FY16 the number of sessions drops for MH/AD but not for IDD. Interestingly, the number of sessions per individual did not dip in FY16 and the commensurate numbers increased across all three fiscal years for the IDD program.

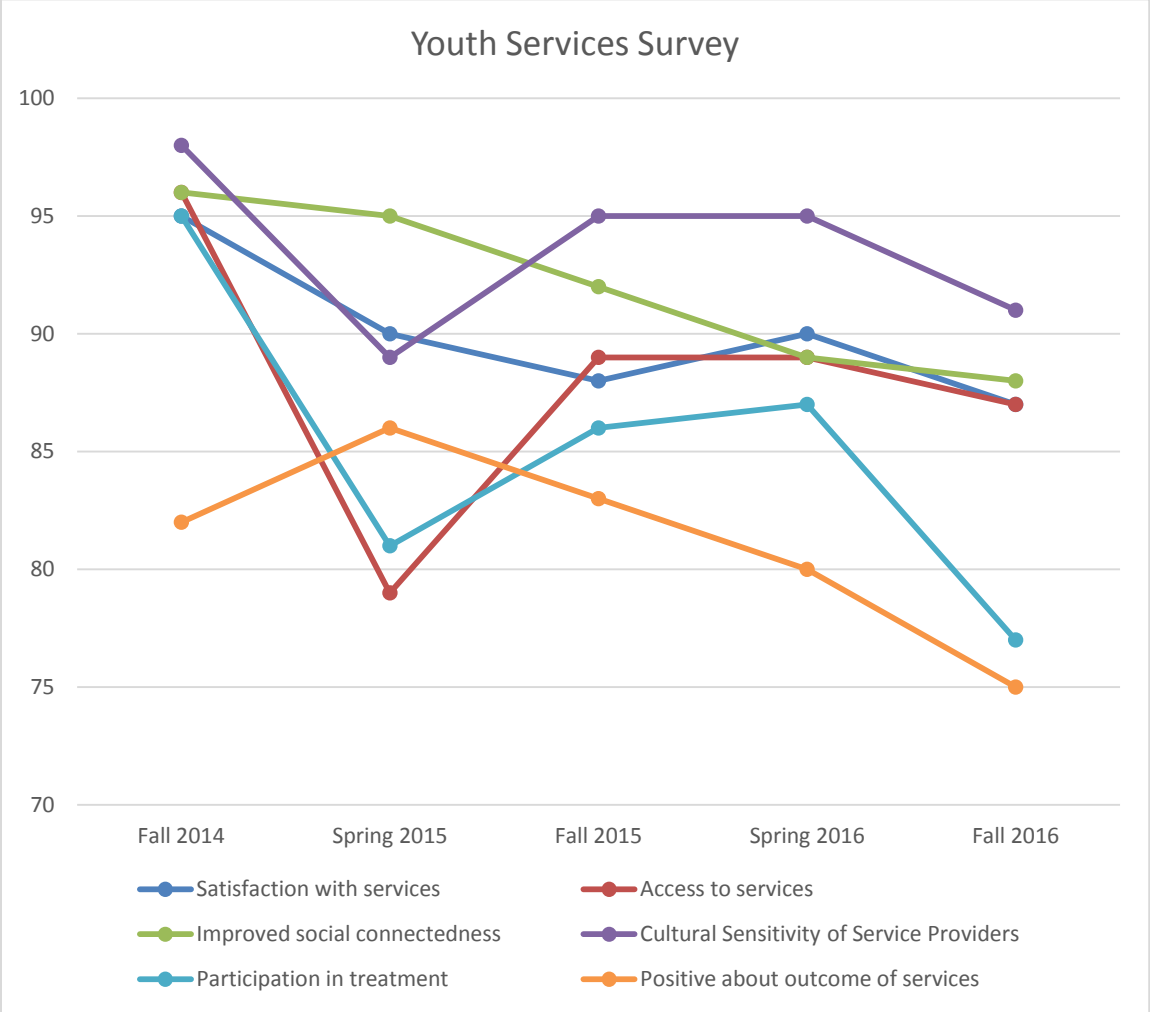
Individuals served surveys

As part of an attempt to improve our services surveys have been conducted over the past five years to gather various inputs. A nationally recognized consumer satisfaction survey, the Mental Health Statistics Improvement Program (MHSIP), is used by hundreds of behavioral healthcare agencies across the nation. The agency uses the survey as it has benchmarks which allow the agency to compare its scores to other similar agencies nationally. In addition, in FY16 the State required that all CSBs report a consumer satisfaction measure as one of its contractual reporting requirements. The MHSIP has a scale, Satisfaction with Services, which can be used as this measure. The State initially required a score of 80, but recently increased the expectation to 90th percentile. Below is a chart representing scores for LMCS since the fall of 2014.



Other than a slight increase in the spring of 2015, the Satisfaction with Services scores have been consistent. The two lowest scoring scales – Positive about Outcomes of Services and Improved Social Connectedness – both show much lower scores than the other four scales as can be seen above. Both of these scales will be monitored more closely by the Individual Advocacy Committee which has as one of its goals improving scores on the MHSIP and the Youth survey.

The Youth Services Survey (YSS) was used to measure various satisfaction scores as reported by families of youth in our services. The scores from the fall of 2014 to the fall of 2016 are presented in the following chart.



In analyzing these scores there is a clear downward trend on all the scales. This may be related to a major change in the services provided to the child and adolescent clients during this time. For many years LMCS had provided a large proportion of its C&A services in the community rather than the clinic. However, after the State went to a fee-for-service model and the managed care organizations limited authorization of services

provided by non-licensed clinicians, the fiscal viability of the community program which primarily used paraprofessionals in service provision, became problematic. Therefore, in FY15 the provision of community services was severely limited. Services did continue in the clinics and a school-based program was begun in one county. However, the survey data reveals a decrease in scores on all categories suggesting that families would prefer that our C&A services be provided in the homes. Nevertheless, the funding model prevents that without incurring significant losses which had been occurring for the previous five years under the managed care funding model. While there has been some increased funding with fewer restrictions for implementation of services in the schools, the funding may end in 2018 with an expectation that the services will be covered by school funds and managed care funding. Given the limited budgets of the schools in the local area, this does not bode well for this service model.

Developmental Disability surveys

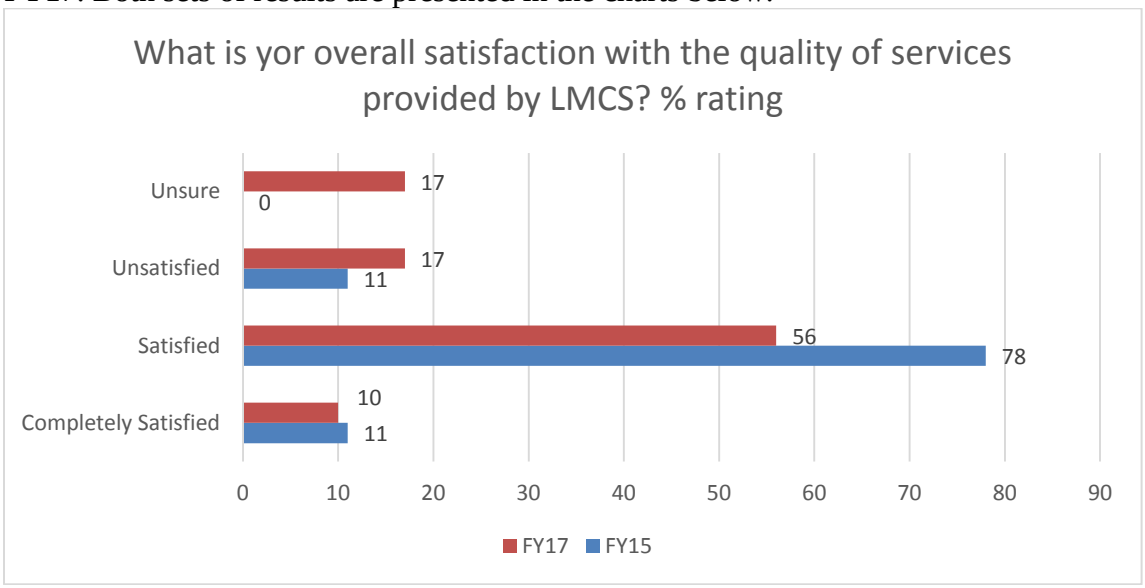
LMCS has conducted surveys with individuals served in our Developmental Disability Program, Kaleidoscope, for several years as part of the benchmarking initiative of the Georgia Association of Community Boards (GACSB). The same survey is administered annually in February and March then the responses are submitted to the GACSB for analysis. In the table below are the results for the surveys from the past three fiscal years.

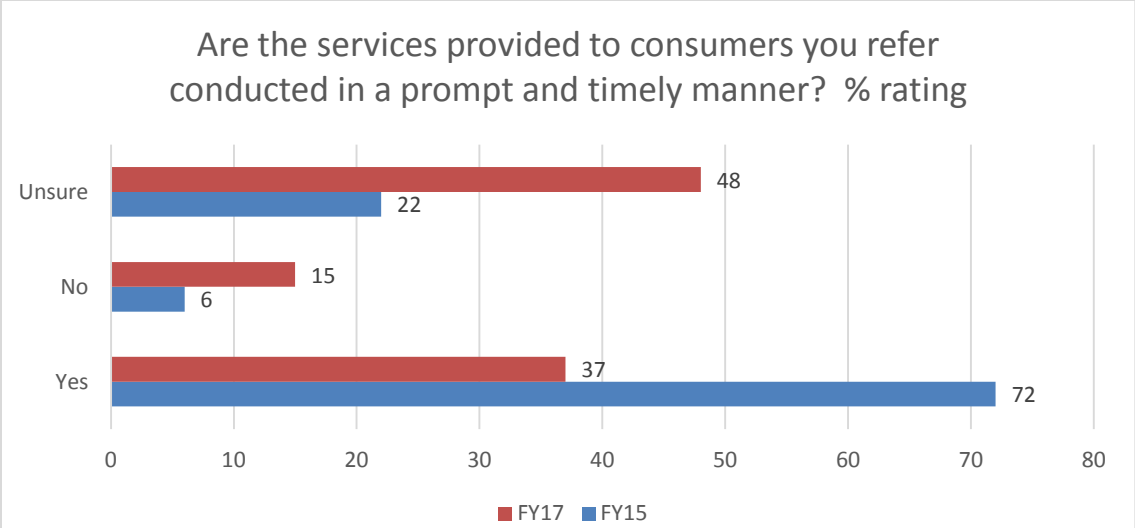
Item	FY14	FY15	FY16
1	98	98	94
2	99	93	100
3	99	99	100
4	96	99	100
5	98	98	100
6	97	99	100
7	53	50	34
8	*	*	*
9	97	94	100
10	93	93	100
11	51	59	56
12	99	96	97
13	89	93	100
14	86	92	88
15	98	92	100
16	98	100	100
17	99	99	97
18	100	100	100
19	97	99	97
20	95	100	97
	n=304	n=106	n=37

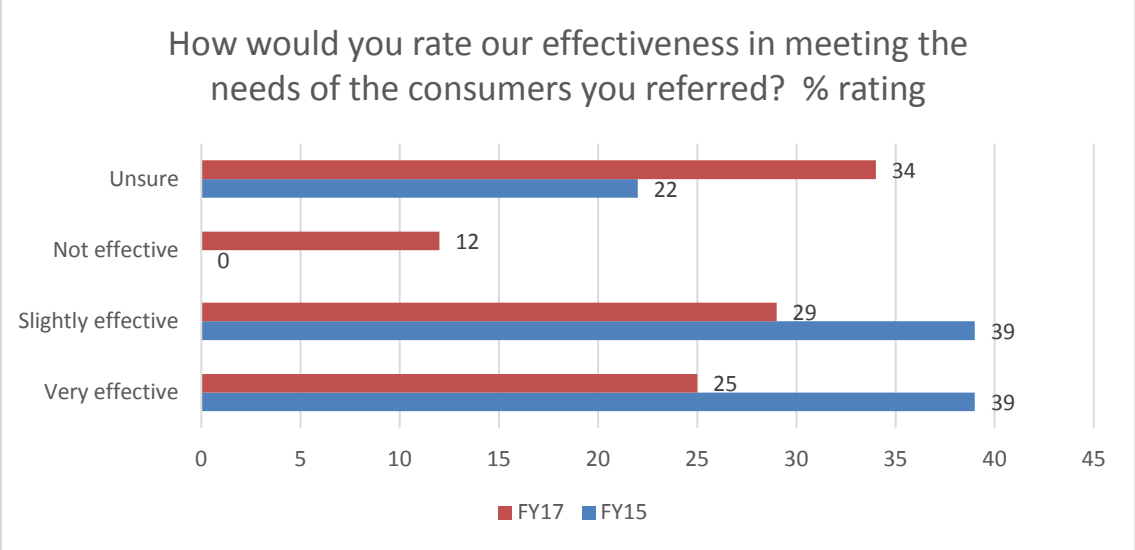
As one can see almost all the items resulted in positive ratings over 96% on a "yes/no" scale. The only exceptions were items 7, 8, and 11. Item 7 is "Have you gone on vacation in the last year?". Item 8 is a multi-response item "Which of the following have you done in the last month? (check all that apply)" which would be difficult to put in the table above. Item 11 is "Can you go on a date with a boyfriend or girlfriend if you want to?" While 51% responded yes in FY14, 36% responded they "Don't want to" and 4% noted they were "Married." Another question about the data above may be the differences in the number of respondents. In FY14 the data encompassed two agencies – LMCS and Highland Rivers – as we were still in a collaborative relationship with the other agency. In FY15 the 106 respondents represented about 50% of the active individuals served by LMCS. In FY16 the program was short-staffed and going through changes in management which led to admittedly less than optimal responding by individuals. Nevertheless, scores continue to remain high. With the improved stability in management over the past nine months the scores from the current year's survey will be highly anticipated.

Outside stakeholder survey

LMCS also conducts stakeholder surveys on a periodic basis to obtain feedback regarding the perception by entities in the community who may utilize the services LMCS provides. Two surveys have been conducted over the past three years, one in FY15 another in FY17. Both sets of results are presented in the charts below.







These survey data items reveal an overall positive rating of the services and effectiveness of services provided by LMCS. As noted above LMCS changed its service model to the C&A population by significantly reducing in-home services due to significant financial losses and the limited number of sessions authorized by care management organizations for this service. This may be the reason that there was an apparent significant reduction in positive ratings from FY15 to FY17 as most of the respondents to the two surveys involved schools, public welfare, and juvenile justice. LMCS is working to expand services in schools to meet some of these concerns, but without support from the payers through the authorization process, these admittedly desirable services will continue to be limited.

Staff Productivity

Lookout Mountain Community Services imposed a productivity expectation in fiscal year 2008. Using the national standard promoted by David Lloyd of 60% of hours worked,

LMCS set the goal for outpatient staff at 100 billable hours per month. Community staff had an expectation of 75 billable hours per month. However, due to significant problems with the efficiency of the electronic health record the agency was using, staff were not able to attain this goal. Therefore, in July 2009 LMCS changed to a more user-friendly EHR which resulted in significant increases in performance for the outpatient and community staff.

Under the old EHR in FY09 the outpatient staff achieved an average of 85 billable hours per month. After switching to the new EHR in FY10 the outpatient staff increased the average billable hours per month to 117. Some of this increase could be attributed to the simplicity of the new electronic record, but the implementation of an incentive plan for outpatient and community staff may have also incentivized the increased productivity. In FY11 the increase appears to be less than 1% (117 to 119), but the measure in FY10 was based on services provided while the target in FY11 was changed to actual billable claims, a more direct measure of revenue generating potential. In FY13 the incentive moved to revenue billed rather than billable hours. However, the differential payment rates for clinical staff for the same services created morale problems since many of LMCS clinicians come in as trainees and associate licensed clinicians whose services are paid less than fully licensed clinicians. Thus, after one year the incentive plan reverted back to billable hours. The goal was set at 112 billable hours. In FY16 changes in the algorithm that gave extra time for group services was modified which negatively impacted the hours for those clinicians, such as substance counselors, who conducted significant numbers of groups. In FY17 the goal reverted back to 100 billable hours of authorized services. While this has created some challenges for staff, the change of all outpatient services being reimbursed on a fee-for-service basis with a large majority requiring authorizations has necessitated this shift. Data from FY17 suggests that clinicians are adjusting to this new expectation slowly but gradually.

The table below gives some indication of the changes in productivity that have occurred since FY14.

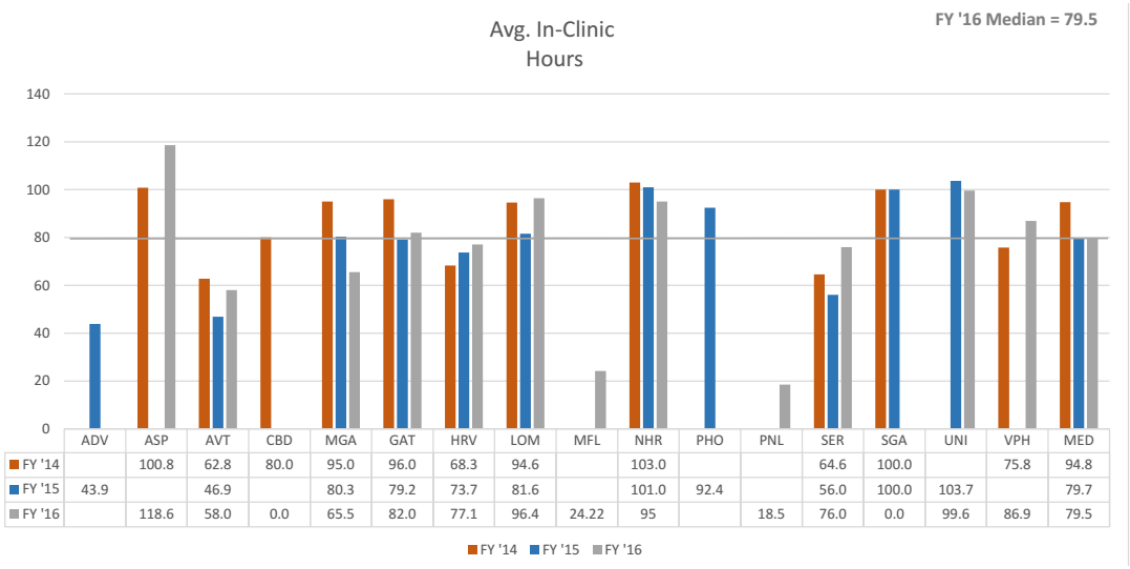
Median Billable Hours per Month

	Outpatient	C&A Community Services	Adult Community Services
FY14	77	51	62
FY15	88	57	78
FY16	92	59	83

As one can see there has been an increase in the median number of hours provided by clinicians across the three fiscal years. As noted above the low productivity combined with the change in services being authorized for child and adolescent services provided in the community led to the diminution of community services to almost zero. Interestingly, the adult community services program has shown an increase in productivity across the three years. This may be partially explained by the authorizations coming from a different

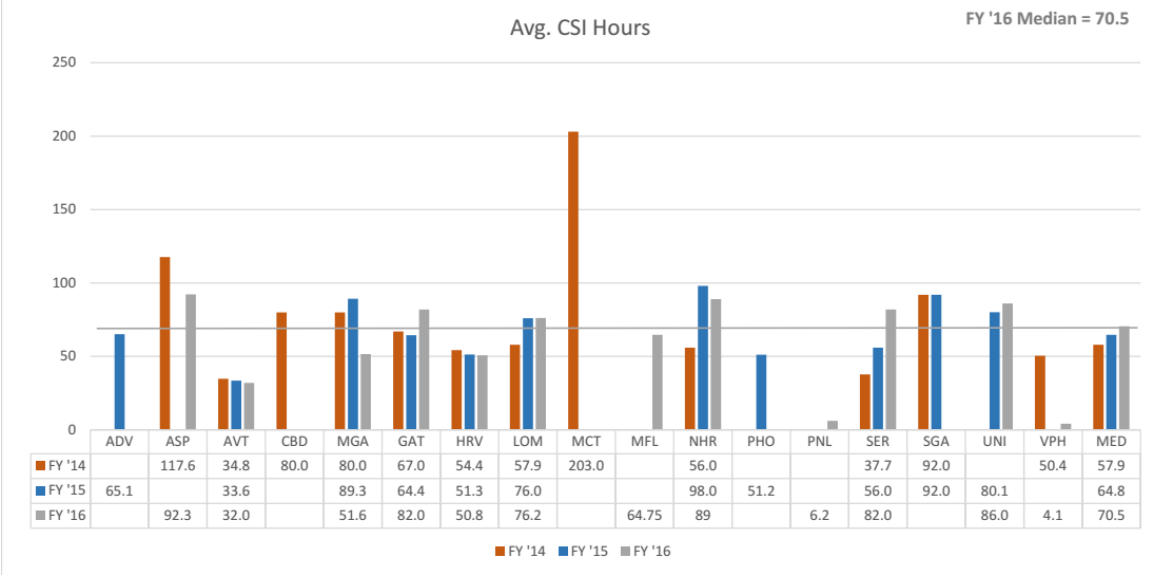
payer than those provided to child and adolescent clients. While the median for outpatient clinicians still is not at the goal of 100 billable, authorized hours, the clinicians continue to show improvement. The incentive plan, plus more consistent disciplinary action along with supervisory coaching has led to improvement in clinicians that had previously struggled to achieve the expected billable hour target.

To put these scores in perspective the following tables provide annual benchmark data from 21 CSBs in Georgia for FY16. The median scores are the last column labeled MED and Lookout Mountain is LOM in the middle of the chart.



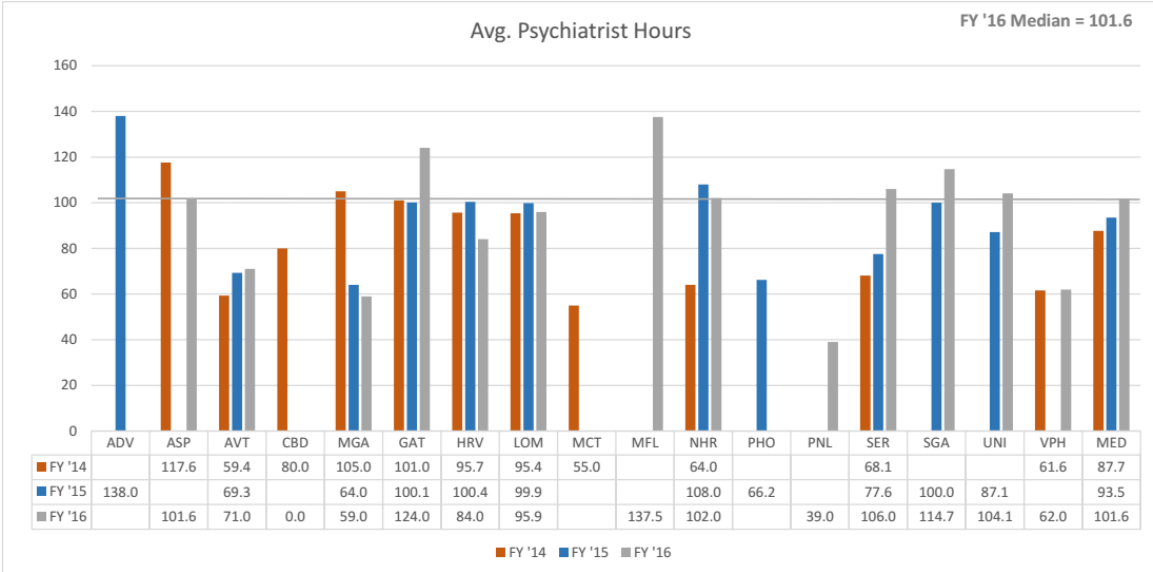
	ADV	ASP	AVT	CBD	MGA	GAT	HRV	LOM	MFL	NHR	PHO	PNL	SER	SGA	UNI	VPH	MED
FY '14		100.8	62.8	80.0	95.0	96.0	68.3	94.6		103.0			64.6	100.0		75.8	94.8
FY '15	43.9		46.9		80.3	79.2	73.7	81.6		101.0	92.4		56.0	100.0	103.7		79.7
FY '16		118.6	58.0	0.0	65.5	82.0	77.1	96.4	24.22	95		18.5	76.0	0.0	99.6	86.9	79.5

For in-clinic services which includes non-medical services such as individual and group LMCS is third highest in the state at 96.4 hours per month. The table below which denotes CSI hours includes both adult and community staff. In the table above there is a breakdown between adult and Child and Adolescent staff as we have found a significant difference in the productivity levels provided by those staff. In the table above for FY16 our Child and Adolescent clinicians provided an average of 59 billable hours per month while the adult community staff provided 83 billable hours. The statewide median for both groups was 70.5. LMCS' median for both groups was 76.2. Some of this may be attributable to very different authorization requirements for adults and youth; some may be due to the different clinical needs of the recipients of services.

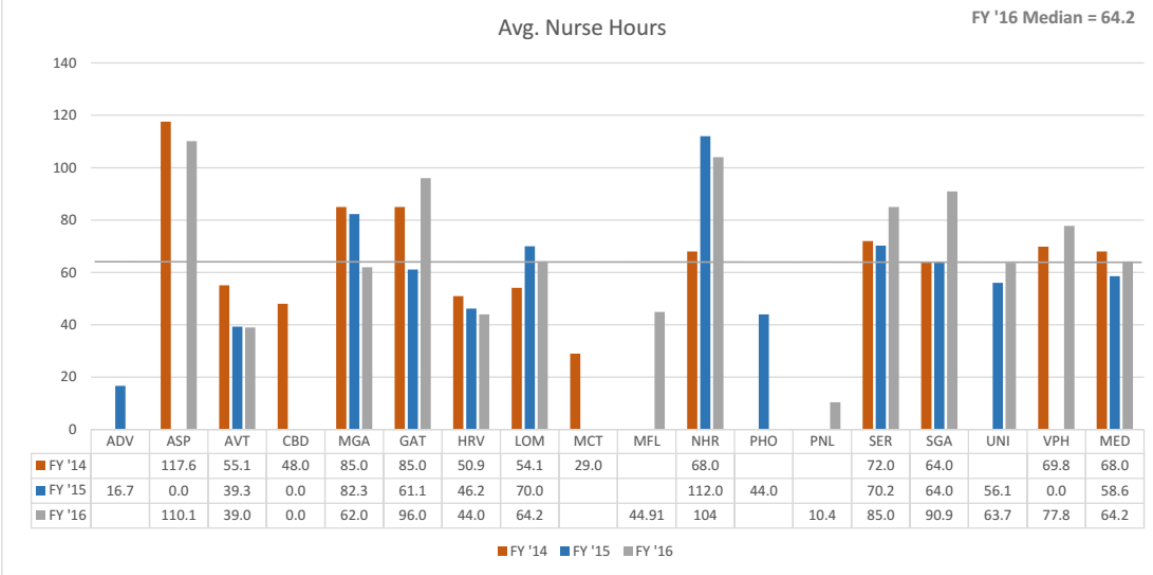


	ADV	ASP	AVT	CBD	MGA	GAT	HRV	LOM	MCT	MFL	NHR	PHO	PNL	SER	SGA	UNI	VPH	MED
FY '14		117.6	34.8	80.0	80.0	67.0	54.4	57.9	203.0		56.0			37.7	92.0		50.4	57.9
FY '15	65.1		33.6		89.3	64.4	51.3	76.0			98.0	51.2		56.0	92.0	80.1		64.8
FY '16		92.3	32.0		51.6	82.0	50.8	76.2		64.75	89		6.2	82.0		86.0	4.1	70.5

Another clinical group that is pivotal to all services are the psychiatrists and nurses. During the past three years LMCS has made some significant changes with these services. With the loss of two in-house psychiatrists LMCS has had to move to telepsychiatry to meet the needs of its recipients. There has been an increase in nursing services primarily to improve the focus on the whole health of the individuals served. During the past two years LMCS hired a Director of Nursing and increased the number of nurses and started using Medical Assistants to handle non-billable services such as helping with the telepsychiatry. Support staff and medical assistants also began to reach out assertively to notify individuals of their appointments and to backfill cancelled appointments. Productivity for both nurses and doctors has improved due to these changes. Below are the two charts from the benchmarking group of CSBs for nurses and for psychiatrists.



	ADV	ASP	AVT	CBD	MGA	GAT	HRV	LOM	MCT	MFL	NHR	PHO	PNL	SER	SGA	UNI	VPH	MED
FY '14		117.6	59.4	80.0	105.0	101.0	95.7	95.4	55.0		64.0			68.1			61.6	87.7
FY '15	138.0		69.3		64.0	100.1	100.4	99.9			108.0	66.2		77.6	100.0	87.1		93.5
FY '16		101.6	71.0	0.0	59.0	124.0	84.0	95.9		137.5	102.0		39.0	106.0	114.7	104.1	62.0	101.6



	ADV	ASP	AVT	CBD	MGA	GAT	HRV	LOM	MCT	MFL	NHR	PHO	PNL	SER	SGA	UNI	VPH	MED
FY '14		117.6	55.1	48.0	85.0	85.0	50.9	54.1	29.0		68.0			72.0	64.0		69.8	68.0
FY '15	16.7	0.0	39.3	0.0	82.3	61.1	46.2	70.0			112.0	44.0		70.2	64.0	56.1	0.0	58.6
FY '16		110.1	39.0	0.0	62.0	96.0	44.0	64.2		44.91	104		10.4	85.0	90.9	63.7	77.8	64.2

While LMCS psychiatrist hours per month of 95.9 is below the median for the state, the nursing hours of 64.2 is exactly at the median. Considering that there has been significant transition with several new psychiatrists and nurses starting during FY16, these numbers are better than expected. These numbers are expected to improve in FY17 as the focus by all support staff on aiding the psychiatrists in their provision of services continues.

DOJ Settlement

The State settled a lawsuit with the Department of Justice in October 2010. The settlement had two main areas of agreement: (1) all Olmstead consumers as of September 30, 2010, would be moved to the community and (2) services would increase in the community to decrease the likelihood of individuals needing hospitalization. Over the next two years the State implemented mobile crisis services in all areas of the state and implemented a continuum of intensive services such as ACT, Community Service Teams, Intensive Case Management and Case Management. LMCS received funding to provide Case Management to individuals who are severely mentally ill, but require close monitoring but are currently in residential placements in the community. Currently, LMCS is serving approximately 60 individuals in this case management option. In FY16 LMCS received additional funding for a Community Support Team to serve individuals with intensive needs. The team began in December 2015 and has successfully maintained many individuals in the community that previously had been cycling through the hospital/crisis stabilization unit system.

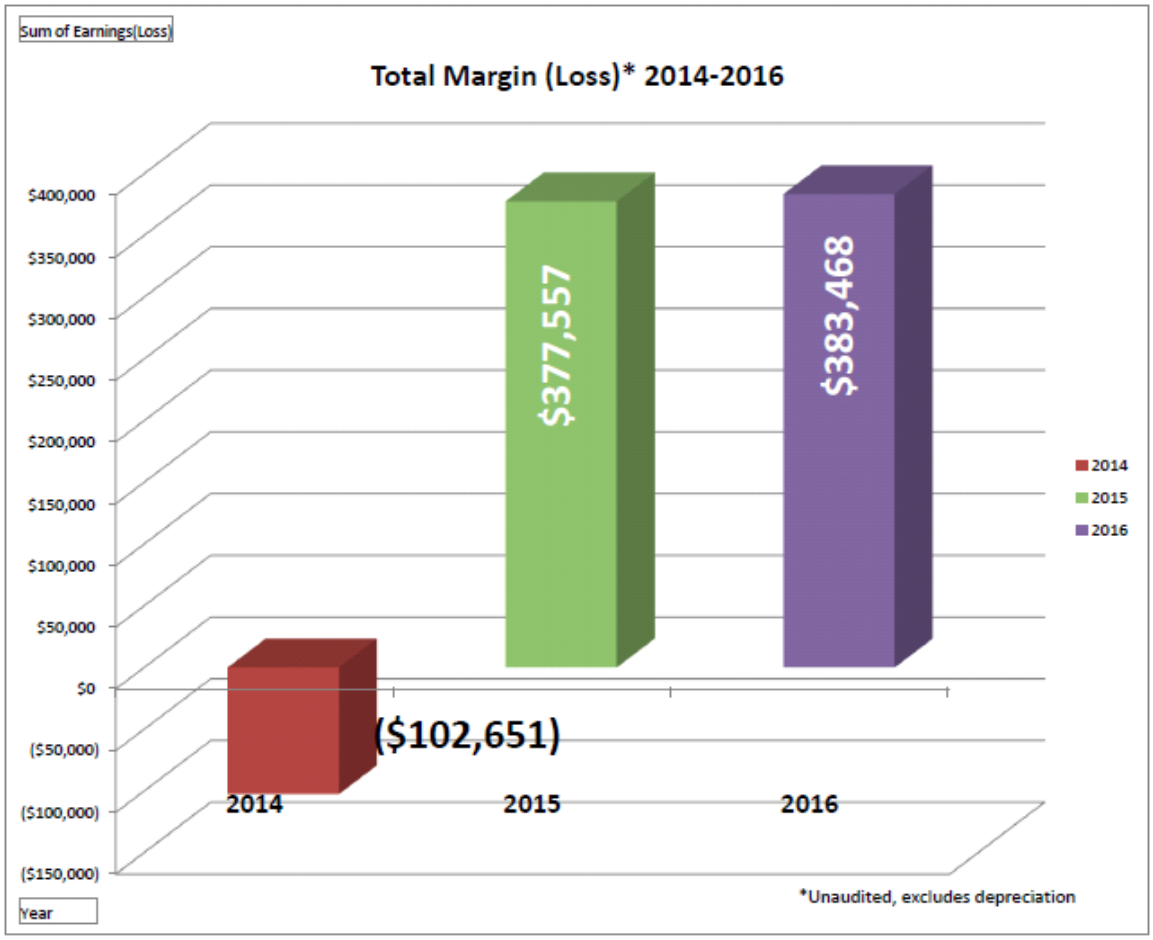
In the Developmental Disabilities program, LMCS was given funding to develop a Community Living Arrangement (CLA) Home which would allow placement of four DD individuals who have been in the hospital for years. These individuals are all medically fragile and require around the clock nursing staff. The CLA home in Summerville opened in June 2011. Several other homes similar to the one in Summerville have been opened across the state. All of these homes have experienced a number of problems including

medical and financial. LMCS has continued to struggle with maintaining fiscal viability while assuring clinical/medical quality. Though four individuals have died after moving to the Magnolia CLA, none of the deaths have been found due to substandard medical care as substantiated by individual investigations which are conducted by the State on every death of a DD consumer in a residential setting. While the State wants more of these medically fragile homes to be built many providers have been reluctant to do so, including LMCS, as they have proven to operate at a financial loss given the intensity of the staffing needs contrasted with the limited rates for the services. In March 2017, the State finally received approval for higher rates, but analyses by our financial officer suggests that without additional funding the new rates will not cover the costs of operation. This is primarily due to the fact that since these are medically-fragile individuals they are often in and out of the medical hospital. When they are in the hospital LMCS cannot bill for any services to that individual. With a limit of four individuals to a home, the loss of 25% of the revenue for even a short period of time adversely affects the viability of the program.

Financial Summary

The table below reveals the revenue and profit/loss for the past three fiscal years.

Category	Revenue	Profit/loss	Net Operating Margin
FY14	$22,464,468	($102,561)	(0.6)%
FY15	$22,126,780	$377,557	2.1%
FY16	$22,373,837	$383,468	1.1%

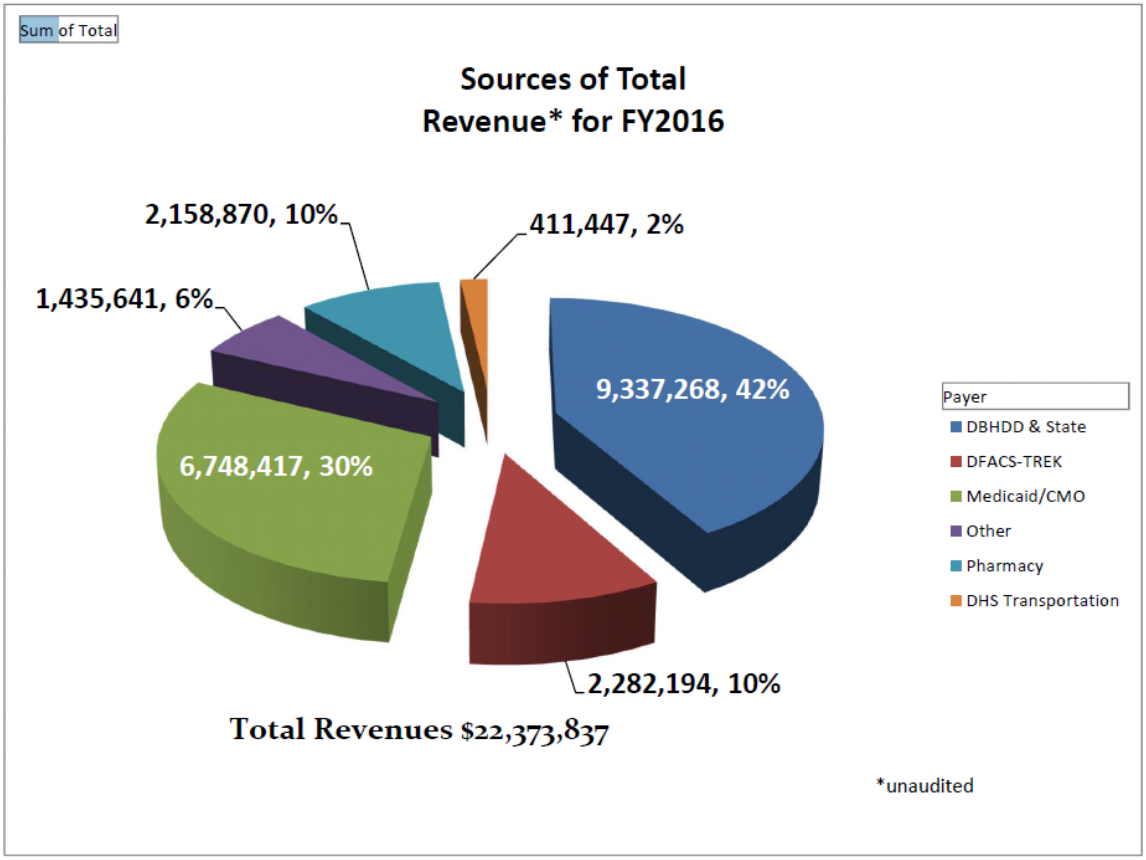


In reviewing the year over year analyses from the chart above the only year that LMCS experienced a loss in the last four fiscal years was FY14. In FY14 several negative factors impacted the financials. Staffing levels which began to increase in FY12 and FY13 with an expectation of caseload increases continued. However, the commensurate increase in cases seen did not occur as expected. In addition, the agency internship program brought in several interns which took many of the cases normally seen by fulltime staff. While there were no direct costs for the interns, the other clinicians did not change their scheduling with paying individuals to increase their billable hours and thereby the agency's fee-for-service revenue.

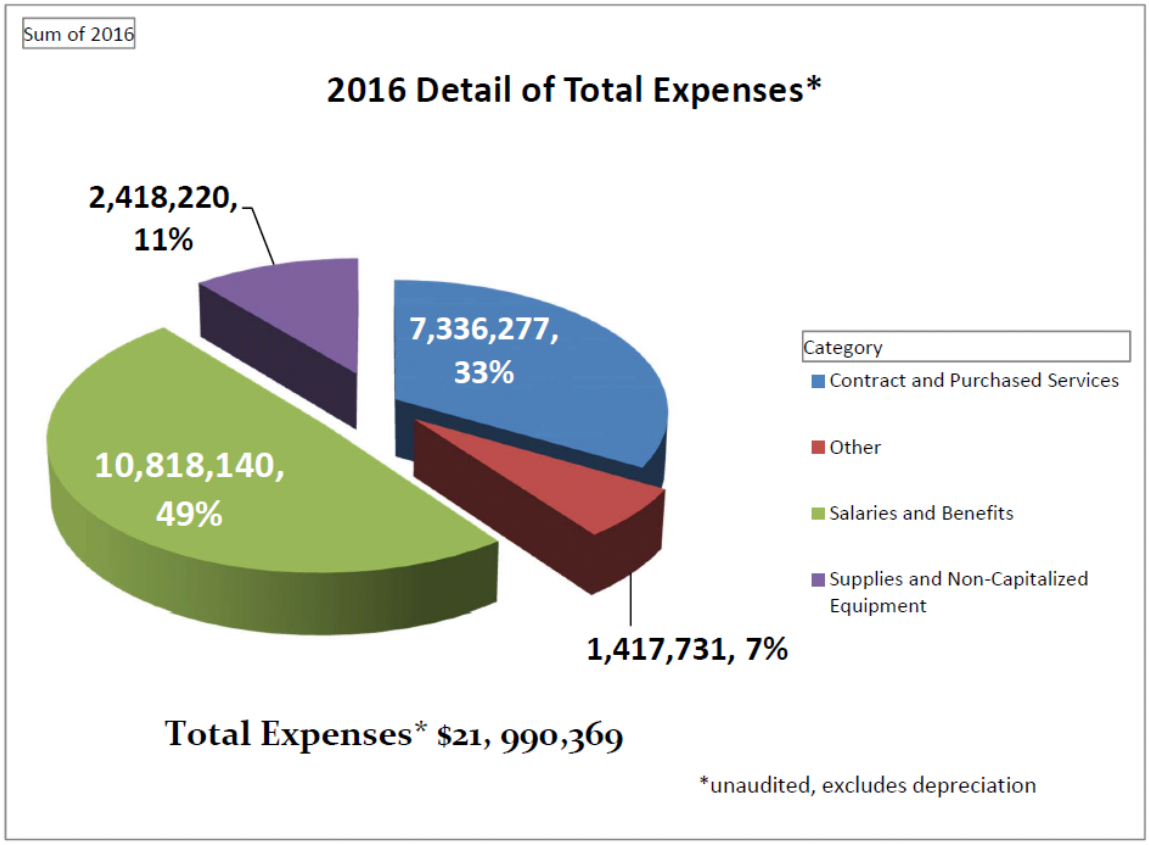
One additional factor had a significant impact on the agency financials. In December 2013, the agency had a slight margin of about one percent. However, in January and February the agency had to close all programs other than residential due to inclement weather. Since the agency normally earns about $63,000 per day, the loss of five working days represented almost one-quarter of a million dollars as most of our employees are full-time all were given administrative leave for these days of closure. Without a significant increase in productivity, the loss of revenue proved difficult to overcome. In addition, due to the extremely cold weather, many of our individuals did not come in for their normally scheduled appointments due to limitations in transportation in the area.

The following two fiscal years did not have any significant weather events requiring program closures as had occurred in FY14.

For a clearer understanding of LMCS revenues and expenses the following charts present a breakdown of data from FY16.

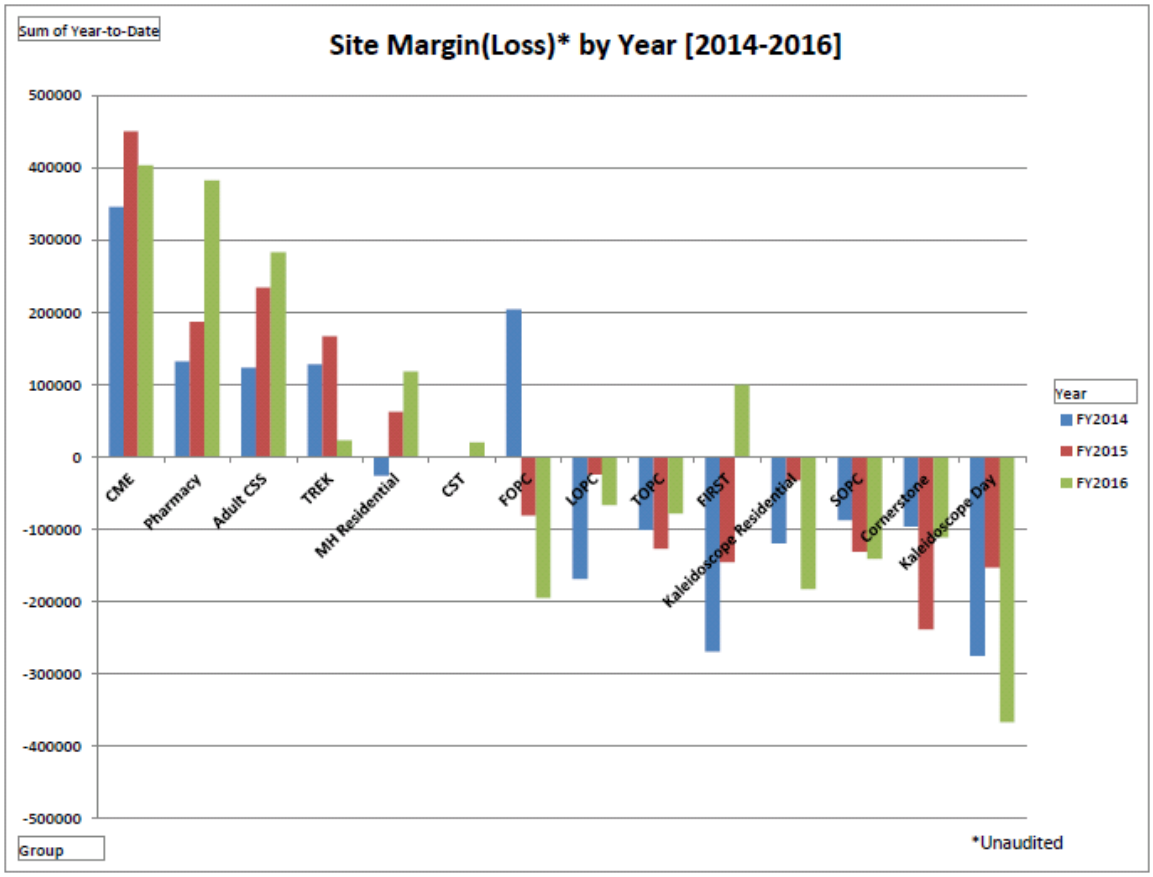


Of the more than $22.4 million of revenue for FY 2016, over half or $11.6 million (52%), was paid by Georgia State funding sources. This includes 42% by DBHDD and 10% by DFCS-TREK. Medicaid/CMO generated $6.7 million (30%) and the remaining from Other Sources at $4.0 million (18%).



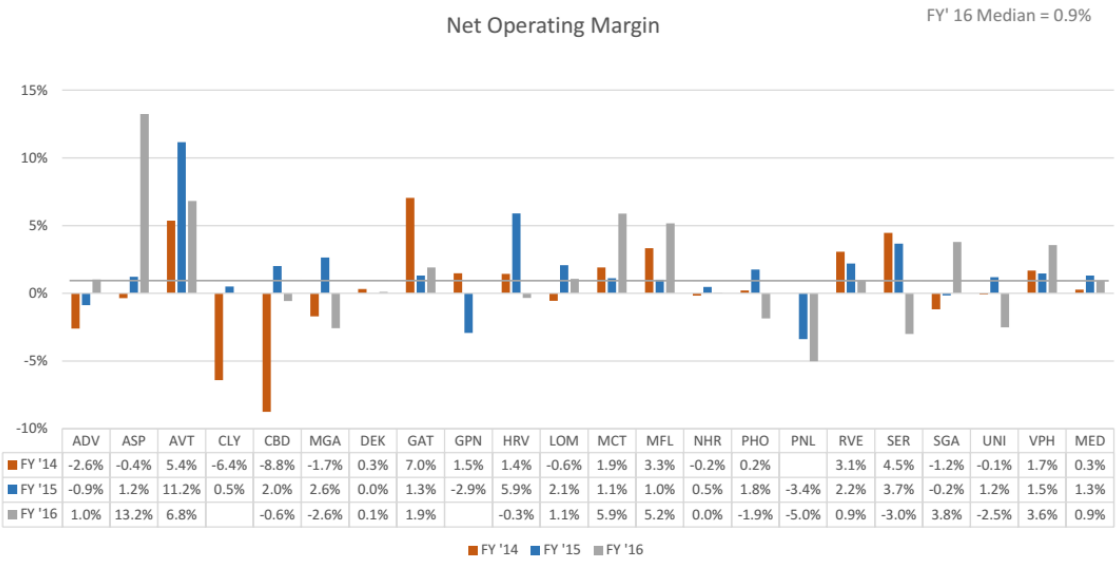
The largest component of LMCS' $21.9 million annual financial expenditures is salaries and wages. At $10.8 million, salaries and wages is 49% of total expenses. The next largest expense is Contract and Purchase Services (host homes, nursing, foster parents, etc.) at $7.3 million (33%). Supplies were $2.4 million (11%) and Other expenses at $1.4 million (7%). In Georgia CSBs who do not outsource staff incur a State-defined cost for health insurance of approximately 30% based on salaries, whether or not the individual staff takes the insurance. The leads to a benefits cost for LMCS of approximately 41.6% which is not competitive with other private agencies who may have benefit costs as low as 22%.

The chart below presents the margins for the past three fiscal years by each LMCS program.



Profit(loss) varies by site and service. For the past three years, the Care Management Entity (CME) has been the organization's most profitable program, while DD Day Programs have been the loss leader. LMCS aims to at least break even in all of programs while producing a small margin as an organizational whole.

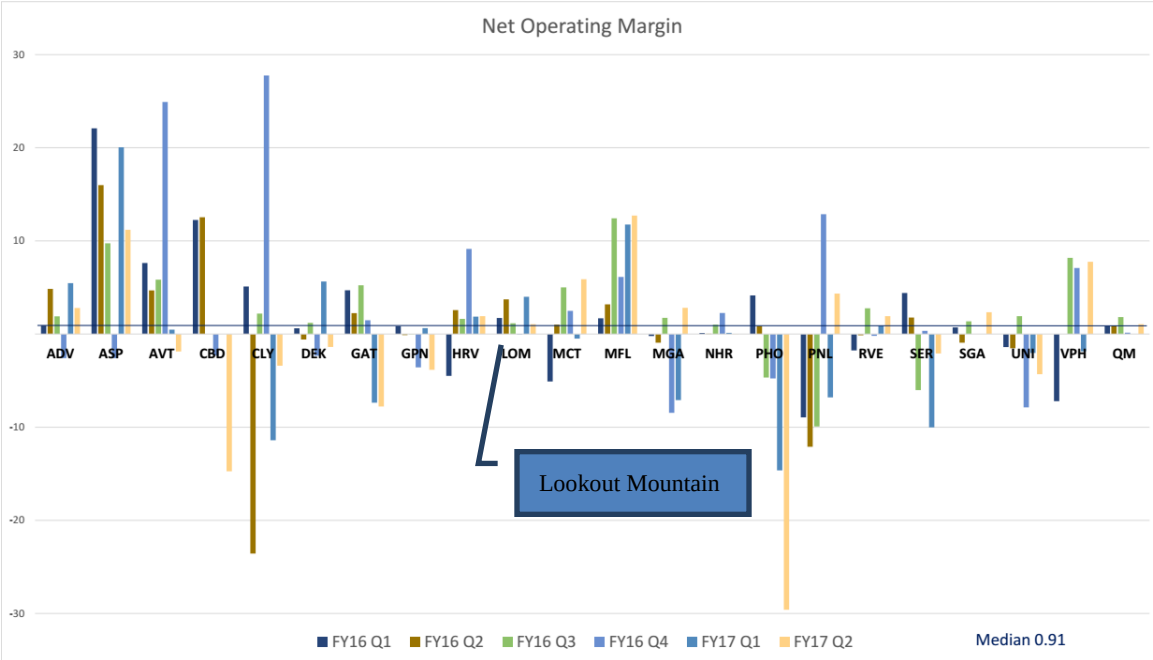
In looking at the organization as a whole the chart below provides the net operating margins from the benchmarking group for the previous three fiscal years.



	ADV	ASP	AVT	CLY	CBD	MGA	DEK	GAT	GPN	HRV	LOM	MCT	MFL	NHR	PHO	PNL	RVE	SER	SGA	UNI	VPH	MED
FY '14	-2.6%	-0.4%	5.4%	-6.4%	-8.8%	-1.7%	0.3%	7.0%	1.5%	1.4%	-0.6%	1.9%	3.3%	-0.2%	0.2%		3.1%	4.5%	-1.2%	-0.1%	1.7%	0.3%
FY '15	-0.9%	1.2%	11.2%	0.5%	2.0%	2.6%	0.0%	1.3%	-2.9%	5.9%	2.1%	1.1%	1.0%	0.5%	1.8%	-3.4%	2.2%	3.7%	-0.2%	1.2%	1.5%	1.3%
FY '16	1.0%	13.2%	6.8%		-0.6%	-2.6%	0.1%	1.9%		-0.3%	1.1%	5.9%	5.2%	0.0%	-1.9%	-5.0%	0.9%	-3.0%	3.8%	-2.5%	3.6%	0.9%

As one can see with the exception of a small minority of CSBs, most of the agencies have had difficulty achieving any comfortable margin. Lookout Mountain (LOM in the chart) has improved slightly and is above the median of 0.9% for FY16. With the advent of full fee-for-service funding in July 2016, the potential for some agencies to improve their margins will depend heavily on the productivity of the staff and the efficiencies of an agency's process.

To give one an idea of how the fee-for-service model for state dollars has changed the margins for CSBs, the chart below shows the net margins over the past six quarters.



As one can discern some agencies that had been experiencing larger margins, such as AVT and GAT, experienced losses due to process issues at the state level which are impacting the cash flow for these agencies. Lookout Mountain has experienced some of these problems with the State but did not incur such as negative impact as others. The State is aware of these issues and has been aggressively trying to resolve the barriers. However, they have had to provide some supplemental funding to three agencies due to cash flow problems due to internal process issues. They have also provided technical assistance through onsite consultation and webinars monthly from MTM Services which has helped some agencies that have implemented the suggested changes.

Summary

LMCS continues to make changes to address the ever-changing fiscal environment. With the recent losses, LMCS must strive to maintain increased productivity and efficiencies which have come with open access and the agency-wide expansion of the incentive plan. In addition, we will need to increase the services to the individuals we serve ensuring that they get the "right service in the right amount in the right time."