Census Development =

Good Clinical Outcomes +
Good Patient Satisfaction Scores
Achieved Consistently Over Time

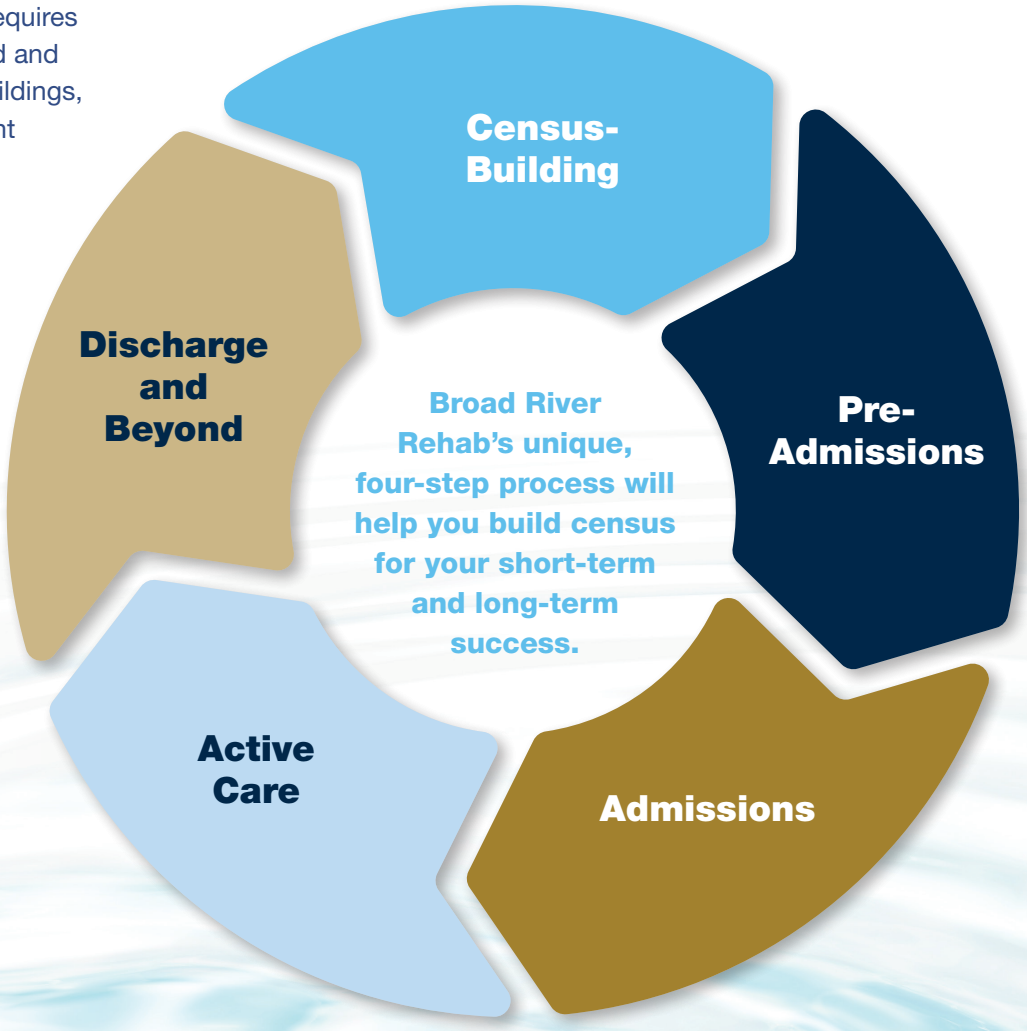
BROAD RIVER REHAB

We totally get it. You're overloaded.

You're dealing with staffing shortages, complex clinical and reimbursement issues, and keeping-up on regulatory requirements – all while providing top-quality care to your patients and residents.

While changes in payment/reimbursement systems and outside regulatory requirements fall outside of your control, the one thing you CAN control is building and maintaining your census over the long-term – ***if*** you have Broad River Rehab by your side as the right rehab partner.

But it doesn't happen overnight. It requires a holistic, deliberate process to build and maintain census throughout your buildings, guided by a partner who has the right knowledge, tools, data set, and ***proven results*** to manage your progress every step of the way.



STEP #1

PRE-ADMISSIONS

Broad River Rehab's Differentiation:

- A SNF that provides cost-effective, value-based care by decreasing rehospitalizations and improving quality metrics wins more referrals. Broad River Rehab empowers you to share real data with your key referral sources and become part of their preferred provider networks.
- Our team fosters relationships with hospitals and physicians in your region by directly engaging our therapists and Director of Rehab through community involvement. By pairing clinician-to-clinician, we remove barriers that other rehab providers build by installing an "intermediary" who is not in the best position to know how referrals work.
- Our therapy and Rehab Director directly engage with hospitals, physicians, and other specialized practices, such as Orthopedics, to ensure your facility is top-of-mind when referrals are made.

Part A Census Navigator:

Quickly Identifies What Your Community Needs

Broad River Rehab's knowledge and expertise is supported by a full range of proprietary data and analytics tools. Our Part A Census Navigator™ uses the latest available data from CMS to show you the flow of Medicare Part A patients from hospitals to skilled nursing facilities.

PROVEN OUTCOMES

		SNF 1	SNF 2	SNF 3	SNF 4	SNF 5	SNF 6	SNF 7	SNF 8	SNF 9	SNF 10	
Market	State	NC	NC	NC	NC	NC	NC	NC	NC	NC	NC	
	County	Guilford	Guilford	Guilford	Guilford	Guilford	Guilford	Guilford	Guilford	Guilford	Guilford	
	Rank by Vol.	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
	Volume	200	167	119	89	77	69	61	58	20	13	
	MKT Share	22.9%	19.1%	13.6%	10.2%	8.8%	7.9%	7.0%	6.6%	2.3%	1.5%	
	CMS Beds	135	210	134	23	126	107	60	105	40	20	
	Bed Use Rate	1.5	0.8	0.9	3.9	0.6	0.6	1.0	0.6	0.5	0.7	
						Facility						Market
Metrics	ALOS	22.1	17.5	22.0	31.1	27.1	26.9	20.9	21.5	17.0	15.4	22.6
	Payment	$ 12,603	$ 8,358	$ 8,723	$ 19,721	$ 12,220	$ 13,467	$ 8,712	$ 11,311	$ 9,432	$ 11,685	$ 11,578
	30-Day RR	7.0%	9.6%	4.2%	29.2%	11.7%	1.4%	3.3%	8.6%	0.0%	7.7%	9.0%
	90-Day RR	7.5%	11.4%	5.9%	32.6%	11.7%	2.9%	3.3%	8.6%	5.0%	7.7%	10.3%
						Facility						Market
CMS Stars	Overall	2	3	3	4	2	2	5	2	5	5	2.9
	Quality	3	2	5	2	2	4	5	4	4	4	3.2
	Survey	2	2	2	5	2	2	4	2	4	5	2.5
	Staffing	2	4	2	1	2	2	5	2	5	5	2.6

STEP #2

ADMISSIONS

Broad River Rehab's Differentiation:

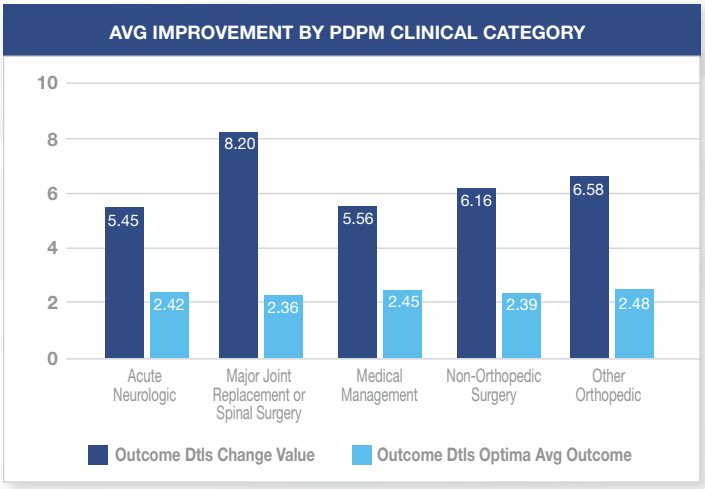
- With us, Discharge Planning begins on Day One.
- We work with your entire Interdisciplinary Care Team to identify the appropriate Clinical Care Pathways/ Programs for your patient population.
- We track outcomes beginning on Day One for all Clinical Pathways/Programs.

Document Navigator:

Quickly Identify Medical Necessity

Our Document Navigator™ (DocNav™) tool helps us to identify, as a team, all the clinical areas of medical necessity which need to be addressed by the Interdisciplinary Care Team. It quickly and accurately reads your incoming patient documentation and identifies conditions, procedures, medications and more.

PROVEN OUTCOMES



STEP #3

ACTIVE CARE

Broad River Rehab's Differentiation:

- Our evidence-based intervention begins during the Active Care process to proactively ensure positive clinical outcomes and reduced rehospitalizations.
- Broad River Rehab's EMR configuration enables allows for daily and weekly ACO reporting on key metrics, including Section GG: Self Care and Mobility. *No other rehab provider delivers this capability.*
- We conduct daily audits of therapy documentation occurs to measure level of skilled care and decrease audit risks (refer to DocAudit below).
- All Home Evaluations are completed by Registered therapists to ensure accuracy and efficiency.

Documentation Auditor (DocAudit):

100% of Clinical Therapy Documentation Audited 365 Days/Year

Our Documentation Auditor™ (DocAudit™) tool ensures documentation accuracy and focused clinical education. For patients, the clinical notes are critical toward documenting care that is delivered in their healing journey. For providers, the accuracy of documentation is a critical factor in receiving and keeping appropriate reimbursement for the care services delivered.

DocAudit™
100% OF CLINICAL THERAPY DOCUMENTATION 365 DAYS/YEAR.

PROVEN OUTCOMES

Outcome Statistics		
BRR Avg Outcome Improvement **5.84**	BRR Avg Item Start **1.92**	BRR Avg Item End **2.89**
Natl Avg Outcome Improvement **2.42**	Natl Avg Item Start **1.90**	Natl Avg Item End **2.30**

STEP #4

DISCHARGE AND BEYOND

Broad River Rehab's Differentiation:

- Broad River Rehab empowers your SNF to communicate and provide all the necessary health information post-discharge and helps to differentiate your facility as a premier choice that ensures safe transitions back to home.
- We equip patients and families with Care Pathways that outline clear, easy-to-follow patient understanding of chronic conditions (CHF, COPD, diabetes, etc.) to increase success once the patient returns home.

Clinical Pathways
FROM BROAD RIVER REHAB
HELPING YOU NAVIGATE...

- We document all outcomes, which typically show increased intensity yields and better clinical success that enable us to send patients home much better-equipped for transition.

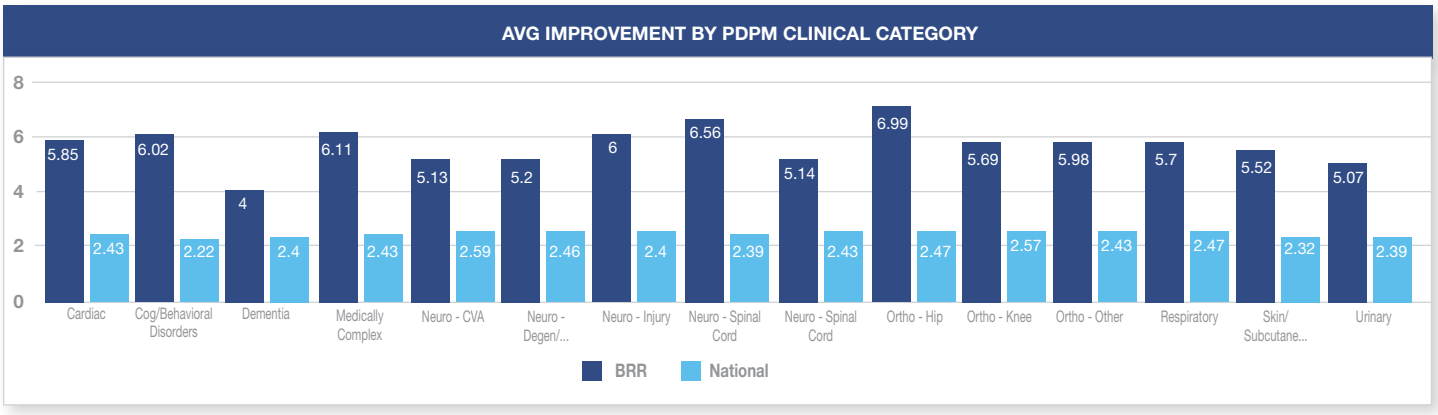
Care Coordination Program:

Managing Patients' Health Outcomes and Preventing Rehospitalizations

Together with our preferred partner, Comprehensive Rehab Consultants, we provide a proven Care Coordination Program, that combines three key elements of clinical success:

- **Continuity of Care**
  Our clinician enrolls your patient with a designated care coordinator (RN) that conducts weekly follow up on acute, chronic, and preventive health conditions upon discharge from their home.
- **Comprehensive Care Plan**
  A unified care plan based on physical, mental, cognitive, psychosocial, and functional assessments is created and followed post-discharge.
- **Sharing Health Information**
  Coordination of care with other clinicians, facilities, community resources, and caregivers by managing transitions of care across the healthcare spectrum.

PROVEN OUTCOMES



For More Information

To learn more about how Broad River Rehab can help you build and maintain census, please contact:

Randy Wadley at **330.495.8854**
or by email: **RWadley@BroadRiverRehab.com**

BROAD RIVER REHAB

1 Pond Street
Asheville, NC 28704

broadriverrehab.com