Gorton
Blues
Gray
Ellinger
James
Lawless
Beard
Feigel
Stinnett
McChord

A G E N D A
PLANNING COMMITTEE
May 12, 2009
1:00 P.M.

1. **Family Care Center Audit** – Stinnett (1-12)
2. **Newtown Pike Design Ordinance** – Gorton (13-18)
3. **Newtown Pike Status** – Blues (19)
4. **Liberty Rd Widening Status** - Stinnett
5. **Items Referred to Committee** (20-21)

"Planning Committee, to which should be referred matters relating to parks, planning and zoning, housing, transportation, grants, legislation and social services."

Council Rules & Procedures, Section 2.102(1)

CPAs & ADVISORS

lue

Blue & Co., LLC / 2650 Eastpoint Parkway, Suite 300 / Louisville, KY 40223
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blueandco.com

April 14, 2009

Ms. Marlene Helm
Commissioner, Department of Social Services
Lexington-Fayette Urban County Government
200 E. Main Street
Lexington, KY 40507

Dear Marlene:

We appreciate the opportunity to work with you and the Staff at the Family Care Center. Enclosed is a letter which states that we were unable to complete the financial audit as originally requested and our reasons for not being able to do so. Also enclosed is the final copy of the Revenue Cycle Assessment. Our Revenue Cycle Assessment report is intended solely for the information and use of the Lexington-Fayette Urban County Government and the Family Care Center's management.

If you have any questions concerning any of the matters noted above, please do not hesitate to call.

Sincerely,

Blue & Co., LLC

blue

Blue & Co., LLC / 2650 Eastpoint Parkway, Suite 300 / Louisville, KY 40223
main 502.992.3500 fax 502.992.3509 email blue@blueandco.com

blueandco.com

January 15, 2009

Ms. Marlene Helm
Commissioner, Department of Social Services
Lexington-Fayette Urban County Government
200 E. Main Street
Lexington, KY 40507

Dear Ms. Helm:

Blue & Co., LLC ("Blue") was engaged to perform a financial statement audit of the Family Care Center Health Clinic (the "Clinic") for the period July 1, 2007 - June 30, 2008. After analyzing the Clinic's general ledger and after several meetings and conversations, we have determined that we would be unable to issue an unqualified ("clean") audit opinion on the Clinic's financial statements based on the following items:

1. **The Clinic's trial balance did not include all of the Clinic's revenues and expenses, and certain Clinic expenses were paid and accounted for in the County Government's general fund.**

   Our initial analysis of the Clinic's trial balance and discussions with management and others indicated that not all of the Clinic's revenues and expenses were included in the trial balance given to us. Certain expenses (salaries, utilities, other) were being paid and expensed as part of the County Government's general fund, but were not being properly indentified and included in the Clinic's separate trial balance. According to SAS (Statements on Auditing Standards) No. 58, auditors should modify the standard (unqualified) report for several situations, including when the financial statements are materially misstated due to:

   - The omission of a financial statement element, account, or item.
   - An inaccuracy in gathering or processing data from which financial statements are prepared is noted.

2. **Total Clinic revenues per the general ledger could not be reconciled to system reports.**

   We attempted to reconcile Clinic revenues by comparing the amount of revenues reported on Physicians Computer Company system reports with revenues reported on the Clinic's trial balance, but were unable to reconcile the variance noted. SAS No. 58 states that auditors should modify the standard report when:

   - A difference between the amount classification, or presentation of a reported financial element, account, or item and the amount, classification, or presentation that would have been reported under generally accepted accounting principles exists.

3. **The Clinic lacked sufficient internal controls surrounding certain accounting areas.**

   Based on our findings discussed in 1-2 above, it is clear that as of June 30, 2008 certain internal controls were lacking at the Clinic. Auditors must assess the risk of material misstatement at the relevant assertion level, including the following assertions:

   - Existence or Occurrence (amounts actually exist or transactions have occurred)
   - Completeness (all transactions and events that should have been recorded have been recorded)
   - Rights and Obligations (assets are the rights of the entity and the liabilities are the obligation of the entity)
   - Accuracy and Classification (amounts related to transactions have been properly recorded)
   - Valuation or Allocation (asset, liability, equity, revenue and expense interests are included in the financial statements appropriately)
   - Cutoff (amounts are included in the proper period)

Modified Reports

SAS No. 58 discusses four categories of reports that depart from the auditor's standard report.

- Qualified opinions – Qualifies the auditors' opinion on the financial statements, stating that, except for the effects of the matters to which the qualification relates, the financial statements are fairly presented in conformity with GAAP (generally accepted accounting principles).

- Adverse opinions – State that the financial statements are not fairly presented in conformity with GAAP.
- Disclaimers of opinion – Do not express an opinion on the financial statements to which they relate.
- Reports with additional explanatory language – Results in an unqualified opinion that includes explanatory language to highlight a matter relating to the financial statements.

Our knowledge of items listed in 1-3, would require a modification from the standard audit report, or a change in the scope of services Blue would be able to provide. Modified reports are less useful to management, Boards of Directors, and other users of financial statements than standard reports. We are respectful of the Clinic's financial resources and do not want to charge a fee for an outcome that County Government, management, and other financial statement users may not find useful, based on our initial work and analysis.

The reasons listed above that do not allow for the issuance of an unqualified opinion on the Clinic's financial statement appear to have been in existence for a number of years and existed for the period July 1, 2007 - June 30, 2008. We understand that management is in the process of improving internal controls and correcting financial reporting processes to address the matters identified.

If you have any questions concerning any of the matters noted above, please do not hesitate to call.

Sincerely,

Blue & Co., LLC

EXECUTIVE SUMMARY

BACKGROUND

The Family Care Center ("the Center"), established in 1989, is a single site, multi-service healthcare center owned and operated by the Lexington Fayette Urban County Government (LFUCG). The Center offers comprehensive primary child and adolescent health services. The Center's medical staff was established through a contractual partnership between the University of Kentucky (UK) Colleges of Medicine, Nursing, Dentistry and LFUCG. The Center had its administrative functions centralized in one location. This central location is responsible for scheduling, demographic and charge capture, billing and collection, practice management services, and financial reporting for the group.

Blue & Co., LLC was engaged to perform a revenue cycle assessment in order to assist the Center's management in reviewing its revenue cycle operations. The review focused on the elements outlined in the chart. The chart provides an overview of our review findings and ratings.

ENGAGEMENT OBJECTIVES

Our objective for this review was to evaluate the operational practices for services provided from July 2003 through June 2008 related to the revenue cycle of the Center. To accomplish this objective we documented and tested selected areas of the revenue cycle. The review focused primarily on the consistency and operating effectiveness of the revenue cycle functions performed by the Center.

SCOPE OF WORK

To define the scope of the review and to obtain a detailed understanding of the Center's operations we interviewed personnel involved in revenue cycle operations. Practice policies and procedures, operational forms, system generated reports, and other miscellaneous supporting documents, as provided by management personnel, were also reviewed. In addition, we randomly selected and evaluated 200 patient encounters (40 for each fiscal year beginning July 1, 2003 to June 30, 2008) to ensure that practice revenue cycle functions as described by management were followed.

SUMMARY OF FINDINGS AND RATINGS

The review findings and ratings are summarized below:

Description of Ratings:

= Best Practices ◯ = Below Standard, Major Concerns

● = Satisfactory, Minor Concerns

APPROACH/PROCEDURES PERFORMED

DESCRIPTION OF RATINGS:

Performance benchmarks within the healthcare industry provide information on how your organization ranks in critical areas compared to your peers. Benchmarking can be applied to a variety of areas as an improvement process by focusing management on specific opportunities. Benchmarking data against better-performing medical groups helps identify the business practices and behaviors these groups employ to achieve success.

"Best practices" are proven services, functions or processes that produce superior outcomes or results that meet or set a new standard.

"Satisfactory" indicates that various elements in the functions or process that produces superior outcomes or results have been achieved.

"Below Standard" indicates that minimal elements in the functions or process that produces superior outcomes or results have been achieved.

APPROACH/PROCEDURES PERFORMED

The following procedures were performed in order to complete the engagement:

a. Interviewed management and LFUCG employees in the following areas: Finance, Budget, Social Services, IT Revenue and Accounting and reviewed key documents involved with the revenue cycle of the Center.

b. Reviewed organizational documents, policies and procedures.

c. Performed a walkthrough of the revenue cycle from patient registration through the final disposition of the patient account.

d. Randomly selected and tested a sample of 200 patient accounts (40 per fiscal year, July 1, 2003 to June 30, 2008 dates of service) analyzing the billing time lag, accuracy of patient demographic information, collection of copayments and deductibles, documentation of rendering/billing provider, proper account follow-up, and accuracy of insurance payments.

e. Completed an analytical review of the accounts receivable metrics.

OBSERVATIONS/FINDINGS AND RECOMENDATIONS

FAMILY CARE CENTER

REVENUE CYCLE ASSESSMENT

For the Period July 2003 – June 2008

FEBRUARY 2009

Patient Registration and Prior Authorization

When a new patient arrives at the Center, the front-desk employee should verify for completeness the registration form and make a copy of the patient's insurance card for the Center's records. Not only does this card contain the patient's relevant insurance policy information but it also designates the patient's copayment amount, if applicable. The front-desk employee should always verify if the established patient's responsibility/guarantor, address and insurance policy has changed since the last visit. For those patients who have not been in the Center within the last year it is recommended that a complete new patient information sheet be requested.

The patients seen in the Center are registered directly into the system. Patients fill out a registration form during their initial visit. The form contains the necessary patient name, address, telephone number and responsible party information. The form also indicates by signature of the responsible party that they have been provided the Health Insurance Portability & Accountability Act (HIPAA) Privacy documents. Patients are also provided a brochure of services offered at the Center.

- It is recommended that the patient registration form contain the patient's insurance information. It is our understanding that the overwhelming majority of patients presenting for service have State assistance from Medicaid, though this does not change the need for the responsible party to become involved in documenting the subscriber of coverage, birthdates and policy identification number.

Insurance verification was completed by telephone; copy of card or via the website for Medicaid patients prior to the appointment. This generally occurred 1-3 days prior to the appointment. The internal established process allows the insurance verification individual to place a "check mark" on a one page verification log located in each patient record. We did not find that eligibility verification was performed for commercial insurance patients.

OBSERVATIONS/FINDINGS AND RECOMENDATIONS

- It is recommended that all verifications are saved in a paper or electronic format. The simple task of placing a mark on a page does not document that verification was completed. Many patients receiving Medicaid belong to manage care plans with designated primary care providers. A patient can be eligible for coverage yet assigned to another primary care provider.

● *Demographic Capture*

The Center's challenge is to properly capture the guardian/responsible party and address demographic collection data. Due to the patient population, there were several documented cases that the patient's guardian and/or address frequently changed. Through a review of the patient's chart we were able to locate all guardian linkage documents.

If the patient's address was changed during the course of their services at the Center, we could not locate the vast majority of documents to support the change of address. The unwritten policy of the Center is to update any changes at the time of the visit and place a copy of the updated document, containing staff initials, in the patient chart.

- Accurate demographic information is essential to having an effective revenue cycle. We recommend a formal policy be developed and monitored through an internal front office demographic data capture audit.

○ *Charge Capture*

During the period of 2003-2008 the encounter forms were printed by front office staff and attached to the patient chart. The provider of service was responsible for authenticating the services rendered during the patient visit on the encounter form. Upon the completion of the visit, the provider gave the encounter form to the patient to be delivered to check-out staff. The charges and any applicable co-payments were entered into the billing system by check-out staff.

Billing is a complicated process that, when performed correctly, can have an impact on the speed and amount of payment. If done poorly, coding can not only delay payment, but also lead to legal issues, refunds and penalties.

It is important to ensure that charges for all services at the proper levels and the location of services, are entered into the billing system accurately. During our on-site interviews and based on previous management reports, it was validated that a reconciliation of daily charges was not completed.

- It is recommended that a policy be established for reconciliation of daily charges for all services rendered. One possible solution for the Center may be the following process:

  1. At the end of the day, a staff member generates a report to identify any patients who arrived in the office, but whose accounts do not show charges posted for that day.
  2. A missing charge ticket report confirms the inclusion of all patients and all charges for the day.
  3. In the event that missing charges are identified, the staff member sends communication to the provider listed who performed the service, indicating that the charges must be entered prior to the end of the next business day.
  4. Before posting, documentation must be retrieved to ensure that the service was rendered, coded and charged correctly.

This process control is vital to optimizing the daily revenue. Through our review and discussions with staff the validation process did not occur from 2003-2008. As of the date of this report, a validation process has been implemented and controls are completed on a daily basis.

As previously indicated, charges were entered at face value upon the completion of the encounter form. Without the proper charge entry controls in place, this can cause claim denials. When a physician provides service to a patient, the Center's billing employee must enter the correct CPT codes to bill to the patient or the patient's insurance company.

OBSERVATIONS/FINDINGS AND RECOMENDATIONS

A common problem in medical practices is that incorrect codes are chosen. During our review we found occurences where an established patient was treated in the office and the staff/physician selects code 99203 (new patient) when they should have used 99213 (established patient), which caused a denial from the insurance company. The insurance company's computer program did detect that an established patient service is being billed as a new patient.

- It is recommended whether or not physicians assign their own CPT billing codes, a qualified coder (preferably certified) should review the codes before the claim is billed.

◯ *Medical Records Documentation*

The services the physician performs must be documented in the patient's medical record. The documentation in the medical record must support the CPT and diagnosis codes that were billed to the patient or his/her insurance company.

Medical record entries should be accurately dated and authenticated by the provider of service whether it is the physician, nurse practitioner, medical assistant. Legibility of the recorded information is an important aspect for the usefulness of the medical record.

Our assessment did not include the accuracy of CPT or diagnosis coding applied to a patient's account. We did find 17 cases in which we were unable to precisely determine the provider of service, due to illegible signature of the provider.

- It is recommended that the providers rendering services at the Center receive education on the appropriateness of documentation in the medical record.

◯ *Billing*

A goal of any practice is to submit claims, free of errors, to payers in a timely manner as a courtesy to patients and in an effort to receive prompt payment for services rendered. In best practices, prior to submitting claims, charges are reviewed for accuracy. Every effort is made to eliminate errors in registration, procedure and diagnosis coding and charge entry to ensure timely reimbursement. During the review process, any discrepancies are resolved immediately. Following this editing process, claims are submitted electronically by the next business day. All claims accepted and rejected from the payer are monitored by the billing manager to ensure that rejections are resolved expediently. The Center did not submit claims electronically from 2003 to 2008. All claims were submitted in a paper format. As of the date of our review, claims are submitted electronically to the payer.

As part of our review we also analyzed the patient account sample for the number of days between date of service and date billed. In our sample the average number of days from date of service to claim submission was two days. The Center's performance in claim submission was acceptable. We were advised that if a claim contained errors those errors were altered manually and mailed via US Postal Service. From an internal control perspective, this process lacks the ability to track changes made to a claim because manually fixing the error directly on the claim form, only applies to that individual document. If the claim was rebilled, the claim would contain the original error. We were not able to quantify the number of claim forms altered at the time of submission, though we were advised that the occurrence was not uncommon. The lack of processes in claim submission henders the ability to perform accounts receivable follow-up and compliance with internal process controls.

- It is recommended that there be a means to track changes made on the claim form prior to submission to the payer. It is preferred that all

OBSERVATIONS/FINDINGS AND RECOMENDATIONS

changes be verified through the accounts receivable software system and an electronic claims submission vendor.

Rendering Provider and Billing Provider

In our sample we also reviewed each patient chart to document the provider(s) rendering the service versus the name imprinted on the claim form as the provider name documented as billing the service.

While we did note in numerous situations where the rendering and billing provider did not match, we must indicate that the majority of medical records did reflect the signature of the billing provider. We also compared the billing provider to the payment remittance advise. From the beginning of our review in 2003 until May 2007, the rendering and/or billing provider was not documented on the Medicaid payment remittance advise, yet showed all services were reimbursed to the Center.

- It is recommended that a formal policy be implemented including the documentation requirements of State and Federal regulations as it relates to a Primary Care Center.

Denial Management

In best practices, the policy is to identify, monitor, and take action on all submitted claims that are rejected/denied by the payer in a timely manner. Depending on the nature of the rejection, a claim is corrected and resubmitted or an appeal is communicated over the telephone, via the payer's website, or in writing to the payer. The practice will monitor and research claim errors to determine the cause of rejections. A claims rejection report generated manually or by the practice management billing system is analyzed to determine specific claims that have been denied and the causes for denial. This analysis is used to train providers and staff in an effort to reduce denials in the future.

In our assessment sample, we did come upon claims that did not receive payment. We reviewed the practice management billing system to locate a reference to a denial. We were unsuccessful in locating any references indicating the reason for denial. Claims that did not receive payment on the first submission were rebilled. In a limited number of cases, the rebill occurred as many as five times. There were three cases where the services were written-off to a zero balance using Medicaid Adjustment, without justification for making the adjustment. We also noted where claims did receive the full per diem payment and a denial. Again, we could not locate any reference to the denied portion of the claim.

- It is recommended that all zero payments/denials are referenced in the practice management billing system. It is also recommended that, if possible, denials are corrected and rebilled within three business days from receipt date.

Cash Application and Adjustments to AR

In best practices the payments received are handled in a timely manner with sensitivity to internal controls. The following is an example of how the payment posting process occurs.

The practice accepts payments remitted and transferred directly from the payer in the form of an electronic funds transfer. Remittances are accepted when available but are not posted until practice staff confirm the remittance total to the funds transferred. For all non-electronic payments, payer and patient checks, the checks are copied; a bank deposit slip has been completed and deposited in the bank within 24 hours of receipt. Payments are posted to the accounts receivable system, based upon the receipt date within 24 hours. In many practices, this complete activity occurs the same day of receipt. Any correspondence, including rejections, with no payment attached is flagged in the accounts receivable system. A transaction code is posted to the charge on the account to identify the type of rejection and assigned to practice staff working account follow-up. Practice staffs are responsible for posting payments accurately on a line-item basis. Payment posting should be monitored very closely to ensure timeliness and accuracy. At the end of the business day, all payments are cross-referenced with the amount indicated on the deposit slip.

OBSERVATIONS/FINDINGS AND RECOMENDATIONS

Payments received from insurance companies are generally directed to the location of the Center. Payments received from Medicaid were received through an electronic funds transfer.

Paper checks received at the Center's location are processed entirely by one person. We recommend that more than one person be involved in receiving the mail and preparing the deposit. A possible solution would be to have the front office restrictively endorse the checks, run an adding machine tape and create the deposit slip. A second person posts the payments and produces a batch posting report. The bookkeeper or third person will reconcile the tape to the posting report and the deposit receipt from the bank.

When payments and/or explanation of benefits were received at the Center a notation was made on the explanation of benefits. This included the receipt date, as well as the completion date. During our review, we found that when posting the payment to the account it was not uncommon to take up to 30 days. We recommend payments be posted within 24 hours upon receipt. The original receipt date was used throughout the 30 day course of posting payments from the explanation of benefits. We also found that upon completion of the posting of payments, the Center staff did not reconcile the amount received against the actual amount posted. This internal control is essential in the validity of the payments received and posted. In our sample, we did find that a payment was eventually posted to the account. However, it was noted during our review that the explanation of benefits contained numerous notes where payments had been posted to the incorrect patient account or were originally omitted in posting.

- It is recommended that checks and balances occur after the posting is completed. It is recommended that the payment posting process be completed within 24 hours upon receipt. It is recommended that any balances (credits or debits) be adjusted accordingly based upon the original charge entered at the time of service.

In reviewing accounts, the method of posting Medicaid payments remained consistent. In fact, the following process of posting payments and adjustments can be documented back to the year 1999. The original charge entered at check-out was adjusted off entirely to Medicaid adjustment at the same time the Medicaid payment was posted. An additional charge indicating the Center's current Medicaid rate would be added to off-set leaving the balance at zero.

- It is recommended that the original charge entered at the time of billing are not adjusted off, yet a credit or a debit adjustment be posted to a balance of zero. The process of adjusting original charges and posting new charges does not provide an accurate statement of the accounts receivable.

Refunds / Credit Balances

In best practices, the policy is to return all monies that are not due to the Practice. A process is developed that once the refund is identified the credit balance representative enters the adjustment into the system and generates a check. The checks are given to a second person who verifies the refund, approves the check and mails. An additional control is that the bookkeeper maintains and audits the check stock used by the credit balance representative. The process involves three separate individuals and provides the necessary segregation of duties and control.

The credit balances include overpayments from patients or payers. A practice is committed to complying with State and Federal laws as well as minimizing the impact that refunds have on receivables. A credit balance can artificially decrease the accounts receivable balance and skew management reports regarding business office performance.

The Center had one individual responsible for validating and preparing refunds. This individual is no longer employed by the Center. It is our understanding, if an account contained a credit balance the documentation was forwarded to the office administrator. We remain unclear of the process that occurred after a credit balance was identified.

In our sample, we did not identify a circumstance where an overpayment occurred. We were unable to confirm that there was an approval or dollar threshold limitation in place.

OBSERVATIONS/FINDINGS AND RECOMENDATIONS

- We recommend three requirements to be included in the Center's process regarding refunds and credit balances. First, we recommend the Center establish a goal for credit balances based on daily revenue. We recommend that there be no more than one day of average daily revenue represented by credit balances. Second, develop a systematic way to age the credit balances. Credit balance older than 5 years are required to be reported to the State under unclaimed property rules. Third, develop an approval process for dollar level thresholds for refunds and adjustments.

Conclusion

After careful review of the billing operations, inclusive of the period July 2003 - June 2008, we conclude that the accounts receivable process was in substandard order and was not producing optimal results. Moving forward, it will be imperative that the accounts receivable process be strengthened including the development and implementation of strong internal controls and staff education to improve performance. Policies and procedures need to be updated to reflect the current processes and new policies need to be developed where none existed. Currently management has contracted with an outside medical billing company to address many of the deficiencies we noted, with a goal of bringing the operations to a level that meet or exceed industry standards.

SUMMARY OF RECOMMENDATIONS

- The patient registration form should contain all of the patient's insurance information.
- All insurance verifications should be saved in a paper or electronic format.
- A policy should be established for reconciliation of daily charges for all services rendered.
- A qualified coder (preferably certified) should review the codes before the claim is billed.
- All providers rendering services at the Center should receive education on the appropriateness of documentation in the medical record.
- A means to track changes made on the claim form prior to submission to the payer should be established.
- All zero payments/denials should be referenced in the practice management billing system.
- Proper checks and balances should occur after the posting is completed.
- The original charge entered at the time of billing should not be adjusted off, yet a credit or a debit adjustment should be posted to a balance of zero.
- FCC should address all requirements related to refund and credit balance issues.

DRAFT 11-12-2007
REVISED 4-1-2008
REVISED 4-29-2008
REVISED 5-4-2008
REVISED 4-16-09
REVISED 5-6-09

ORDINANCE NO. _____

AN ORDINANCE RELATING TO THE NEWTOWN PIKE EXTENSION AND SCOTT STREET CONNECTOR TRAFFIC MOVEMENT, SAFETY, ACCESS, AND DESIGN.

WHEREAS, there have been extensive and lengthy studies conducted by the partners in the Newtown Pike Extension Project (the "NPE Project"), including an Environmental Impact Statement (the "EIS"), Commercial Design and Property Access Standards, and the Southend Park Urban Village Plan; and

WHEREAS, the NPE Project involves the connection or extension of Newtown Pike from West Main Street to South Broadway and the connection of a spur road (the "Scott Street Connector") from the intersection of Newtown Pike Extended at Patterson Street to South Limestone Street; and

WHEREAS, the purpose of the NPE Project combines neighborhood planning with roadway engineering to develop the new road as an amenity for the area and to support its high quality redevelopment, which includes improving flow of through traffic; drawing unnecessary traffic out of the downtown area; setting a combination of standards and guidelines governing public and private building construction; and improving access to the University of Kentucky central campus by a more efficient vehicular route, and reducing motor vehicle congestion in the downtown area; and

WHEREAS, the EIS has been approved by the federal government, and the Kentucky Department of Transportation is preparing to commence right-of-way acquisition for the NPE Project; and

WHEREAS, it is imperative to the success of the NPE Project to manage access to the new roadway and control certain design criteria of the nearby properties; and

WHEREAS, this Council desires to increase traffic safety on the Newtown Pike Extension and the Scott Street Connector, improve traffic flow, provide access to adjacent development, control certain design criteria of nearby properties, and plan for the future of these roadways under the powers granted to this Urban County Government by the Constitution and laws of the United States and Commonwealth of Kentucky, including the police power;

NOW, THEREFORE, BE IT ORDAINED BY THE COUNCIL OF THE LEXINGTON-FAYETTE URBAN COUNTY GOVERNMENT:

Section 1 – That it is the intent of this Council to increase traffic safety, improve traffic flow, provide for access to adjacent development and plan for the future of the Newtown Pike Extension and Scott Street Connector.

Section 2 – That this Council hereby adopts the Newtown Pike Extension and Scott Street Connector Traffic Safety and Movement Plan (hereinafter referred to as the "Plan"), which consists of this Ordinance and the Map, marked as Exhibit "A", which is attached hereto and incorporated herein by reference.

Section 3 – That no permits be shall issued, no plans shall be approved, and no access shall be allowed by any agency, department, employee, or other agent or servant of this Government, except in conformance with the Plan. Only slight changes in location of up to thirty feet will be permitted to allow for engineering considerations.

Section 4 – That all access roads which are indicated in the Plan and not yet constructed shall be dedicated to public use by the owner and/or developer, and it shall be the policy of this Government to encourage owners of access roads which have already been constructed to offer them for dedication to this Government.

Section 5 – That when the Newtown Pike Extension and Scott Street Connector are fully developed as shown on the Plan, the only full median openings shall be at the locations shown on the Map, including the following intersections:

Fully Signalized Intersections

a. Newtown Pike Extension and Main Street;

b. Newtown Pike Extension and Manchester Street;

c. Newtown Pike Extension and Versailles Road;

d. Newtown Pike Extension and Patterson Street;

e. Newtown Pike Extension and Broadway; and

f. Scott Street Connector and Limestone Street

Non-signalized intersections

a. Scott Street Connector and the existing Norfolk-Southern rail yard entrance (west side);

b. Scott Street Connector and Magazine Street (east side); and

c. Scott Street Connector and Chair Street (east side) and DeRoode Street (westside)

Section 6 – That access shall be controlled for the Scott Street Connector from the intersection with Newtown Pike Extension to the new Broadway Street Bridge. Except as provided for in the Plan and this Ordinance, no additional entrances shall be permitted. Access to Scott Street from properties located between the Broadway Street Bridge and Limestone Street shall not be controlled, but shall be allowed by permit.

Section 7 – That right turn-in/right turn-out access points will be located and constructed only at the following intersections with Newtown Pike Extension:

a. Merino Street (northbound and southbound);

b. Spring Street (northbound); and

c. DeRoode Street between the Scott Street Connector and Broadway (southbound).

Section 8 – That two additional right turn-in/right turn-out access points shall be included in the project. The first shall be a minimum of 200 feet south of the intersection of Newtown Pike Extension and Versailles Road (southbound), for the purpose of accessing the corner parcel (currently the Stop and Shop retail facility). The second shall be a minimum of 200 feet from the intersection of Newtown Pike Extension and West Main Street (northbound), for the purpose of accessing the corner parcel (currently the Salvation Army). The location of this right-in/right-out is to provide emergency vehicles to the rear of the building located on the site.

Section 9 – That corner clearance for roadways and driveways intersecting with Newtown Pike Extension shall be considered. Corner clearance represents the minimum distance that should be required between an intersection and adjacent driveways. Driveways and entrances shall be located outside the functional area of the intersection (i.e., where turn lanes are located or where queues regularly exist). For minor approaches, such as Merino Street, driveways shall be located a minimum of 100 feet from the driving lane edge of Newtown Pike Extension.

Section 10 – That all development within the NPE Design Area (which includes frontage properties shown on Exhibit "A" and any other property consolidated to a frontage property), excluding Single Family detached and Two-Family residential structures, shall require approval of a final development plan by the Planning Commission. There shall be no issuance of any building permit without approval and certification of the final development plan. Structures on the development plan shall be a minimum of two (2) stories in height and, in addition to the requirements of the Zoning Ordinance and Land Subdivision Regulations, shall comply with the standards and the guidelines in the Newtown Pike Extension Commercial Design and Property Access Standards dated May 11, 2007, which are incorporated herein by reference as if fully set out herein.

Section 11 – That prior to the adoption of any amended ordinance that will alter the textual or graphic representation of this Ordinance, the Urban County Council shall receive a report from the Planning Commission outlining any concerns and/or recommendations.

Section 12 – That the Mayor is authorized and directed, on behalf of the Urban County Government, to request assistance from the Commonwealth of Kentucky, including but not limited to, the Department of Transportation, in implementing the Plan through the closing of median openings; revoking or granting right turn-in/right turn-out access points as indicated in the Plan; installing traffic signals as indicated in the Plan; and through any other means to advance the intent of the Plan. The Mayor is also authorized and directed, on behalf of the Urban County Government, to request assistance from any other person or entity, including the United States Government, to implement the provisions of the Plan.

Section 13 – That this Ordinance shall become effective on the date of passage.

PASSED URBAN COUNTY COUNCIL:

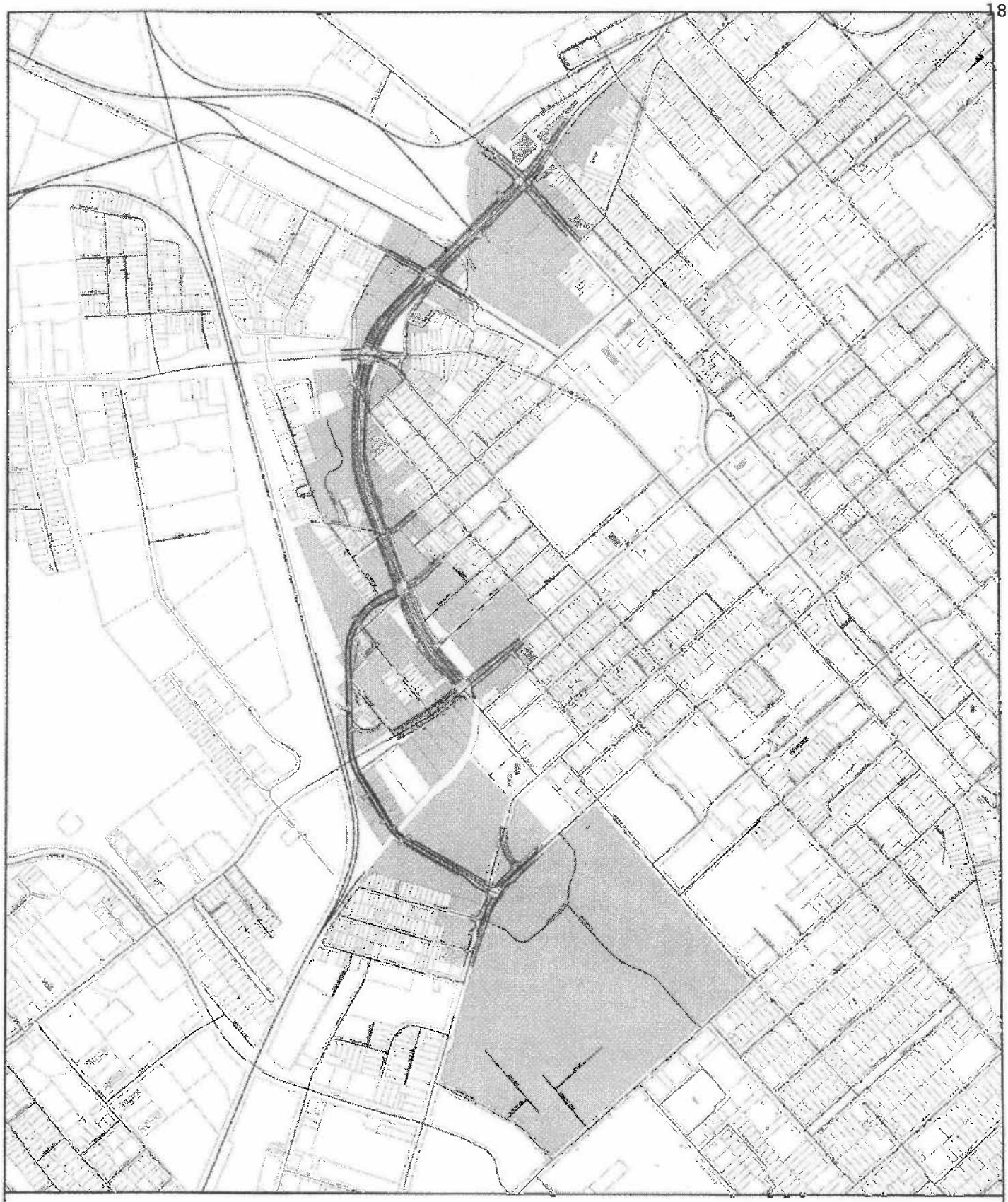
_____
MAYOR

ATTEST:

_____
CLERK OF URBAN COUNTY COUNCIL

PUBLISHED:

Plandata/Strategic Planning/NPE/Draft NPEordA



Frontage Parcels Along Proposed Newtown Pike Extension

DIVISION OF PLANNING

N
W E
S

0 285 570 1,140
Feet

General Symbology

- Railroad
- Proposed Road
- Street
- Parcel
- Frontage_Parcels

Newtown Pike Extension
Update for Planning Committee (May 12, 2009)
Information current as of May 6, 2009

Phase IV

Right-of-Way

- 20 – Total Parcels
- All relocation offers have been made.
- All acquisition offers have been made.
- All parcels have begun the process of eminent domain for right-of-entry.
- 2 parcels have been purchased.
- 2 parcels are pending approval before the Urban County Council.

Utilities

- Construction will be let with utility coordination notes. Utility relocation will be done in conjunction with the project during construction.
- Kentucky Utilities Transmission will not need to raise major transmission line running down Manchester.
- Kentucky American Water (KAW) has major relocation of a 16" water line under the center pier of the proposed bridge. KAWC anticipates it will be November 2009 before this line will be relocated.

Construction

- Plans are in their final stage. The Kentucky Transportation Cabinet (KYTC) has reviewed and is preparing to submit to the Federal Highway Administration (FHWA).
- A July 24 construction letting date has been set by KYTC.

Phase I

Right-of-Way

Advanced Acquisition

- 2 parcels have been purchased

Mitigation Area

- 55 – Total parcels
- We have purchased 13 parcels.
- 5 offers are pending.
- A right-of-way consultant is being hired to acquire the additional parcels in Phase I. The right-of-way consultant's contract will be before the Urban County Council before summer break.

Planning Committee- Issues Outstanding

04/16/09

Issue	Member Referred	Date Referred	Status
• Liberty Road Project Status	Stinnett	Jan 06	Bi Monthly Written Report
• Newtown Pike Status	Blues	Feb 06	Bi Monthly Report
• Loudon Avenue Phase 1 Status	James	Oct 06	Bi Monthly Written Report
• Development Plan Adherence	Myers	Jan 07	Winter-Spring 09
• Land Bank	James	June 07	Jan 09
• Student Housing Issues	Lawless	Sept 07	Winter-Spring 09
• Fence Regulations- Sight Distance Issues	Blues	Dec 07	Unknown
• Mobile Home Trailer Park Quality of Life	James	Dec 07	On Hold
• Infill Redevelopment Committee Recommendations	Gray	Feb 08	Unknown
• Tree Protection Ordinance	James	Mar 08	Unknown
• Streetscape Plan	Gorton	Mar 08	Task Force to be Formed
• Downtown Master Plan	Lawless	Apr 08	Committee Work Complete?
• Electrical Inspector's Fee Schedule	McChord	May 08	Feb 09
• Management Audit Recommendations	Crosbie	May 08	Subcommittee Formed
• **Family Care Center Audit**	**??Stevens**	**May 08**	**Final Audit Delivered Mid March**
• Review Civil Penalties/Impose Fines on Property Owners Who Operate a Home Office/Occupation in Violation of the Zoning Ordinance	Henson	July 08	Seeking Legal Opinion
• Impose Restrictions on Issuing Permits to Individuals/Property Owners When There are Pending Written Complaints Regarding Violations of Zoning Ordinances	Henson	July 08	Seeking Legal Opinion
• Place Reasonable Time Limits for Completion of construction projects approved for existing 1/2 Family Residential Building Permits and Fence/ Retaining Wall Permits	Henson	July 08	Seeking Legal Opinion
• Special Districts	Myers	Sept 08	Seeking Legal Opinion
• Zoning Violation Fines	Myers	Sept 08	General Assembly Action Required
• Newtown Pike Design Ordinance	Gorton	Oct 08	Spring 09
• Destination 2040 Recommendations	Ellinger	Jan 09	Spring 09

Planning Committee- Issues Outstanding (continued)

• Parks Master Plan	Stinnett	Feb 09
• Hisle Property Master Plan	Stinnett	Feb 09
• Big Blue Horse Branding Issue	Lawless	Feb 09
• Extended Stay Zoning Ordinance Text Amendment	Lane	Mar 09
• Art 16 Zoning Ordinance re Rear Yard Parking in Residential Areas	Henson	Apr 09