Make the mark.

Skilled nursing facility | Benchmarking report

Based on 2016 data
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Introduction

Our inaugural "Make the mark" report is an extension of our tradition of providing unparalleled information on the skilled nursing facility (SNF) industry to providers, investors, and other capital sources.

For the past two decades, the Plante Moran EDGE® reports have allowed any one of approximately 15,000 Medicare-certified SNFs to benchmark key operating, revenue and expense indicators to competitor facilities, and also to local, state, and national averages. Benchmarks are also available by ownership type, allowing proprietary, nonprofit, and governmental organizations to obtain meaningful comparison data to support operational efficiency and strategic planning initiatives.

Our Make the mark publication provides a summary of important indicators of SNF operating and financial health:

- Medicare profitability
- Occupancy and payor mix
- RUG concentrations and case mix
- Departmental cost per day
- Staffing levels and labor costs

For additional benchmarks and a facility specific Plante Moran EDGE® report, contact us at plantemoran.com.
**Executive summary**

*The SNF industry is in a period of transition that will likely continue for several years.*

An increase in hospital referrals to home health services, and the growth of managed care and value-based payment models that emphasize length of stay management and clinical performance are all driving down demand for SNF services. The excess capacity has increased competition, and providers that have aging physical plant or workforce challenges are most vulnerable.

The Silver Tsunami and the increasing clinical capabilities of SNFs suggest that the future will be bright for facilities that can provide high-quality, cost-efficient care. We believe the following will be critical attributes for success:

- **Cost-effective management of an episode of care.** The SNF industry has historically operated with minimal consideration of the total price for that care. Health plans and new CMS models will increasingly hold SNFs accountable for the payor’s total cost, and SNFs will be wise to track performance metrics on a per episode basis rather than per diem.

- **Labor models that allow providers to quickly respond to changes in occupancy** as it is inevitable that SNFs will continue to face census volatility and will need to manage labor costs accordingly.

As you review this report, the following trends are expected to continue:

- **Medicare margins decreased as expenses continue to outpace revenue.** Medicare Part A rates increased by approximately 2 percent from 2015 to 2016, while expenses increased almost 3 percent.

- **Occupancy continues to decline.** The average occupancy in 2016 was 82 percent compared to 87 percent in 2015. Managed care utilization continued to increase while traditional Medicare declined.

- **Increases in direct nursing care, administration, and dietary services led an overall increase in routine costs of 4.5 percent.**

- **Direct nursing care hours declined; however, wages have grown more than any other position due to the competitive environment.**
Overview of state of industry

The industry seems to be constantly changing.

The following are the most current proposals that could affect the industry:

**PAYMENT MODELS**

- CMS has introduced many new payment models, some are mandatory while others are voluntary. The success of the programs and authority granted CMS means these initiatives will only grow and expand. Providers should expect to see these programs expand to the commercial insurance world as well.

**VALUE-BASED PURCHASE (VBP): THE SNF VBP PROGRAM OFFERS PROVIDERS INCENTIVES BASED ON READMISSION RATE PERFORMANCE**

- Beginning Oct. 1, 2018, all PPS rates will be cut. All eligible skilled nursing facilities will begin receiving incentive payments as of Oct. 1, 2018. Thus, in a perfect scenario, there may not be any reductions to PPS rates.

- Centers for Medicare and Medicaid Services (CMS) has set the achievement benchmark SNFRM rate at 16.40 percent, which is the mean score for all SNFs in CY 2015. CMS has also set the achievement threshold benchmark SNFRM rate at 20.41 percent, which is the 25th percentile for all SNFs in CY 2015.

**RCS-1 MODEL – REVISIONS TO THE CASE-MIX METHODOLOGY**

- Covered in RUG concentration section.

**AFFORDABLE CARE ACT (ACA) REPEAL**

- Would introduce Medicaid reform with per capita allotment.
- Could reduce provider tax minimum from 6 percent to 3 percent.

**CY 2017 NEW PAYMENT MODELS**

- Comprehensive care for joint
- Replacement model
- Oncology care model
- Next-generation ACO model
Data sources and limitations

The benchmarks are based on data compiled from 2016 and 2015 year-end Medicare cost reports provided by CMS.

Most facilities have all of their beds certified for Medicare. As a result, the per diem costs, as reported on the Medicare cost report, represent the average cost for all patients. The actual per diem costs for Medicare patients are usually higher than average due to the staffing costs associated with elevated acuity for short-term patients and a higher per diem cost for admissions, discharge planning, and case management of post-acute patients.

Medicare cost reports are not deemed to be reliable sources for balance sheet information such as cash, accounts receivable, and debt as many SNFs are operated in complex structures with bifurcation of assets and operations. As such, this report does not include any ratio analysis that requires balance sheet information as results compiled from this source could potentially be misleading.

The data represents over 14,000 nursing facilities across the United States.
Definition of regions

The benchmarks provided are based on regions of the United States. We have sectioned the United States into eight regions, which are defined below:

- PACIFIC
- ALASKA & HAWAII
- MOUNTAIN
- WEST NORTH CENTRAL
- WEST SOUTH CENTRAL
- EAST NORTH CENTRAL
- NORTH ATLANTIC
- SOUTH ATLANTIC
Medicare profitability

Medicare profitability measures the operating results of caring for a Medicare Part A resident at a skilled nursing facility.

For 2016, the national average Medicare Part A profit was $89 per patient day. This was a decrease of $3.00 per patient day, or -3 percent. Pacific region appeared to be double the national average with a profit of $179 per patient day. Even though expenses per day were approximately $50 per day higher than the national average of $409 per day, the average Medicare rate for the Pacific region was $638. This was approximately $140 per day higher than the national average rate of $498 per day.

The East North Central region average Medicare Part A profit was $92 per patient day, which was higher than the national average. Even though the average Medicare Part A rate was lower than the national average, the higher profit was generated by the lower average expense of $392 per day.

Another way to look at Medicare Part A profitability is based on an episode of care. An episode of care can be defined as the care provided by the skilled nursing facility for a specific medical problem or specific illness during a set time period. The national average for Medicare Part A profit was $3,900 per episode of care. In 2016, an average episode of care was costing providers around $18,900 nationally, with the national average revenue per episode being around $22,800.

The therapy portion of the Medicare Part A rate represents approximately 40 percent of the Medicare Part A rate components. It is important for skilled nursing facility providers to measure their therapy costs against the average rate being reimbursed from traditional Medicare. Understanding your profit margin on the therapy component will help with managing therapy departments, along with negotiating therapy contracts. For 2016, the national therapy net profit was $63 per day, which stayed flat compared to 2015.
Medicare profitability (PPD)

<table>
<thead>
<tr>
<th>Region</th>
<th>2016 National avg.</th>
<th>2015 National avg.</th>
<th>Profit (Loss)</th>
<th>Other ancillary expense</th>
<th>Therapy expense</th>
<th>Capital expense</th>
<th>Routine expense</th>
<th>Revenue</th>
<th>Total expense</th>
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<td>Alaska &amp; Hawaii</td>
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Medicare therapy profitability

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<tr>
<th>Region</th>
<th>2016 National avg.</th>
<th>2015 National avg.</th>
<th>Therapy revenue (ppd)</th>
<th>Therapy expense (ppd)</th>
<th>Therapy net profit (loss) (ppd)</th>
</tr>
</thead>
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<td>Alaska &amp; Hawaii</td>
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<td>$139</td>
<td>$164</td>
<td>$135</td>
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<td>Mountain</td>
<td>$197</td>
<td>$185</td>
<td>$197</td>
<td>$135</td>
<td>$63</td>
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<tr>
<td>West North Central</td>
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<td>$168</td>
<td>$133</td>
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<td>West South Central</td>
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<td>$191</td>
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<td>$131</td>
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<td>2016 National average</td>
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<td>2015 National average</td>
<td></td>
<td></td>
<td>$195</td>
<td>$132</td>
<td>$63</td>
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</tbody>
</table>
Occupancy and payor mix

**Occupancy is defined as the number of residents over the total number of beds available.**

Occupancy trends from 2015 to 2016 have decreased from 87 percent to the 2016 national average of 82 percent. The North Atlantic region experienced the highest occupancy at 93 percent, with the lowest occupancy at 70 percent in the West South Central region. The average occupancy for the East North Central region was 79 percent, which was lower than the national average.

Occupancy in the next 5 – 10 years for nursing facilities is expected to grow due to the increasing senior population with the “Baby Boomer” generation reaching the age of 65 by 2030, which will be projected to be 20 percent of the U.S. population.

**Payor mix is defined as payor days over the total resident census, or the utilization of payors.**

Medicare payor mix trends from 2015 to 2016 have slightly declined by 1 percent to a national average of 15 percent. This decline, along with future declines in the traditional Medicare category, is due to a shift to managed care contracts. Managed care payors are included in the private category.

West North Central region appeared to have lowest Medicaid and Medicare utilization at 47 percent and 11 percent, respectively. However, private/other was the highest at 42 percent.

Managed care contract rates vary by provider. Thus, it is important for skilled nursing facilities to review their contracts, renegotiate rates, and manage their operations according to managed care contract rates.

**Medicare average length of stay is defined by Medicare resident days over Medicare discharges.**

The national Medicare average for 2016 was 46 days, which was a decrease of approximately three days from 2015.

For the East North Central region, length of stay was at 44 days, which was lower than the national average.

Skilled nursing facilities should target for a lower Medicare length of stay to become attractive partners with hospitals. With a strategy of lower length of stay, a skilled nursing facility will need to increase marketing efforts to maintain optimal occupancy levels.
# SNF Payor Mix

## 2015 National Average
- Medicaid: 52%
- Medicare: 16%
- Private: 32%

## 2016 National Average
- Medicaid: 52%
- Medicare: 15%
- Private: 33%

## Region Breakdown
- **North Atlantic**
  - Medicaid: 56%
  - Medicare: 14%
  - Private: 30%
- **South Atlantic**
  - Medicaid: 52%
  - Medicare: 18%
  - Private: 30%
- **East North Central**
  - Medicaid: 47%
  - Medicare: 15%
  - Private: 38%
- **West South Central**
  - Medicaid: 59%
  - Medicare: 16%
  - Private: 25%
- **West North Central**
  - Medicaid: 47%
  - Medicare: 11%
  - Private: 42%
- **Mountain**
  - Medicaid: 56%
  - Medicare: 17%
  - Private: 27%
- **Alaska & Hawaii**
  - Medicaid: 48%
  - Medicare: 13%
  - Private: 39%
- **Pacific**
  - Medicaid: 53%
  - Medicare: 17%
  - Private: 30%

## Occupancy %

<table>
<thead>
<tr>
<th>Region</th>
<th>2015 National Average</th>
<th>2016 National Average</th>
<th>2015 National Average</th>
<th>2016 National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pacific</td>
<td>84%</td>
<td>83%</td>
<td>77%</td>
<td>78%</td>
</tr>
<tr>
<td>Alaska &amp; Hawaii</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mountain</td>
<td>78%</td>
<td>79%</td>
<td>85%</td>
<td>82%</td>
</tr>
<tr>
<td>West North Central</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>West South Central</td>
<td>85%</td>
<td>93%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>East North Central</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>South Atlantic</td>
<td></td>
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<tr>
<td>North Atlantic</td>
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<tr>
<td>National Average</td>
<td></td>
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</table>
Average length of stay

MEDICARE LENGTH OF STAY

Three-day decrease

Managing length of stay while achieving cost-effective quality outcomes should be a top priority given the growth of Medicare Advantage and value-based payment models. Length of stay for Medicare Advantage beneficiaries is typically less than 20 days.
RUG concentrations

RUG (Resource utilization group)

Classifies residents in a SNF into one of 66 possible groups that include two case-mix indexed components — (1) therapy and (2) nursing. The RUG system incentivizes higher therapy utilization.

- Approximately 92 percent of Medicare residents fall into the therapy RUG category, with the next highest category concentration being special care, which was approximately 4 percent.
- Resident classification within the RUG categories impacts revenue. In addition, it is important to be aware of the concentration of residents into ultra-high rehab utilization and high ADLs, which are considered to be target risk areas for PEPPER (Program for Evaluating Payment Patterns Electronic Report).

Proposed rulemaking: Revisions to case-mix methodology-RCS-1

- CMS is considering replacing the RUG-IV case-mix classification model with the Resident Classification System, Version I (RCS-1) model.
  - The intention is to “better account for resident characteristics and care needs, thus better aligning SNF PPS payments with resource use and eliminating therapy provision-related financial incentives inherent in the current payment model used in the SNF PPS.” (42 CFR Parts 409 and 488, CMS-1686-ANPRM).
- In the current RUG IV model, therapy and nursing are the two case-mix adjusted rate components.
- The RCS-1 model creates four rate components: PT/OT, SLP, nursing, and nontherapy ancillary.
  - A resident would be classified into each of the four components, a case-mix adjustment is applied, and a single per diem payment is derived.
- RCS-1 payment rates would include a variable per diem adjustment, which reduces the per diem payment rate as the length of stay increases.
- Oct. 1, 2018 is the proposed implementation date of RCS-1 from CMS; however, many industry experts believe the likely date will be Oct. 1, 2019.
ROUTINE COST PER DAY HAS INCREASED BY 4.5 PERCENT FROM 2015 TO 2016, WHICH IS OUTPACING THE REVENUE GROWTH UNDER THE MEDICARE PROGRAM. A main driver of the increase was due to salaries, especially direct care.

THE NATIONAL AVERAGE FOR THERAPY COSTS FOR 2016 WAS $135 PER DAY, WHICH WAS AN INCREASE OF 2 PERCENT OVER 2015 COST PER DAY OF $132. With the exception to the Alaska/Hawaii region, the Pacific region was the highest cost region at $169 per day. Average therapy costs for the East North Central was $131 per day, which was lower than the national average.

OTHER ANCILLARY COST FOR 2016 WAS $54 PER DAY. Pharmacy cost represent the majority of other ancillary cost at $42. Pharmacy costs have stayed flat since 2015.
Direct nursing wage (excluding benefits) and supply costs represent 41 percent of the total routine cost of care. Nursing administration represents an additional 7 percent.

Implementing flexible staffing models that allow for a quick response to census fluctuations will be important to future success.
# Allocated expenses by region

**TOTAL ALLOCATED EXPENSES**

$5.00 | 5%
--- | ---
per patient day

## MEDICARE ROUTINE COSTS (PPD)

<table>
<thead>
<tr>
<th>Allocated expenses</th>
<th>Pacific</th>
<th>Alaska &amp; Hawaii</th>
<th>Mountain</th>
<th>West North Central</th>
<th>West South Central</th>
<th>East North Central</th>
<th>South Atlantic</th>
<th>North Atlantic</th>
<th>2016 National average</th>
<th>2015 National average</th>
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<td><strong>$133</strong></td>
<td><strong>$115</strong></td>
<td><strong>$110</strong></td>
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</table>
Other Medicare ancillary costs (PPD)

Other Medicare ancillaries are presented as national averages. The average for each region is consistent to the national average.
Staffing cost per day

Staffing-related costs represent approximately 60–65 percent of operating costs of a nursing facility.

The challenge within the industry is a competitive nursing environment, which will continue to drive the cost of nursing wage rates up, along with the increased utilization of purchased nursing.

- The national average for direct routine salaries for 2016 was $71 per patient day. This was up by 3 percent compared to 2015. The Alaska/Hawaii region was the most expensive with direct routine salaries of $115 per patient day. This region was much more expensive due to higher staffing hours of 4.83 direct staffing hours per patient day along with higher direct care wage rates.

- The national average for direct staffing hours per patient day for 2016 was 3.97 hours based on hours paid. This was a decrease of .06 hours per resident. Due to a much more competitive nursing environment, recently nursing facilities are finding it harder to retain nursing staff and will rely on purchased nursing agencies. Purchased nursing would not be reflected in the staffing hours or direct routine salaries.

- In addition, wage rates in total have increased from 2015 to 2016 by 3 percent. With the exception of the Alaska/Hawaii region, the highest average wage rates were paid in the North Atlantic region at $21.44 per hour, while the lowest wage rates were $16.22 per hour in the West South Central region.

- Benefits decreased from 2015 to 2016 with the national average at 20 percent in 2016 and 21 percent in 2015. In following trends with wage rates, the highest and lowest benefits were North Atlantic region at 24 percent and West South Central region at 14 percent.

- It is projected that between 2010 and 2020 that employment in the country’s healthcare sector will grow at a rate of 30 percent, which is more than double all other employment sectors. There will be a need for over 1.2 million new RNs in the United States during this time frame, with 400,000 new LPNs and 500,000 nurse aides.

NATIONAL AVERAGE FOR DIRECT ROUTINE SALARIES

$71 | 3%

per patient day

PROJECTION

30% GROWTH

between 2010-2020
Direct routine salaries (PPD)

Direct staffing hours
Direct staff – Average wage rates

Direct care average wage rates increased by 12 percent across all direct care positions:

- RNs 4%
- LPNs 25%
- CNAs 6%

Increases in average wage rates may be attributed to increases in wage levels or higher overtime utilization.
Benefits as a percentage of wages have begun to trend downward with a 1 percent decrease over 2015. The downward trend can be the result of cost-effective benefit solutions or rising wage levels.
Support staff wages increased on average by 2.3 percent, with laundry, housekeeping, dietary, and social services averaging around 3 percent.
About Plante Moran

**Firm at a glance**

- 1924 year founded
- 2,200+ professionals
- 20,000+ clients
- 24 offices in the United States and abroad
- 49 states
- 72 countries with clients
- 24,000+ clients
- 49 states with healthcare clients
- 42 years of experience in the healthcare industry as a firm
- 60+ trained professional staff who specialize in healthcare
- 200+ average years of healthcare industry experience per partner
- 26 senior care and living providers across the continuum
- 1,000+ states with healthcare clients

**Your one-stop shop**

Our audit, tax, and consulting professionals have a deep understanding of the risks, trends, and growth strategies impacting senior care and living providers today. Our clients benefit from our experience serving organizations of all sizes and structures all across the healthcare continuum.
Nationally recognized leaders

Publication contributions
Our team of nationally recognized thought leaders is committed to staying ahead of the curve. Our experts are regular contributing authors at national publications such as:

- MarketWatch
- McKnight’s Long-Term Care News
- Becker’s Hospital CFO Report
- Becker’s Hospital Review
- Senior Housing News
- STAT News

Conference and association participation
We are also sought-after presenters at numerous national and state healthcare industry associations and conferences, including:

- LeadingAge
- Lincoln Healthcare Leadership Events – SL100, LTC100, Post Acute 360

Key capabilities
Our audit, tax, and consulting experts can help you focus your organizational efforts to streamline processes, reposition services, evaluate partnerships, and consistently reduce costs and improve outcomes to reach your long-term goals.
Please contact us with any questions.

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