PRODUCTIVITY COMMISSION

INQUIRY
INTO
NURSING HOME SUBSIDIES

Submission
by
Mid North Coast Aged Care Discussion Group

September 1998

Chairman - Dennis Marks
Telephone: 02 6585 2811

INTRODUCTION

This document has been prepared and is lodged as a joint submission to the Productivity Commission's "Inquiry into Nursing Home Subsidies" as per Parts 2 and 3 of the Productivity Act 1998 by the Mid North Coast Aged Care Discussion Group. The group consists of service providers covering an area from Dungog to Woolgoolga who are members of the Aged Services Association of NSW and/or the Australian Nursing Homes and Extended Care Association.

Our initial response to the questions that need to be answered, in the August 1998 Issues Paper, is that we are concerned, astonished and stunned that these questions need to be answered now. Surely we have the right to expect that the answers to these questions were all considered prior to the drafting of the legislation. They seem so basic to the principal of placing in legislation the philosophy of a single national funding program, and, a process of coalescence to that single target.

However, as representatives of service providers and practitioners working daily with the Aged Care Act 1997, and its' Aged Care Reforms, it was obvious that sooner rather than later the basics, as outlined in this review, and many other aspects of the reform package and its' outcomes, would have to be questioned.

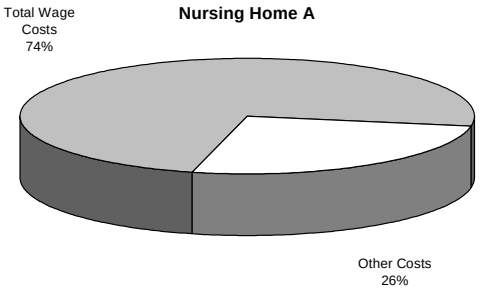
We believe that many of the answers are so fundamental to the operations of Aged Care Facilities that to have developed a reform package without the information, clearly indicates that the reform package was initiated and driven by a known financial goal rather than the Stated goal of a better service and future for the aged of Australia.

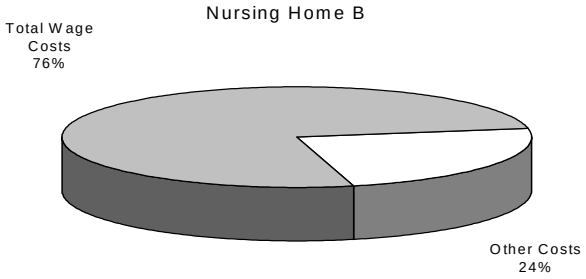
Our knowledge of the industry is NSW based and therefore our responses to the questions as outlined in the Issues Paper are limited by those industry and geographical parameters. However, the responsibility for drafting the legislation was with departmental officers who had the unique ability to assess the whole industry. The peak bodies, generally, have limited or no exposure to both the "for profit" and "not for profit" sectors and we would suggest that in the case of the limited exposure it has never been on a financial Australia-wide basis.

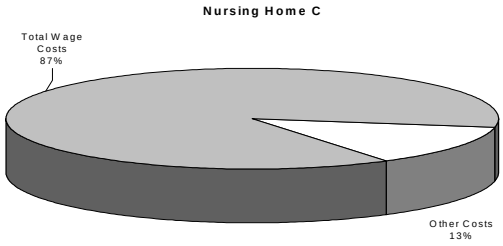
The method this submission uses is to provide information, respond and address issues and questions as highlighted through the *italic* print commencing at page 10 of the Issues Paper.

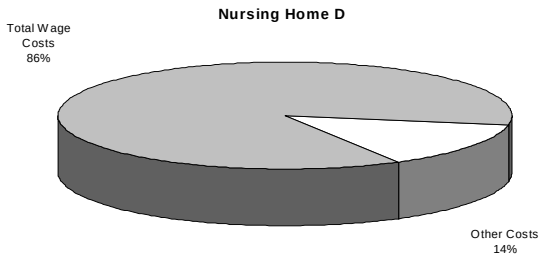
3. Nursing Home Costs

Typical profiles of the costs of providing services to high care residents (including capital as well as recurrent costs)









Extent of differences in the costs of services across and within States and Territories and the reasons for those differences

As NSW operators, we do not have access to information that would allow us to comment on the extent of the differences between States and Territories, however we know that there are significant variations in :

- ➔ Award Structures, provisions and rates,
- ➔ staffing requirements set down by the licensing authority,
- ➔ building requirements set down by the licensing authority., and
- ➔ requirements of recommending authorities associated with the licensing authority, ie,
- ➔ Fire Boards and Local Councils.

Impact on service provision costs in any particular location of factors such as the size of a facility, its ownership and integration with other facilities.

We have been advised that the initial RCS Review clearly identified that the location and size of a facility influenced its financial performance. It is reasonable to assume that the factors which influence this situation are the ability of the service provider to pick and choose the Resident population and for the prospective population to have some choice in the admission.

Our experience bears out the fact that the larger Nursing Homes in regional centres are usually the only service provider in the area, and their extensive waiting list dictates that the person with the most need will get the bed. In the majority of cases, the ability or inability to pay, the question of potential RCS income stream, or cost of care are not issues up for consideration.

The ability to develop some economies of scale through ownership arrangements and integration with other facilities, and the sharing of infrastructure costs, seems, on the surface, a practical way to reduce funding providing the integrated model includes facilities serving the same communities. However, a review of Church structures and Private Operators operating and reporting back to State or regional central offices does not appear to generate the same potential to save.

It is interesting to note that the costs in the small to medium acute bed hospitals in NSW, which now come under Area Health Services and share large infrastructure arrangements, have maintained or increased the bed day costs under the new structures even though the procedures, programs of care and services have been reduced.

We believe a community's identification with a facility is important and when control is diverted away from the geographical area of service there is a dollar measurable withdrawal of community support.

Wage and wage-related Costs

Is the commonly espoused 75/25 ratio of wage to non~wage costs reasonable?

In delivering services, what is the scope for substitution between labour inputs and equipment?

Attachment 1 shows a summary of costs for some of the Nursing Homes we represent which highlights the proportion of total costs attributable to wage and wage oncost as a percentage of total costs.

With regard to the scope for substitution between labour inputs and equipment, we would suggest there are significant limitations. It is a people industry and it is a care industry. Unfortunately, machines cannot and do not care and, in many cases, when they are used, for example with the lifting of Residents, staff still need to be present for Resident assurance and support, along with the ever present occupational health and safety factor.

What proportion of total wage costs are accounted for by the different types of employees?

See Attachments II and Ill

What is the scope to vary the proportions of different types of employees or to employ people to do more than one job?

This is a situation that will vary depending on the:

- RCS profile
- Size of the Nursing Home
- Location
- Availability of Staff
- Industrial Matters
- Licensing authorities
- Duty of Care Interpretations

Under certain circumstances there could be some very positive outcomes where the seven (7+) factors are favourable, however, our experience would indicate that in our area the possibilities are marginal.

How significant are labour on-costs such as superannuation, payroll tax and workers' compensation premiums?

These costs are of great significance to every Nursing Home operator to whom they apply, As representatives of not-for-profit organisations, we are not involved with payroll tax.

It is a simple matter of fact that these costs, which the Nursing Home operator has no control over, must be fully funded to at least State average. The fact that all three have been the subject of specific funding arrangements in the recent past (even in the case of the single funded Hostel superannuation arrangement), clearly indicates that the funding deserves individual treatment so as to ensure no one operator is financially disadvantaged because of an inequitable system.

How significant are current variations across States and Territories in award rates for nursing staff and personal carers ?

We are not in a position to comment on the overall significance of the variations because we do not have access to either the Award rates and provisions, or the licensing authorities provisions and requirements. However, there are significant funding variations in RCI and RCS rates, (from Attachment 11 we know the greater proportion of costs are wages) and it is fairly obvious the current and past departmental staff have deemed the variations to be of great significance.

Are there similar variations in award rates for other categories of employee and in labour on-costs ?

We are not in a position to comment other then to say there are sure to be industrial isolation and occupational health and safety factors which cause variations in the costs of the non nursing and personal care staff. These variations may occur between various regions of States as well as between States.

Are over-award payments common in the sector and what are the reasons for them? For example, are over-award payments necessary to attract staff to more remote areas?

Our experience is that over-Award payments are not common, however, we are operating in an environment of high unemployment across a broad range of professions and occupations. We are not aware of the incentives that may or may not be used by operators in other areas to attract staff.

Does the experience vary across jurisdictions and different types of employee?

Not known.

Are enterprise bargains or certified agreements becoming more common?

To the best of our knowledge there are no staff to whom an Award specifically applies who operate outside that Award. There are some positions which have duties and responsibilities, to which no Award applies, who have negotiated an employment arrangement rather than certified agreement.

Is the small size of many providers an impediment to enterprise bargaining?

The size of the provider operations should not normally restrict the opportunity to become involved in either of these alternatives, however, the lack of resources and flexibility under the funding regimes and licensing arrangements appears to have eliminated the incentive for operators to become involved.

Have pay rises under enterprise bargains or certified agreements been at least partially matched by cost savings for providers?

Not known.

Do differences in staffing profiles contribute significantly to differences in wage costs across and within jurisdictions?

See Attachments I, II & Ill

Attachments 1, 11 and 111 were submitted after a meeting on 21 August 1998. The fact that, prior to that meeting, the staff profiles of the organisations had never been considered side by side, and yet they are remarkably similar, does indicate that the actual staff profile does not vary greatly- The question as how much of the similarity is as a result of the licensing authorities requirements will be able to be established by the Commission as it reviews the various profiles submitted for varying jurisdictions and geographical areas of jurisdictions.

One of the unfortunate factors which affects our industry is that in the areas of operation that have been subjected to any form of central analysis, surveying or inspection for financial or licensing reasons, the opinions, interpretations and preferences of the inspector have greatly influenced the operations within the region or jurisdiction.

To what extent do differences in staffing profiles result from licensing, regulatory and award requirements as distinct from managerial prerogative?

We believe the above answers clearly indicate our opinion that the staffing profile is generated by outside influences. These external influences are created by the interaction between the licensing, regulatory and Award situations, and the Residents needs. It is obvious there is limited scope for the managers to rationalise many situations without compromising their position with regard to the authorities, the Residents care program and the providers perceived duty of care.

Are there other factors leading to jurisdictional differences in wage costs? For example, how have wage outcomes for nurses in the hospital sector affected wage rates in nursing homes and consequent relativities between jurisdictions ?

It is reasonable to assume that there are justifiable factors that have influenced various industrial courts to allow variations in Award salary rates and conditions between State based jurisdictions. The complexities of industrial law, at times, defy explanation, but it is obvious that unless similar benefits result from similar qualifications and similar work profiles in the acute care facility and the Nursing Home then the ability to attract and maintain staff will be compromised.

Are current disparities in wage costs across and within jurisdictions likely to widen, narrow or remain the same? What factors will contribute to this outcome?

We have stated above that State industrial mechanisms will continue to establish the acceptable reward for the work performed and to try and forecast future trends is an exercise in futility.

It is important that the wage costs within geographical areas remain closely related simply because, as indicated above, any major variations will result in a “brain drain” between the sectors.

Non-wage Costs

Do non-wage costs vary significantly within or across jurisdictions?

From the costing profiles and information we have access to, there does not appear to be any major variation in these non-wage costs. However, the Department has access to information from the deficit financing and participating programs of the past. A casual analysis of that information, which was at least collected and reviewed against a standard chart of accounts, should clearly identify the significance of the variations which can then have historical loadings applied.

Do such variations mainly relate to land and building costs or are variations in non-wage recurrent costs also significant?

It is obvious land and building costs do vary, as do depreciation factors depending on the age and type of facility and equipment. Once again, the historical information available through the Department can be reviewed and manipulated to reflect a possible current situation.

How much control do providers have over their non-wage costs? For example, to what extent are they dictated by the various building and health and safety regulations?

Providers are seeing their control over the non-wage costs eroded continually by the various regulatory authorities. The constant questionable improved standards demanded by authorities, which have approval and recommending powers with no financial responsibilities, has seen the costs of fire services, occupational health and safety, and environmental services continue to grow.

Costs such as :

- Food Services - HACCP
- Fire services - back to station systems,
- Occupational Health and Safety - committees. and
- Environmental services - legionnaires testing, back flow valves on water supply services and hot water mixing valves,

are all examples of where costs are incurred as a result of external authorities implementing strategies that may or may not benefit the organisation. It has become an industry where the service provider has little scope to develop their own risk management philosophy. We would suggest that, in some cases, the dollars spent on these functions may be better used in developing a better Resident care program.

What impact will the new accreditation and certification requirements have on future costs?

As providers in the NSW system, our response to this question is greatly influenced by our observations of Accreditation in both the public and private acute system in this State. The costs on the system are enormous and for little or no benefit to Residents. The fact is that Resident care, recovery and cure rates have not improved in the NSW hospital system since the first Accreditation program survey at The Hornsby Kuringai District Hospital in 1975/76. Maybe there is a lot of written information about every admission, separation, care program and procedure, but to suggest patients have achieved better outcomes as a result of the written material and its survey analysis is beyond a provable fact.

However, the costs cannot be denied. A recent survey of a 39 bed Private Hospital was estimated to have cost that service at least $50,000.00. The analysis of processes, as opposed to the assessment of outcomes, is costly to the service provider and will result in conflict due to variations in interpretation. The true test for Accreditation purposes must be the outcome of the care to each Resident and the measure of each Resident's life parameters being maximised on the day in question.

4. The Merits of Alternative Funding Methodologies

State-based arrangements

Are subsidy arrangements that recognise differences in costs across jurisdictions an effective way of promoting equitable access to quality residential aged care services?

It would be correct to state that this is the only way to promote access to quality aged care services. Surely the operators in the various jurisdictions should have the opportunity to operate on a level playing field. The only acceptable way to develop that level playing field is to adjust subsidies. The alternatives of variable fees to cover variable costs cannot be guaranteed and, as stated above, too many cost factors are beyond the control of the service provider.

Would this rationale also extend to differentiating subsidies within States and Territories as well as between them?

Yes. The rationale would have to become regional or even service based, The currently promoted national RCS fee structure is unsustainable. There are many small modern facilities constructed with community and tax dollars that cannot survive under the current regime and to fund these facilities to survive under a single fee system will mean the system as a whole will collapse. The obvious alternative is to establish regional fee structures which

acknowledge or take into account a set of variables in setting an acceptable and appropriate subsidy.
The current situation will result in many smaller facilities being closed down with the consequent loss of the capital dollars and the community support those facilities have generated.

Are there other rationales for such subsidy arrangements?

Yes there are, but in the future the Government should show some faith in the industry practitioners and seek their input, discuss the alternatives and consider the basics prior to developing any reforms.

Would the objective of equitable access be better served by taking into account differences in total costs, rather than primarily differences in wages costs for nursing and personal care staff?

Any system that considers the whole rather then part must result in better serving the objective of equitable access. However, as a first step it is obvious that in all areas State indexation of all common costs should be fully funded. Any alternative to this will result in the magnification of the problems generated by the initial structures.

Alternatively, should State-based subsidies only reflect cost differences beyond the control of providers?

Providing those costs are fully indexed then this alternative may be acceptable. Our concern would then relate to the definition of "beyond the control of the providers". For example, what control does a provider in a

- remote area have over the cost of fruit and vegetables?
- hot area have over the cost of air conditioning running and maintenance?

The interpretations and distortions of the phrase "beyond the control of the providers" can hardly be imagined.

Does a State-based regime necessarily promote equitable access to services over time?

Yes, provided it is aligned with an outcomes based Accreditation program.

Should indexation arrangements take account of changing cost relativities between and within jurisdictions?

Yes. As indicated above, full indexation factors should flow through the system so as to ensure its' continuing integrity.

Does a State-based regime tend to lock in the quality relativities across jurisdictions that prevailed at commencement?

This question highlights the urgent need to develop a national system an d this perhaps should be the role of The Agency which should be charged with the responsibility to develop that system. It is time for the industry to dictate its' own terms without reference to various State authorities. The expertise and motivation most surely are here now to develop that system. This step in itself would be a move toward reducing the variables that can be changed. It must be remembered some variables relate to unchangeable factors such as geographical location.

Should a differentiated subsidy regime also take account of differences across government, charitable and private providers in liability for sales tax, fringe benefits tax, payroll tax and the like?

Yes. Wherever these situations compromise either party, then the question of subsidy differentiation should be addressed.

Are there other ways of addressing tax-related cost differences? For example, should governments be applying competitive neutrality principles to eliminate any tax-related cost advantages for government~run homes?

Yes. If the private sector operators are willing to fully disclose and substantiate their costs, then the suggested tax advantages should be passed on to the private operators.

Has the State-based subsidy regime reduced incentives for cost effective service delivery? If so, is this a function of the form of subsidy, or of the previous acquittal system which required nursing home operators to return some "unspent" funding to the Commonwealth?

We would suggest that the problem in the past may have related more to the acquittal system rather then the State-based nature of the funding.

Have constraints on the overall level of Commonwealth support offset any such disincentives for efficient provision?

The strict nature of all funding under the deficit financing program, where all wage costs and replacement expenditure were strictly monitored, resulted in bed day costs higher than those in the private sector (ROI excluded). The system as it now operates does not appear to be any more or less efficient if the measure of our efficiency is the ability to deliver care to our Residents at the highest practical level.

Has the State-based subsidy regime had other efficiency impacts?

Are we talking about dollars or care efficiency? It seems fairly obvious we are providing the same number of bed days for more money - our Nursing Homes are full. The question perhaps should be "are we providing better bed days for more money?". The State-based subsidy scheme has had impacts - some Nursing Homes have reduced staff and care programs have suffered as a result of what may be suggested as being steps of efficiency.

How well correlated are current subsidy rates to jurisdictional wage costs?

Not known.

Could changes to the indexation formulas produce a better match in the future ?

All identified indexation must be passed on in full so as to maintain the integrity of the scheme.

Will access to more flexible labour market arrangements and possibly greater reliance on enterprise-based wage deals make it more difficult to link subsidy rates to wage costs in the future?

This question assumes general industry acceptance of these proposed alternatives which we believe is a long term possibility. Resources are currently stretched to the areas of care, Certification, the goal of Accreditation and State authority requirements.

The Industrial matters currently dealt with by Awards are receiving secondary consideration.
However, if there was a greater reliance on enterprise wage deals then the linking of

subsidy and wage costs would become more difficult. This problem can be overcome through the establishment of "regional standard models for funding" that would be the base for subsidy adjustment.

Do such considerations suggest that the information requirements and administrative costs of the State~based subsidy regime will increase in the future ?

No. It is reasonable to assume that information is currently available. Appropriately designed spreadsheets could do the majority of the calculations on the "regional standard models for funding".

Are there other administrative considerations impinging on the use of State~based subsidies, or cost-based subsidies more generally?

Not known.

Proposed National Subsidies

What impacts would coalescence to national average subsidy rates have on access to, and the quality of, residential aged care services across Australia?

It seems obvious to all but the Department that to increase or reduce subsidies in a way that does not reflect regional growth factors will create problems. The major problems in those States where coalescence creates increased funding will be industrial, as the unions fight for their members cut of the increase. For those States where decreases occur, care programs will be reduced.

Would there be significant differences in impact between regions within States or Territories?

Yes, depending on increases and decreases.

What impact would coalescence have on the wages and conditions of employees in nursing homes and hostels?

The impact is more likely to be on the numbers of staff rather than the wages and conditions of the staff..

What impact would it have on the market value of bed 'licenses'?

We would suggest that bed licenses should not have a market value, and the reasons for this relate back to the initial allocation of a bed license at no cost. However, any impact on bed license costs as a result of any changes should be a part of the risk program as with any business operation.

Would the proposed introduction of nationally uniform subsidies improve the incentives for cost-effective provision and, if so, how? Would there be other efficiency benefits or savings in administrative costs?

We have outlined above the facts that would dictate where savings would occur. Any erosion of subsidies will directly affect the major areas of controlled expenditure, ie nursing and care staff. The other benefits and savings that may occur in the area of administrative costs are limited.

Would coalescence simply speed up or slow down expected structural changes in *the residential aged care sector, or would it substantially alter the shape of the sector* in *years to come?*

Coalescence in itself will have little effect on the timing of structural changes. The real influencing factors will be coalescence associated with the inequities of the Aged Care Reforms. The shape of the industry will be clearly defined sooner rather than later as audited accounts of smaller organisations are analysed after the first 2 or 3 years of operation under the reform. It will be then that the reality of the situation will demand remedial legislation to correct the problems.

Alternative funding arrangements

Are there alternatives to *the current and proposed subsidy regimes which would promote more equitable access to nursing home services,, a greater range of choice for residents, and/or more efficient service provision? Are there other criteria which are relevant in comparing alternatives?*

The availability of the appropriate care program is what equitable access is about. In the real world of our operations, our incoming Residents do not have a choice and the efficiency of our service is restricted or limited by our available funds. An outcomes accredited care program is the only acceptable criteria or measure.

What weighting should be given to the various criteria?

See above.

Would any proposed alternatives be consistent with the current resident charging arrangements?

Not applicable.

Would a 'pure' percentage~based subsidy be sensible, or would there be a need for some maximum dollar caps to avoid taxpayers subsidising unnecessary embellishments to services?

If a regional subsidy based on "regional standard models for funding" was available, the pure percentage based growth could be applied in line with indexation without resorting to the traps and arguments created by dollar caps.

With residents meeting a percentage of total costs, would there be a greater incentive for providers to deliver services cost effectively?

The source of funds does not generally act as an incentive toward cost effective operations. It has more to do with the availability of funds and the ability to increase or decrease services.

Under a percentage-based scheme, would some additional 'special needs' funding be required to keep services affordable in very high cost locations?

"Regional standard models for funding" and the application of full indexation factors will ensure all services remain affordable.

Would paying subsidies direct to residents rather than homes increase the pressure on providers to deliver 'the right service at the right price'?

The outcome of such a change can not be anticipated, but for such a system to operate the general running of the Home would have to be controlled by Management and Residents without the external influences created by the guidelines of the various authorities.

The question that needs to be answered is “Is the Resident in a position to demand or decline ‘the right service at the right price’ in the interest of saving fees?".

Our concern would be our negotiations with some Residents and/or relatives who may enter the negotiations with unrealistic expectations for themselves and no respect for the rights and or needs of existing Residents.

We would further suggest that the ability of the service provider to justify, through negotiation, some of the State authorities requirements and the proposed national Certification and Accreditation costs would be impossible.

Or would it simply involve an additional administrative cost, with little or no offsetting efficiency gain?

The costs could be extreme and the possibility of conflict high. It would be hard to envisage any offset against the cost.

How important is resolution of the funding methodology issue for providers and their residents? Will its significance increase or diminish over time?

The resolution of the funding methodology is critical to the successful operation of the facilities currently within the system and those coming on-line in the future. There have been too many false starts, back downs, reviews and now a Productivity Commission Inquiry seeking answers basic to the operations of the reforms. It is time to get it right. The industry needs direction and the problems being created by this discredited funding system will be magnified as time goes on.

Will it continue to be appropriate to separate funding for residential care from funding for other forms of aged care?

Yes. Residential aged care funding needs to remain clearly identified .

What sort of funding methodologies would help to facilitate the integration of support for residential and community-based care?

Not known.

5. Implementation Issues

Participants are invited to identify implementation issues that arise in relation to their preferred funding methodology. For example:

If coalescence is to proceed, what changes (if any) should be made to the phasing arrangements previously announced by the Commonwealth?

Neutral coalescence can not be achieved. Full indexation must occur in all States.

Over what time period should any proposed alternative funding arrangements be introduced?

It would give the industry some confidence in the authorities if, after consultation with practitioners, there was an immediate introduction of an acceptable funding program.

The current attempt to introduce a scheme or reform package and then get it right leaves a lot to be desired.

Are there particular issues that will need to be addressed during the transition period? For instance, would a redistribution of funding across the States and Territories have implications for wages outcomes in individual jurisdictions?

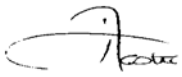
It is time to consider every issue. This is not the time to limit the issues that need to be. addressed. At the end of any review or inquiry there may be a completely revised system, but, providing it meets the needs of the Residents and the industry, and can provide the service there should be nothing to question.

Would any proposed changes to the funding regime require changes to supporting bureaucratic structures and/or regulations and, if so, what would this entail?

We believe it is time for the industry and the national funding authority to take control. The variables between States create division in an industry that should meet a national criteria. State involvement by recommending and licensing authorities should be eliminated.

What sort of accountability requirements should apply to providers?

Providers, as recipients of Government funding, should be required to provide audited feedback on a regular basis. This financial aspect could be closely aligned with outcomes based Accreditation surveys so as to allow realistic analysis of the national operations. It would also appear obvious that current information technology should allow direct transfer of information between the provider and the Department to the point where self assessment and random audit will ensure paper work can be maintained at a minimum.

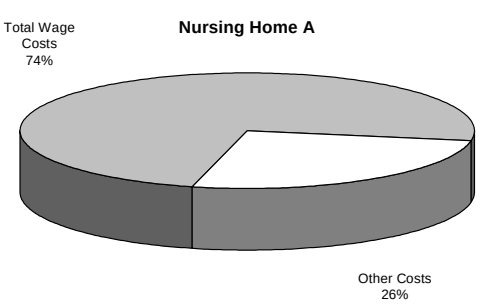


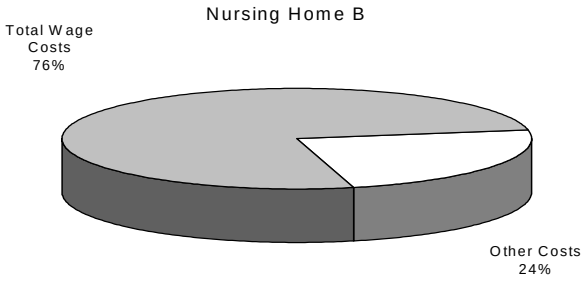
for DENNIS MARKS
CHAIRMAN
MID NORTH COAST AGED CARE DISCUSSION GROUP

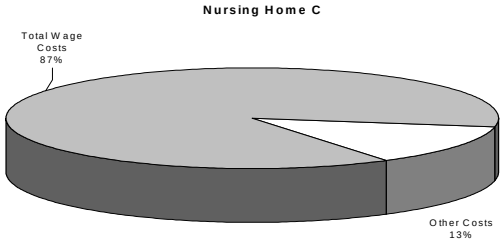
ATTACHMENT I

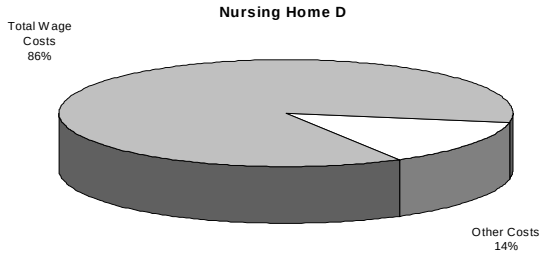
NURSING HOME	**A**		**B**		**C**		**D**	
No. of Beds	**89**		**40**		**50**		**81**	
Total Expenditure 1997/98	**$3,796,772**		**$1,621,175**		**$2,267,700**		**$3,586,361**	
		% of Total		% of Total		% of Total		% of Total
		Expenditure		Expenditure		Expenditure		Expenditure
Salaries								
Care	$2,114,964	55.70%	$960,699	59.26%	$1,350,600	59.56%	$2,173,488	60.62%
Non Care	$407,935	10.74%	$160,108	9.88%	$440,400	19.42%	$623,748	17.40%
TOTAL	$2,522,899	66.45%	$1,120,807	69.14%	$1,791,000	78.98%	$2,797,236	78.02%
Superannuation								
Care	$121,868	3.21%	$58,071	3.58%	$70,900	3.13%	$119,389	3.33%
Non Care	$24,041	0.63%	$9,552	0.59%	$22,600	1.00%	$46,464	1.30%
TOTAL	$145,909	3.84%	$67,623	4.17%	$93,500	4.12%	$165,853	4.63%
Workers Compensation								
Care	$113,903	3.00%	$35,546	2.19%	$84,700	3.74%	$108,327	3.02%
Non Care	$43,587	1.15%	$6,870	0.42%		0.00%	$18,247	0.51%
TOTAL	$157,490	4.15%	$42,416	2.62%	$84,700	3.74%	$126,574	3.53%
TOTAL WAGE COSTS	$2,826,298	74,44%	$1,230,846	75.92%	$1,969,200	86.84%	$3,089,663	86.17%

ATTACHMENT II

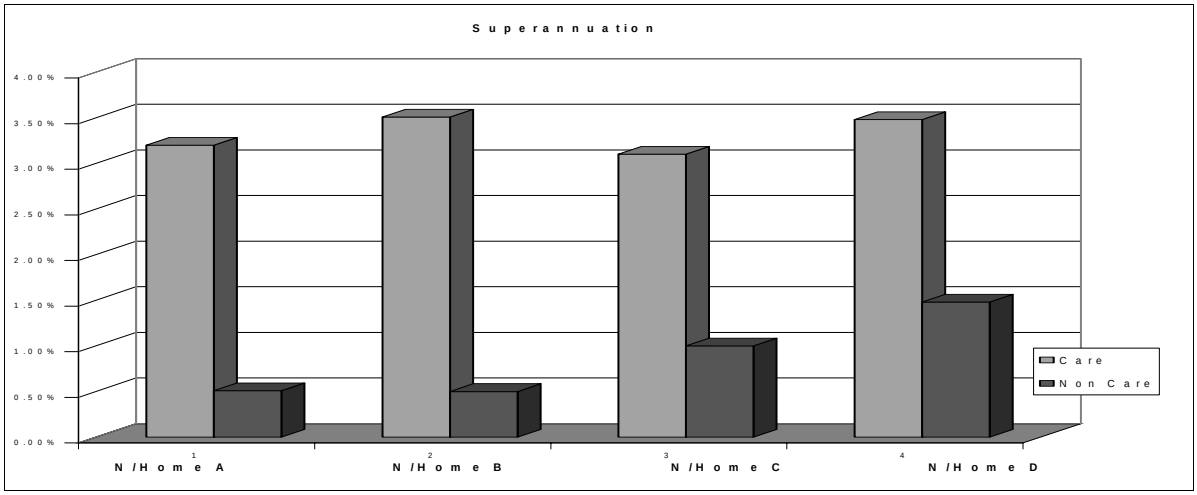




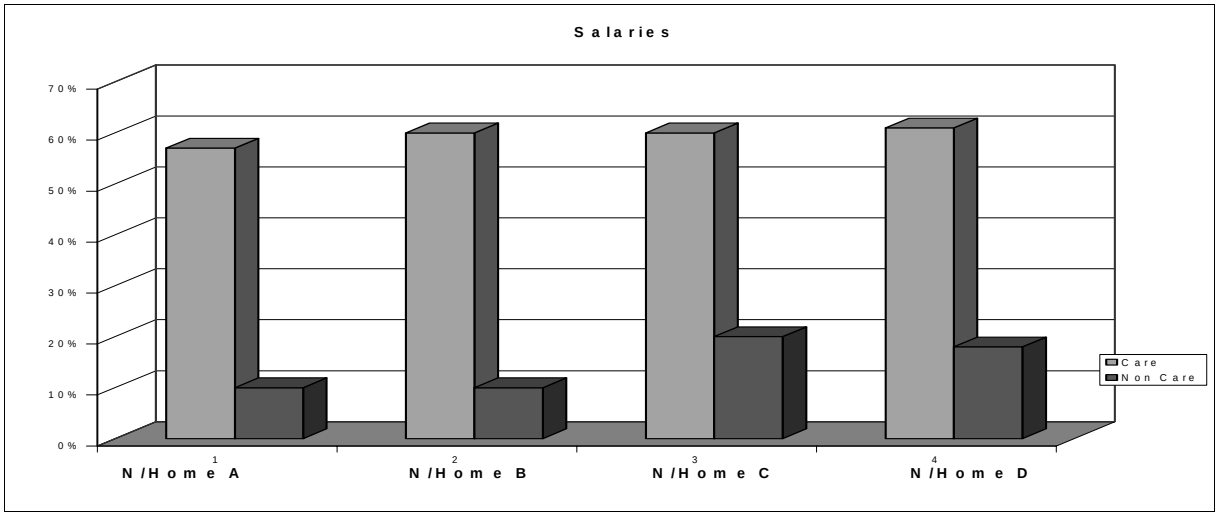




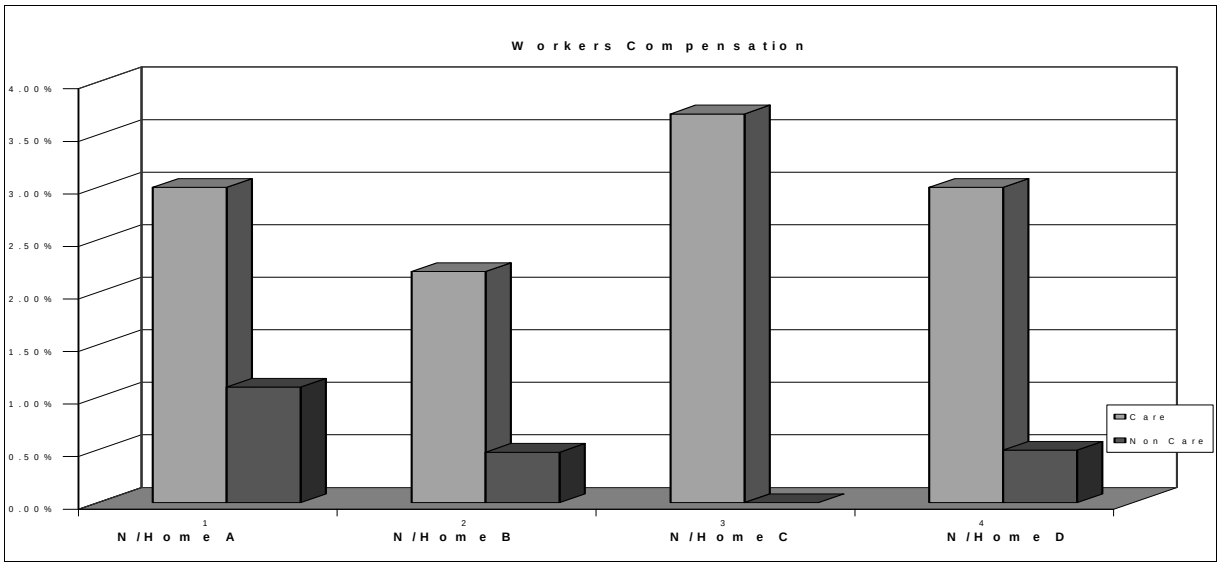
ATTACHMENT III



Percentage of Total Expenditure



Percentage of Total Expenditure



Percentage of Total Expenditure