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Reimagining senior care
State of the Industry Report
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Key takeaways

Throughout this report, we share insights into ways senior care providers can reimagine their business models in the evolving senior care landscape.

These strategies fall into four areas:

Staffing & expense optimization

To attract and retain staff in today's tight labor market, look beyond wage increases. Consider outside-the-box benefits such as free childcare or a greater control of employee turnover and staffing agencies.

Revenue diversification

Explore population health strategies, such as institutional special needs plans (I-SNPs), to create new revenue streams while improving residents' quality of life.

Policy & funding

The providers that stay informed and prepared for the complex compliance requirements surrounding federal relief funds, including some potentially overlooked sources, create the best opportunity to maximize this funding and minimize potential downsides. If your organization hasn't already claimed the employee retention credit for 2020 or 2021, evaluate your eligibility today.

Perform operational assessments

Over the course of the pandemic, senior living owners and operators have found creative ways to repurpose common spaces to generate new revenue streams. Other providers, meanwhile, are taking advantage of a strong mergers and acquisitions market to explore potential combinations or divestitures.

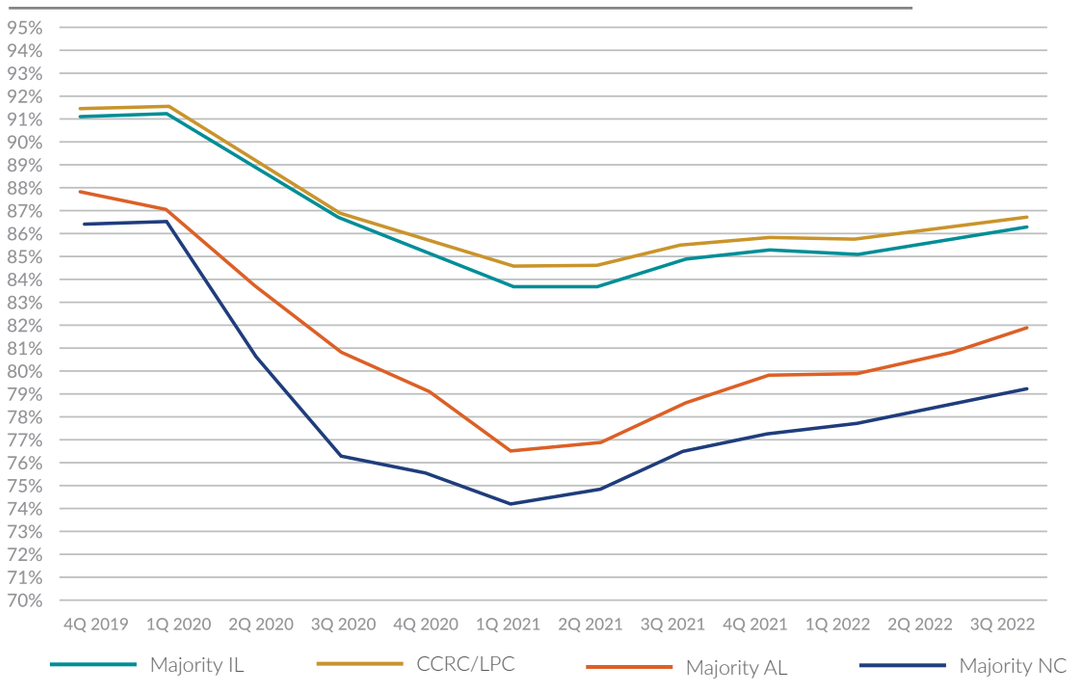
Introduction: The senior care landscape

In this year's report, we examine the current threats to senior care and long-term living providers — and insights to help them reimagine their business models in that changing landscape.

Until recently, declining occupancy was the most financially devastating toll of the COVID-19 pandemic for senior care and living providers. The good news is that occupancy has trended up from the lowest occupancy in the 1st quarter of 2021 through the 3rd quarter of 2022. Although, nationwide census is still short of pre-pandemic levels and the pace of full recovery remains uncertain.

Recovery is impacted by the number of new units that are still entering the market which is impacting overall occupancy levels, rising acuity levels which is increasing turnover and inflationary pressures slowing recovery.

Occupancy trends



Source: NIC MAP Data, Powered by NIC MAP Vision

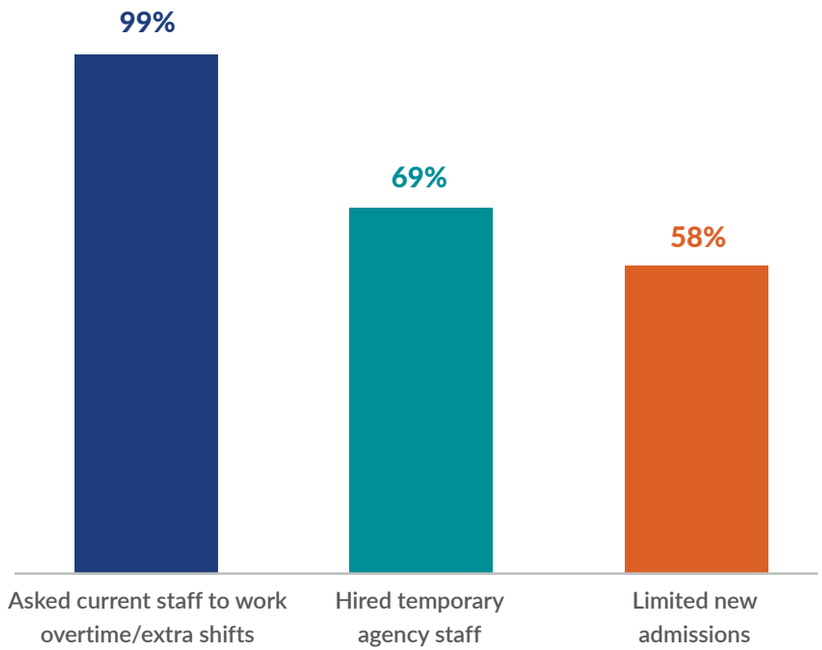
Staffing is the biggest limiting factor for senior care providers today. In a survey by the American Healthcare Association and National Center for Assisted Living (AHCA/NCAL), 58% of nursing home respondents said they were **limiting new admissions** due to staffing shortages, while more than three-quarters of nursing homes and 60% of assisted living facilities were concerned workforce challenges could **force them to close.**

Despite these significant ongoing challenges, long-term demographic trends present a hopeful long-term picture for senior care and living providers. The first baby boomers turn 80 in 2026, and this older cohort will more than double to 28 million in 2040. At the same time, the ratio of caregivers to the 80-plus population will drop, causing more seniors to need housing and care outside of their homes.

These demographic tailwinds are poised to drive long-term inventory growth for senior care and living. However, given the uncertainties facing senior care and long-term living providers, reaping the benefits of this long-term demographic boom will take perseverance and thoughtful strategic planning.

Read on for Plante Moran perspectives on ways to reimagine and future-proof your organization.

58% of nursing homes limiting new admissions due to staffing shortages



Source: American Health Care Association & National Center for Assisted Living, State of the Long Term Care Industry: Survey of nursing home and assisted living providers show industry-facing significant workforce crisis, September 2021.

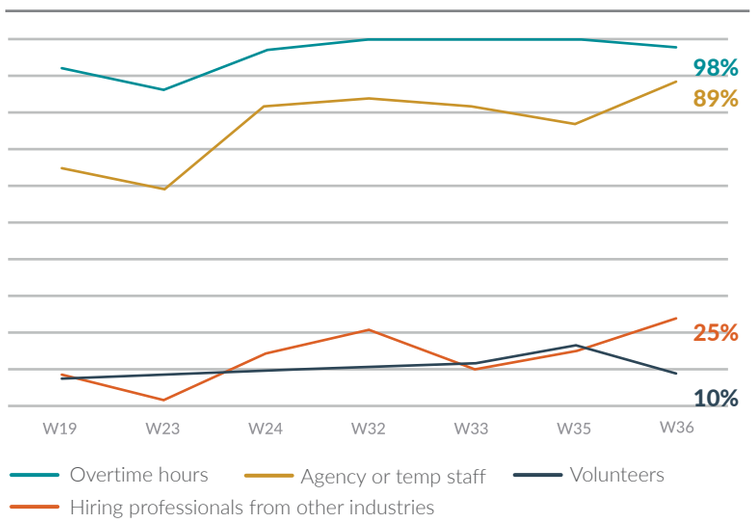
Expense & staffing optimization

Senior care and living providers are facing a twin pandemic, with the current staffing crisis compounding the effects of COVID-19. Nurse turnover rates rose to about 22% in 2021, up from 18% in 2019. Another 30% of RNs are considered "flight risks."

Nursing homes have been hit the worst of all healthcare sectors, as chronic Medicaid underfunding combined with overwhelming pandemic-related expenses have left them struggling to compete for qualified staff. Since the start of the pandemic, nursing homes have lost 15% of their total workforce — more than any other healthcare setting.

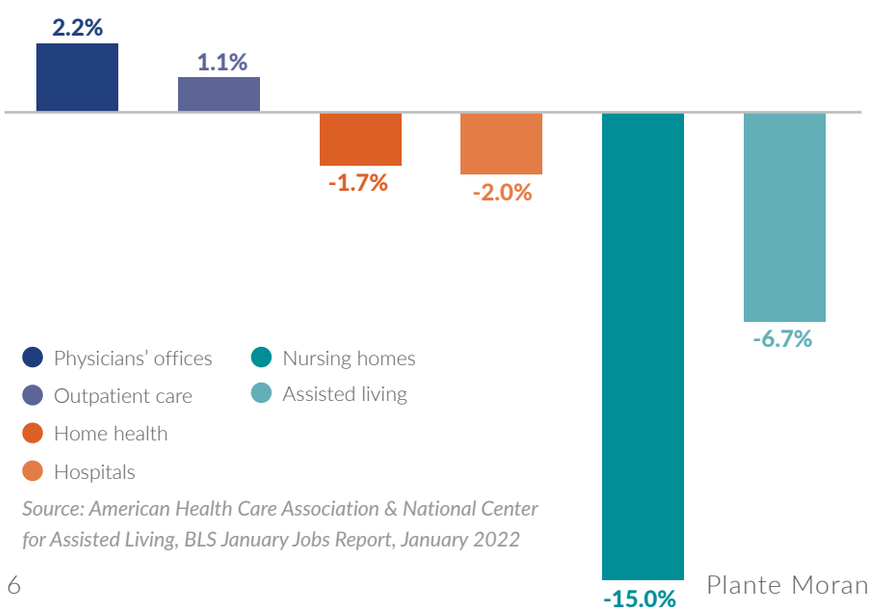
As a result of this severe staffing shortage, providers are almost universally asking employees to work overtime, and the vast majority are backfilling shortages with temporary staffing. A January 2022 NIC Executive Survey showed 98% of respondents were paying overtime and 89% using agency or temp staff. In April 2020, just 85% of respondents were paying overtime and 36% were using agency or temp staff.

How senior housing providers are tackling staffing shortages



Source: NIC Executive Survey Insights

Percent change in healthcare sector employment: February 2020 – January 2022



Source: American Health Care Association & National Center for Assisted Living, BLS January Jobs Report, January 2022

The growing reliance on temporary staff has driven dramatic increases in agency costs.

In hot markets, contract nurses can essentially name their price, particularly with the introduction of online platforms. One example is KARE, a platform that connects senior care and living providers with independent contractors, who set their own pay scale.

Competition for nurses is especially fierce. In 2021, registered nurse salaries increased about 4% to $81,376, according to a Wall Street Journal analysis of about 60,000 nurse salaries, excluding overtime and bonus pay. In 2020, nurse salaries increased 3.3% and in 2019, 2.6%.

Labor and contract disputes in a number of states are contributing to nationwide wage rate increases. In the face of possible strikes, a Connecticut health system settles on a $20 per hour minimum for certified nursing assistants (CNAs) and $30 for licenses practical nurses (LPNs). A landmark contract case in Oregon resulted in wage increases of as much as 30%, pushing minimum rates for CNAs to $18 per hour.

In addition to competing with deep-pocketed hospitals and health systems — some of which are offering nurses double-digit increases — long-term care providers are increasingly seeing caregivers jump ship to join staffing agencies, where they can often earn higher hourly wages while meeting their needs for flexibility.

There have been some innovative approaches to help providers alleviate the staffing crisis, such as a Minnesota initiative to recruit at least 1,000 new CNAs. AHCA and LeadingAge are advocating for Care for Our Seniors Act, which includes provisions to recruit and retain more long-term caregivers, as well as to enhance quality of care, oversight, and safety of facilities.

But for struggling senior care providers, these reforms could come too late. Most providers are spending government stimulus dollars to cover compensation increases, but given the rigid constraints of Medicaid reimbursement rates, the long-term viability of these higher wage rates remains murky at best. Given that wages and benefits accounted for about two-thirds of the typical senior care provider's cost structure pre-pandemic, these sharply increasing labor expenses aren't sustainable without an increase in Medicaid and Medicare reimbursement.

What to do now

During the pandemic, providers have been forced to operate in crisis mode, and many have gotten away from certain operational best practices. Providers need to step back and look at the business in a methodical way, considering how the landscape has changed and what strategies and approaches are available that weren't possible even five years ago.

Focus on current trends vs. a historical look-back

Review monthly dashboards to make sure you're focusing on what's important. Overall trends and patterns in things like overtime, nonproductive time, agency usage, resident acuity, and payor mix, are far more informative than looking back at historical financial performance.

Manage to the staffing grid

Many providers had gotten away from using staffing grids pre-pandemic because census was relatively stable. Consistent use of this fundamental tool can enable providers to set clear expectations upfront while maintaining the staffing ratios that are necessary to deliver the desired quality of care. As census and acuity in a unit fluctuates, following the unit's staffing grid allows everyone from nurse aids to RNs to know exactly what will be expected of them in terms of workload, while keeping administrators aware of the implications from a budget perspective.

Unit	Sample unit 1								
Census	Morning shift			Evening shift			Night shift		
	RN	LPN	CNA	RN	LPN	CNA	RN	LPN	CNA
26	1	1	3.5	1	0.5	3.5	1	0	2
25	1	1	3.5	1	0.5	3	1	0	2
24	1	1	3	1	0.5	3	1	0	2
23	1	1	3	1	0.5	2.5	1	0	2
22	1	1	3	1	0.5	2.5	1	0	2
21	1	1	2.5	1	0.5	2.5	1	0	2
20	11		2.5	1	0.5	2	1	0	2

Renegotiate or terminate vendor contracts

As census has decreased, have you reevaluated the terms and conditions of your vendor contracts? Should you bring some ancillary or other services in-house, such as dietary or laundry? Or are there opportunities to repurpose those services to generate a new revenue stream?

Review or create a written emergency preparedness plan

We have experienced multiple COVID-19 variants and most likely multiple outbreaks. If an outbreak occurred in one of your buildings tomorrow, does everyone know what to do? Do you have a written emergency plan that details everything that needs to happen, from isolation of sick residents to calling in emergency support from local hospitals or the National Guard? Who will notify families? Who deals with the press? What are your policies regarding staff who test positive for COVID-19 but are asymptomatic? Administrators may intuitively know the answers to these questions, but a written plan increases the likelihood that it will be implemented as intended.

Consider outside-the-box benefits

Wage increases aren't the only way to retain employees. Growing numbers of employers are boosting loyalty by addressing their employee's biggest pain points, such as access to childcare. In 2021, 85% of parents spent at least 10% of their total annual income on childcare, up from just 72% of parents who said the same in 2020. Senior care providers can consider repurposing unused facility space, securing a discount from a local daycare to accept employees' children, or even partnering with other employers to create a daycare cooperative. Providers might also consider offering free meals for employees to take home or even repurposing underutilized buses to offer free transportation. These additional benefits may be less expensive than agency, turnover, and recruiting costs.

Create your own staffing agency

Providers are motivated to reduce their dependence on staffing agencies for good reason. Temporary staff lack knowledge of internal procedures and protocols, and they don't have established relationships with the residents, many of whom struggle with dementia and can experience detrimental effects from staff turnover. Some senior living providers are addressing these quality concerns and managing staffing costs by partnering with sister facilities to create internal nursing pools. By establishing a pool of nurses shared across facilities, providers achieve consistency in staffing when reining in staffing costs.

Self-fund health insurance

Skyrocketing labor costs have changed the cost-benefit calculation when it comes to offering health insurance. Today, new cost containment options, such as self-funded medical plans, allow small and midsized providers to deliver benefits to employees in a cost-effective, efficient way. While self-funded plans don't always save significant costs in the first year, incremental savings typically add up to bend the healthcare cost curve and lead to long-term savings. *(See case studies to the right).*

Organizations that self-fund their medical plans save, in part, due to lower taxes and fees. But the more significant savings come from contracting with specialty vendors that provide targeted services, such as pharmacy benefit managers and cancer care coordination. These specialty vendors operate far more efficiently and in a more transparent way than the large, all-in-one health insurance carriers. Employers that switch to self-funded plans often reduce their pharmacy spend by 20 to 30% per year.

Many of these self-funded health plans also drive savings by offering concierge-type services to help employees navigate the complex healthcare delivery system. Healthcare navigators connect members with the level of care they need when they need it, while also advocating on the member's behalf. The ability to engage the person early on and direct them to appropriate resources helps lower employers' overall cost of healthcare.

Examples of savings from self-funded health insurance plans

EMPLOYER A

LOCATION
Columbus, Ohio

EMPLOYEES ON PLAN
75

THE CHALLENGE
Healthcare costs had increased 100% over a three-year period. The insurance carrier suggested "large" claimants were driving increased costs but refused to provide supporting data.

THE SOLUTION
Self-insured medical plan used a group captive to manage the overall risk.

THE RESULTS
With access to actionable claims data, the employer's costs dropped 30% within nine months, resulting in savings of about $180,000.

EMPLOYER B

LOCATION
Southeast Michigan

EMPLOYEES ON PLAN
60

THE CHALLENGE
The company's highly loyal and aging employee base was contributing to annual health insurance cost increases of 12 to 16% per year on their fully insured plan.

THE SOLUTION
To control costs without shifting those costs to employees, the employer switched to a self-insured open-access health plan. The company used its projected savings to provide employees with an advocate and legal support to help negotiate billing disputes.

THE RESULTS
Hospital discounts averaged 65.4% over four years — far greater than the discounts of 45 to 50% promised by traditional insurance carriers. Over that four-year period, the employer saved about $700,000 compared to what it would've paid on the fully insured plan.

Revenue recovery & diversification

The pandemic has changed the revenue drivers for skilled nursing providers.

Post-acute care, which nationally has tended to be less than 25% of patient days of care but has been the lifeblood of financial viability, has been hit hard — first, by a sharp decline in elective surgeries and overall declines in utilization across many types of care, as well as a strong preference for home-based rehabilitation.

These trends drove a steep decline in post-acute care utilization. The percentage of patients discharged to SNFs from hospitals **declined five percentage points** from its 2019 average to just 14% in October 2020, according to a study of more than 70 million commercially insured individuals, including Medicare Advantage (MA) beneficiaries. Use of SNFs for post-acute care declined to **51% of the pre-pandemic rate**, from an average of 324 admissions per 100,000 insured members to 167 admissions per 100,000. As a result, SNFs saw their **share of post-acute spending drop eight percentage points**. *(See chart.)* The study's authors state that these trends point to "a fundamental shift in providing post-acute care at home, rather than in nursing homes."

	2019 average	October 2020
% of patients discharged to SNF	19%	14%
SNF use	324 admissions per 100,000 insured members	167 admissions per 100,000 insured members
Share of post-acute spending	39%	31%

Rachel M. Werner and Eric Bressman, "Trends in Post-Acute Care Utilization During the COVID-19 Pandemic," Journal of Post-Acute and Long-Term Care Medicine 22, no. 12 (December 2021): 2496-2499.

Will this shift to home last? The answer largely depends on whether lawmakers strengthen the home health benefit, which has shrunk over the course of the last decade. But the pandemic could represent an inflection point, given the imperative to reduce infection rates.

The Choose Home Care Act of 2021 proposes to supplement the traditional Medicare home health benefit with expanded services, including transportation, meals, home modifications, remote patient monitoring, telehealth services, and personal care services. Some industry leaders have expressed concern that the bill would limit options for Medicare beneficiaries, but others in the SNF community see advantages in creating incentives for more SNFs to offer at-home services.

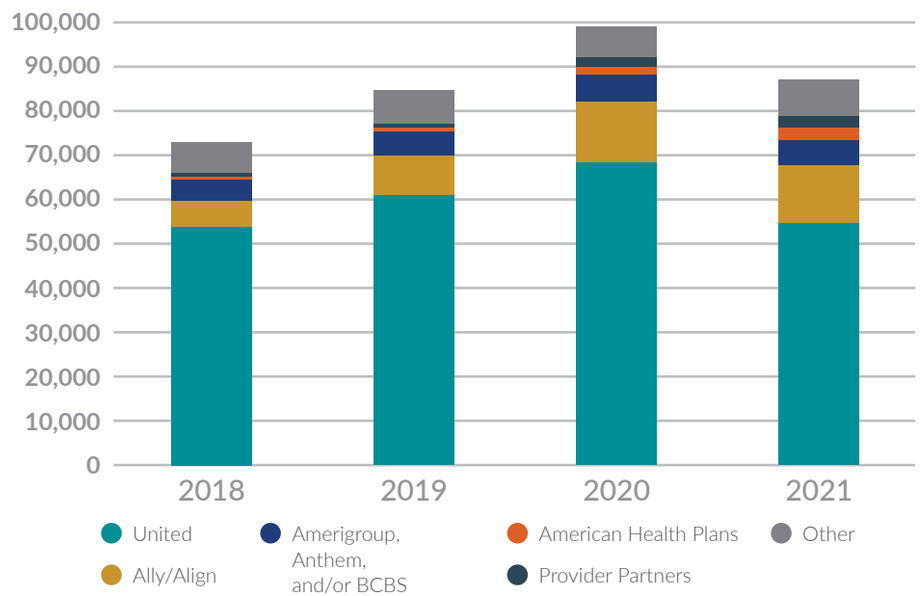
Meanwhile, the number of Medicare Advantage plans offering home care as a supplemental benefit is on the rise, although managed care plans cap the benefit at a very low level (around 60 hours).

Whether you see home care as a complement or a competitor, all of these factors cast a specter of doubt on the long-term financial viability of the transactional, post-acute care side of the business.

New revenue streams for long-term care business

Given the decline in utilization of post-acute care, SNF owners and operators are understandably turning their attention to how to make the long-term care side of the house more attractive to residents and financially viable for the long haul.

Enrollment growth in all I-SNPs by affiliation/parent organization, 2018–2022



Source: Integrated Care Resource Center, CMS SNP Comprehensive Report, February 2018, 2019, 2020, and 2021.

Population health strategies carry the potential for long-term care operators to create new revenue streams while improving residents' quality of life. One of these options is the **institutional special needs plan (I-SNP)**, a Medicare benefit for residents of long-term care institutions. Enrollment in I-SNPs saw strong growth in the years leading up to the pandemic. And while enrollment growth slipped in 2021, these plans remain one of the best vehicles for providers of long-term care to embrace first.

I-SNPs: A primer

What is an I-SNP?

A special needs plan (SNP) is a MA plan targeted to a specialized population. Institutional special needs plans (I-SNPs) target older, more frail residents who live in a long-term care setting. CMS requires each I-SNP to have a model of care, which spells out how the plan will take care of the beneficiary.

What does an I-SNP cover?

Typically, these all-in-one plans cover all traditional Medicare inpatient and outpatient services as well as prescription drugs. Each member is stratified into a risk level, which determines their individual care plan. In a SNP, certain encounters aren't subject to the same medical necessity requirements as traditional Medicare, which means the beneficiary can receive more frequent visits. I-SNPs are also permitted to provide additional benefits that aren't included as part of traditional Medicare.

What are the advantages of an I-SNP?

Residents gain better care coordination provided to them by the place they have chosen as their home, as well as customized benefits that are tailored to nursing home residents.

Nursing home owners and operators benefit from a new revenue stream associated with the I-SNP contract. In addition to a monthly fixed payment to help coordinate the care of the beneficiary, the nursing home also has opportunities to share in savings from managing the resident's overall care costs, including hospitalization. Nursing homes can choose from a range of options that entail different levels of risk and reward. Some providers even establish their own I-SNPs.

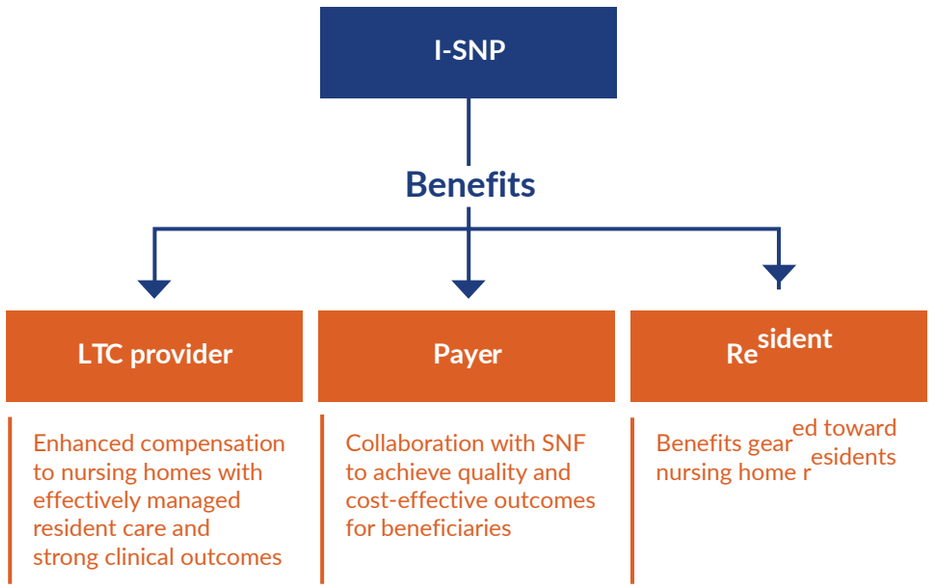
Most importantly, the I-SNP will partner with the facility to strengthen clinical competencies that will help to avoid unnecessary hospitalizations and emergency department visits. This benefits residents and will also help facilities prepare for the continued growth of value-based contracts.

Providers should take time to understand the range of risks and opportunities entailed by these programs. The I-SNP and the nursing home both benefit when the total cost of the resident care is managed effectively and the clinical outcomes are strong.

Skilled nursing providers also have opportunities to build on the momentum to provide more healthcare services in the home. Two population health programs create opportunities to provide nursing home services "without walls."

An institutional equivalent SNP (IESNP) is designed for residents who live in their homes or in assisted living communities but require an institutional level of care (LOC). A determination of institutional LOC is based on the use of the same state assessment tool that's used for individuals residing in an institution. The assessment must be administered by an independent, impartial party with the professional knowledge to identify the institutional LOC needs. IESNPs may be appropriate for life plan communities and assisted living providers. In addition, skilled nursing providers that have experience with I-SNP are considering how to leverage that model into other settings with IESNPs.

Program of All-inclusive Care for the Elderly (PACE®) is an integrated care program for nursing home-eligible residents that have both Medicare and Medicaid benefits and who can live safely at home. The PACE model of care has been around since the 1970s, but the high cost of building and regulating PACE centers has been a limiting factor in their growth. Success with PACE is greatly correlated to state Medicaid payment rates. There are some compelling reasons why senior care and living providers should weigh the benefits of a PACE program. During the pandemic, the model proved a successful alternative to skilled nursing care, with PACE providers pivoting almost overnight to home-based services. In response to pandemic success, and increased funding for home and community-based services, many states are looking to expand PACE programs.



Optimizing existing revenue streams

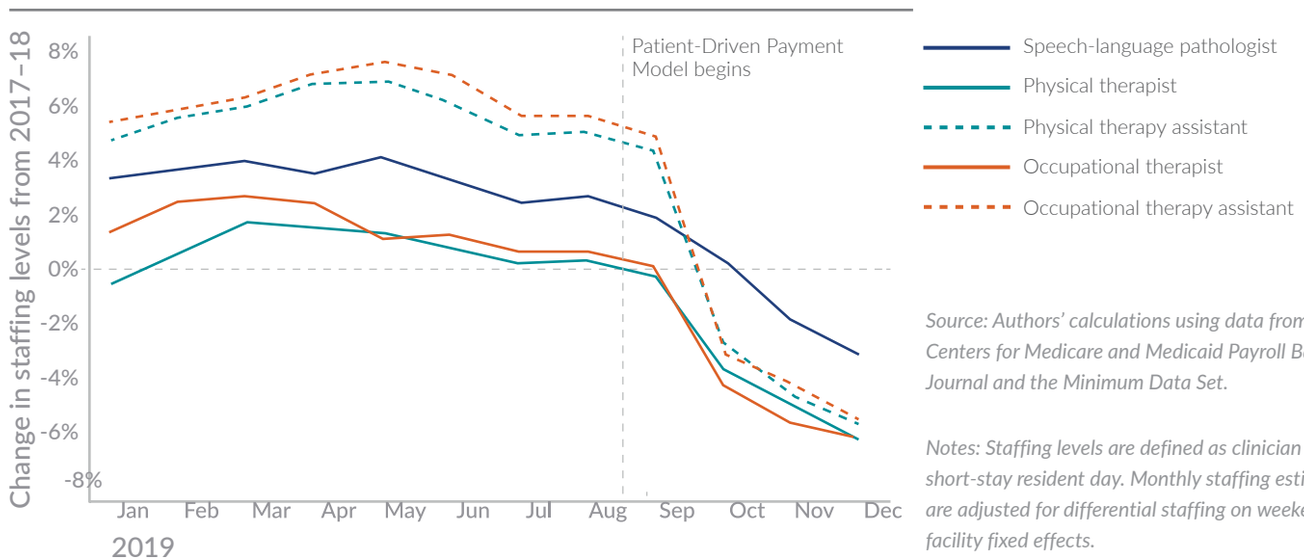
Long-term care providers also must find ways to optimize their existing revenue streams.

The most significant change in Medicare payment methodology in 20 years, the **Patient-Driven Payment Model (PDPM)** was initially viewed by the industry with some trepidation. However, PDPM so far has been overwhelmingly positive for skilled nursing providers, who have seen average increases of 5 to 10% over previous reimbursement rates.

The COVID-19 pandemic, which hit only five months after PDPM was implemented, has been a significant factor in driving higher reimbursement rates, as PDPM rates are higher for patients with greater clinical needs. Since PDPM was designed to be budget-neutral, skilled nursing providers should prepare themselves for a possible reckoning in fiscal year 2023.

Providers also are seeing significantly reduced therapy services. Total therapy minutes per patient-day declined sharply following PDPM implementation, followed by more gradual declines over the next six months for a total decline of 14.7% by the end of March 2020. Physical and occupational therapy disciplines experienced roughly parallel declines. *(See chart below.)*

Therapy decline due to transition to PDPM



Source: Authors' calculations using data from the Centers for Medicare and Medicaid Payroll Based Journal and the Minimum Data Set.

Notes: Staffing levels are defined as clinician hours per short-stay resident day. Monthly staffing estimates are adjusted for differential staffing on weekends and facility fixed effects.

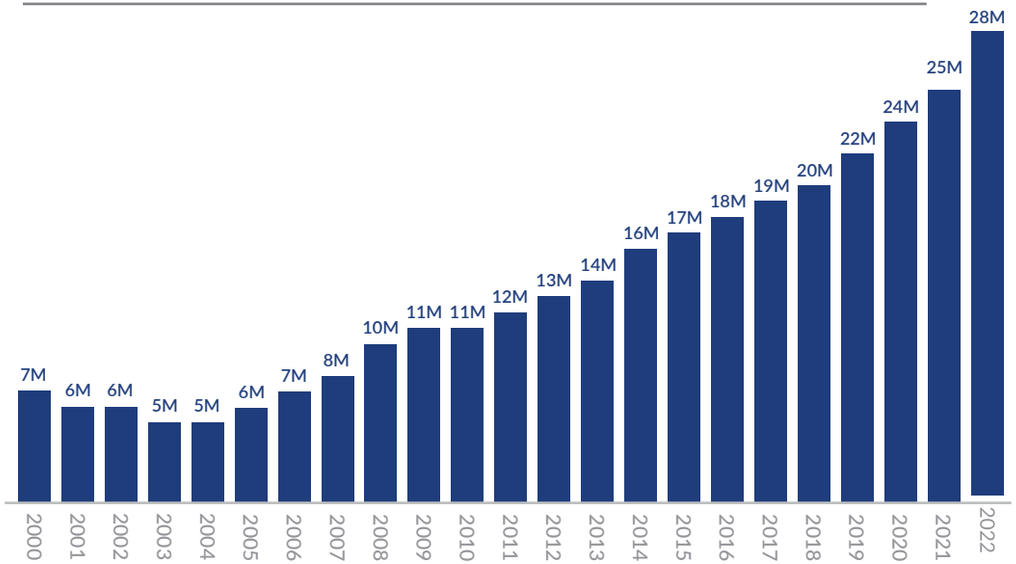
SNFs must engage in ongoing monitoring to ensure these therapy reductions don't have negative implications for patients. However, the reduced staffing costs have been welcome at a time when staff is in short supply and nearly every other expense has escalated significantly.

To achieve optimal PDPM rates, SNFs should:

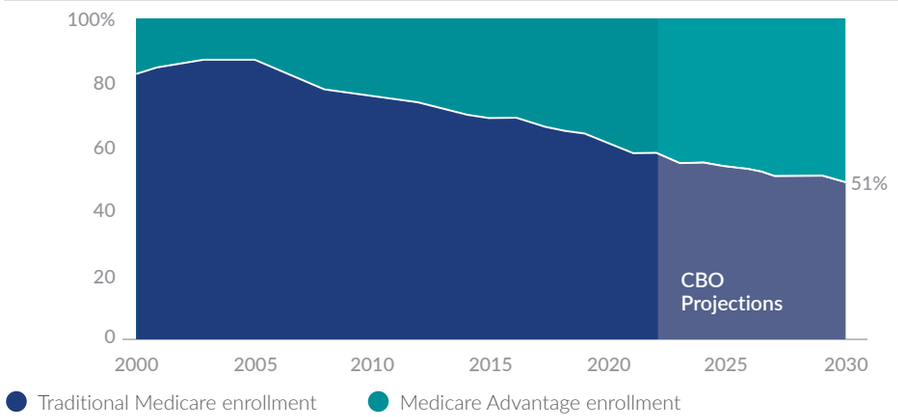
- **Focus on accurate capture and coding of each patient's entire clinical diagnoses.** Take the time to revisit training and processes that were put in place when PDPM was first implemented. Given today's staffing shortage, overwhelmed MDS nurses might overlook some of a patient's clinical diagnoses at admission. For example, speech language pathology requires close coordination between the dietary and speech departments, and lack of communication between those departments can hurt reimbursement.
- **Monitor your region's average PDPM rate.** If your organization's rates differ significantly from those averages, investigate whether there are opportunities to capture more detailed information to increase those rates.
- **Review any Medicare Advantage contracts.** Some MA plans have adopted Medicare's reimbursement methodology, so optimizing the PDPM rate can have a beneficial effect on multiple revenue streams.

The past two decades have seen a steady shift from traditional Medicare to MA. In 2022, Medicare Advantage plans had more than 26 million enrollees — about 42% of the total Medicare population and 46% of total Medicare spending. On the current trajectory, MA enrollment will be higher than the traditional Medicare rolls by 2030.

Total Medicare Advantage enrollment, 2000–2022



Medicare Advantage & traditional Medicare enrollment, past & projected



Source: KFF, Medicare Advantage in 2021: Enrollment Update and Key Trends, June 21, 2021

Perhaps most astonishing is the fact that the average Medicare beneficiary in 2021 could choose among 33 MA plans, which means that providers are keeping track of a staggering array of claim criteria, reimbursement rates, submission processes, and billing time frames.

Optimizing managed care reimbursement from MA or other commercial plans comes down to three things:

- **Cost containment.** Make sure you're managing your ancillary costs for the managed care individual. Therapy is a huge cost area for both Medicare and managed care. Each plan has different requirements for therapy delivery. Whereas one plan might require 80 minutes of therapy per week, another requires 100 minutes. With the conversion to PDPM, many administrators aren't placing the same level of priority on tracking therapy minutes, but keep in mind that oversights can lead to denied claims and underpayments.
- **Understanding your organization's financial performance.** Providers need to clearly understand each plan's requirements and how their actual costs (routine and capital costs from Medicare cost report plus ancillary costs, such as therapy, pharmacy, lab, and X-ray) compare to the managed care rates. Many providers will find that the managed care rates are lower than their actual costs. Armed with this information, they can make informed decisions about renegotiating or terminating these unprofitable plans.
- **Annual contract renegotiations.** While it can be all too easy for overwhelmed administrators to let contract renewal periods slide, a provider's long-term financial health depends on regular evaluation of contracted rates. Come to the negotiating table armed with research on market rates and your cost to provide services under these contracts.

Pandemic financial performance: How bad was it?

Overall financial performance of the SNF industry is regularly evaluated by various stakeholders, primarily using public data provided on Medicare cost reports. These reports are filed five months after a provider's year-end and aren't available for public analysis until several months after that.

The Medicare Payment Advisory Commission (MedPAC) reported findings in March of 2022 that reflected an industry "all payer" net margin. Aggregate Medicare margins also increased from 11.9% in 2019 to 16.5% in 2020. These findings informed its recommendation to reduce SNF payment rates in fiscal year 2023.

While this margin growth may seem hard to believe, keep in mind that the financial impacts of the pandemic have unfolded in waves. For example, census drops were most dramatic late in 2020, whereas labor costs rose steeply throughout 2021. MedPAC acknowledged that the improvement in margin was largely due to both federal and state public health emergency funding.

Also consider that individual providers experienced the pandemic's financial impacts at varying rates and time periods that may not align to the overall trends. There has also been significant variation in the timing and amount of federal relief funds, state Medicaid, and other assistance.

We expect that 2021 cost report data will reflect significantly lower industry all payer and Medicare margins, reflective of continued slow census recovery and the rising cost of labor. Individual facility results will continue to vary widely, particularly for entities that have been able to file for payroll protection program loans and employee retention credits.

How does my organization compare?

In prior reports, we have provided extensive historical benchmarks on revenue drivers and operating costs. Given the impact of the pandemic, benchmarking current key performance indicators can be far more informative than looking back at historical data. While it can be a challenge to find current benchmarks, two reliable sources of benchmarking data for SNFs include:

- The National Healthcare Safety Network (NHSN) database, which was expanded during the pandemic to include the reporting of weekly census information.
- Payroll-based journal data published by CMS, which provides insight on competitor staffing levels.

As you benchmark your financial performance against peers in your market and seek ways to optimize current revenue streams, be sure to learn about the risks and opportunities of population health strategies with the potential to create new sources of revenue while improving residents' quality of life.

Policy & funding

Healthcare providers received billions of dollars in federal relief money beginning in early 2020 and continued through 2022. These funds were critical for providers to navigate the disruption to their operations, but they came with strings attached.

Provider Relief Fund

The $178 billion Provider Relief Fund (PRF) initially gave Medicare-enrolled healthcare providers grants that amounted to at least 2% of their 2018 annual patient revenue, which could be used to cover lost revenue and unreimbursed expenses attributable to COVID-19. Several additional rounds of general distribution and targeted funding followed.

These funds are being administered by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) and have been released in four separate phases.

Although technically a separate bucket of funds, the American Rescue Plan (ARP) Rural payments were announced at the same time as the $17 billion PRF Phase 4, and many providers were eligible for both. Be aware that ARP Rural payments are subject to their own terms and conditions, including a stipulation that the funds can only be used by the recipient provider (i.e., not shared with other subsidiaries or with its parent company).

Recipients are subject to both reporting and compliance audit requirements.

Reporting requirements

PRF recipients that received one or more payments during a payment-received period that exceeds $10,000 in aggregate are required to report HRSA by the end of the reporting time period associated with the date in which they received payments.

PRF payments may be used during the period of availability to reimburse recipients for allowable expenses. *(See chart.)*

Period	Payment Received Period	Period of Availability (Use by date in bold)	Reporting Time Period
Period 1	April 10, 2020 to June 30, 2020	Jan. 1, 2020 to **June 30, 2021**	July 1, 2021 to Sept. 30, 2021
Period 2	July 1, 2020 to Dec. 31, 2020	Jan. 1, 2020 to **Dec. 31, 2021**	Jan. 1, 2022 to March 31, 2022
Period 3	Jan.1, 2020 to June 30, 2021	Jan. 1, 2020 to **June 30, 2022**	July 1, 2022 to Sept. 30, 2022
Period 4	July 1, 2021 to Dec. 31, 2021	Jan. 1, 2020 to **Dec. 31, 2022**	Jan. 1, 2023 to March 1, 2023
Period 5	Jan. 1, 2022 to June 30, 2022	Jan. 1, 2020 to **June 30, 2023**	July 1, 2023 to Sept. 30, 2023
Period 6	July 1, 2022 to Dec. 31, 2022	Jan. 1, 2020 to **Dec. 31, 2023**	Jan. 1, 2024 to March 31, 2024
Period 7	Jan. 1, 2023 to June 30, 2023	Jan. 1, 2020 to **June 30, 2024**	July 1, 2024 to Sept. 30, 2024

Note that providers that received funds during multiple phases are responsible for reporting in multiple periods, and these reports are subject to audit by HRSA.

It is important to note that many organizations are receiving correspondence from various oversight agencies on this reporting already. Because of the varied nature of the correspondence being seen, we recommend each organization to carefully understand what is being requested and act promptly. Consider assistance from your business advisor if you have any questions.

Audit requirement

In addition to reporting to HRSA how the funds were spent, recipients who expended a total of $750,000 or more in federal funds, including PRF payments and other federal financial assistance, during the fiscal year are required to have a compliance audit on those federal expenditures. This audit report is due the earlier of 30 calendar days after the audit is complete.

The type of compliance audit to be performed will likely depend on whether a provider is a not-for-profit (nonfederal) entity or commercial (for-profit) entity.

Commercial organizations have two options for their audit requirement:

1. A financial-related audit in accordance with Government Auditing Standards.

2. An audit in conformance with the requirements of 45 CFR Section 75 Subpart F.

Whereas single audit guidance is well-established, HRSA has deferred to the accounting profession to decide the basis of accounting that will be sufficient to complete a financial-related audit in accordance with Government Auditing Standards. In response, the American Institute of CPAs Governmental Audit Quality Center issued a practice aid covering HHS audit requirements for-profit entities with awards from the PRF program in February 2022. The practice aid provides frequently asked questions, illustrative schedules, notes, and auditor reports to assist auditors of for-profit entities subject to HHS audit requirements.

Employee retention credit

Because of its short lifespan and frequent modifications, some employers may have missed opportunities to claim the employee retention credit (ERC). There are many moving parts when it comes to accurately calculating the value of the credit for a business, as well as big-picture eligibility considerations that can affect members of aggregated groups.

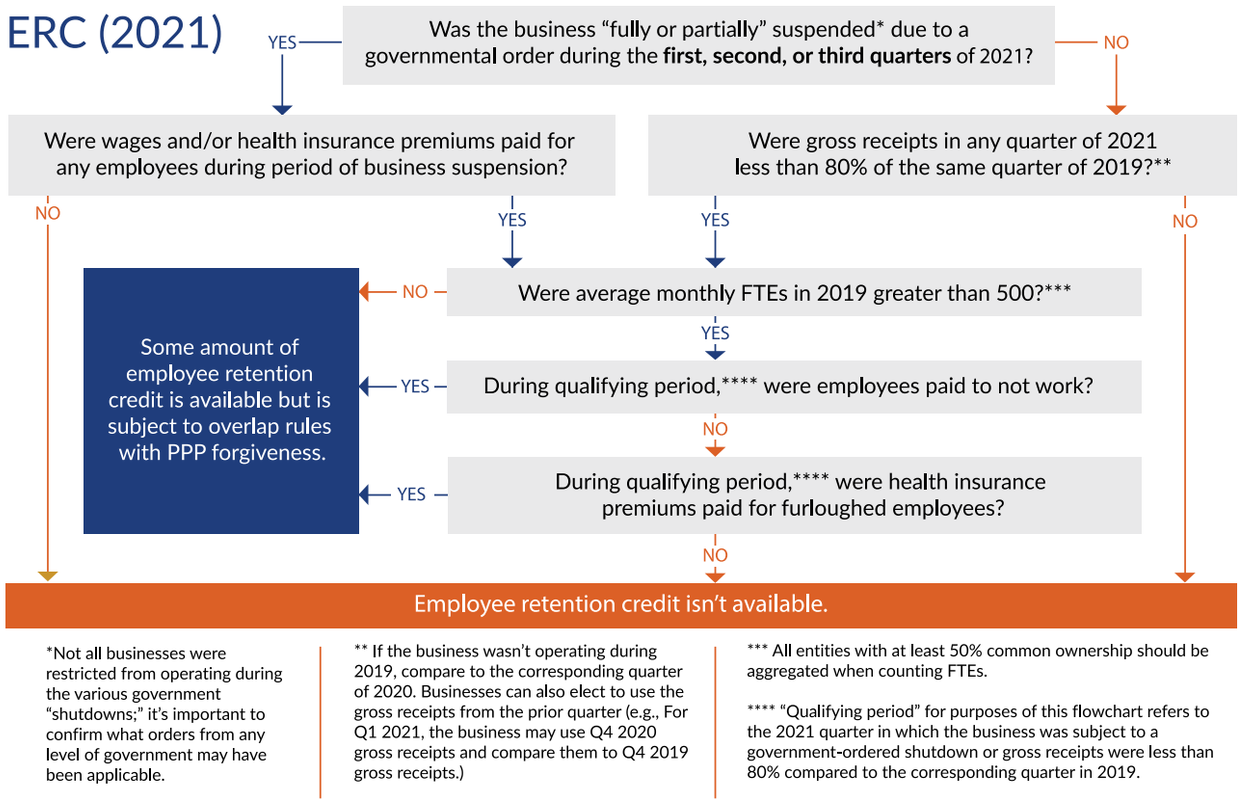
Make sure you consult with your tax advisor to learn whether an opportunity exists for your facility to file a retroactive claim. The Infrastructure Investment and Jobs Act accelerated the expiration of the ERC to Sept. 30, 2021, but qualifying organizations still have an opportunity to amend previous payroll tax filings to claim the credit.

Qualifying for the ERC results in a refundable credit of a significant portion of wages and health insurance paid. Initially created by the Coronavirus Aid, Relief, and Economic Security (CARES) Act, the ERC was enhanced by the Consolidated Appropriations Act in December 2020 and the American Rescue Plan Act in March 2021. These midstream modifications made the ERC more attractive in a few ways:

1. Employers are now able to **claim ERC on any wages not used to support PPP loan forgiveness**. Because employers initially weren't able to claim both — and the PPP was generally more lucrative and also fully forgivable — many companies opted to pursue a PPP loan and forego the ERC.
2. The ERC is most lucrative for "small employers." The definition of a small employer became more accessible by changing 100 full-time employees (for the 2020 ERC) to 500 full-time employees (for the 2021 ERC).
3. Employers have a lower quantitative threshold for 2021 — a **decline of 20% or more in gross receipts** for the quarter as compared with the corresponding quarter in 2019. For 2020, that threshold was 50%. As has always been the case, businesses that don't meet the quantitative gross receipts threshold may otherwise qualify for the ERC through a more qualitative measure; namely, if you determine that the business was partially or fully suspended due to government orders (more than nominal impact).
4. The credit is worth more in 2021.
   - For 2020, the credit is equal to 50% of up to $10,000 in eligible wages per employee for the year, or **$5,000**.
   - In 2021, the credit increases to 70% of $10,000 in eligible wages per employee in each eligible quarter, for a potential credit of **$21,000** if an entity qualified for all three quarters in 2021.

Senior living providers that have not already claimed the ERC should evaluate their eligibility. Although the provision has expired, new claims may still be filed for prior quarters via an amended 941 (Form 941-X) for such quarters. Generally, businesses can claim the refundable credit by filing an amended form within three years of the date the original was filed or two years from the date the tax reported on the original return was paid, whichever is later.

Senior living providers that don't qualify on the basis of the quantitative decline in gross receipts could possibly qualify due to the impact of government orders that fully or partially suspended their operations. For example, providers may have been subject to pandemic-related orders from the Centers for Medicare and Medicaid Services (CMS), as well as state and local health agencies that negatively impacted operations.



*Not all businesses were restricted from operating during the various government "shutdowns;" it's important to confirm what orders from any level of government may have been applicable.

** If the business wasn't operating during 2019, compare to the corresponding quarter of 2020. Businesses can also elect to use the gross receipts from the prior quarter (e.g., For Q1 2021, the business may use Q4 2020 gross receipts and compare them to Q4 2019 gross receipts.)

*** All entities with at least 50% common ownership should be aggregated when counting FTEs.

**** "Qualifying period" for purposes of this flowchart refers to the 2021 quarter in which the business was subject to a government-ordered shutdown or gross receipts were less than 80% compared to the corresponding quarter in 2019.

Lease accounting standards

After many years of discussion and delays, the new lease accounting standard (ASC 842) are finally here, effective for calendar years ending in 2022, and in fiscal years ending in 2023 for all organizations that report under U.S. GAAP.

ASC 842 requires companies to recognize all finance and operating lease assets and liabilities on the balance sheet, which could impact financial ratios (debt service coverage, debt to equity, cash to debt, etc.) and put healthcare providers at risk of violating debt covenants. In addition, the effect of adopting the new lease accounting standard could have an impact on how lenders evaluate debt capacity.

Providers should take the following steps to prepare for compliance with the new lease accounting standards:

- Inventory all operating leases, including embedded leases.
- Review debt agreements to determine what, if any, impact the new lease liabilities will have on debt covenants.
- Reach out to lenders to adjust or renegotiate covenant terms as needed.

Policy changes and federal relief money have been a critical lifeline for healthcare providers, but the many new and complex rules and requirements have created significant uncertainty and concern about whether some of those funds will need to be repaid. Senior care and living providers that stay informed of what's coming and work closely with their financial advisors to prepare will be best prepared to maximize this funding and minimize potential downsides.

Strategic asset planning

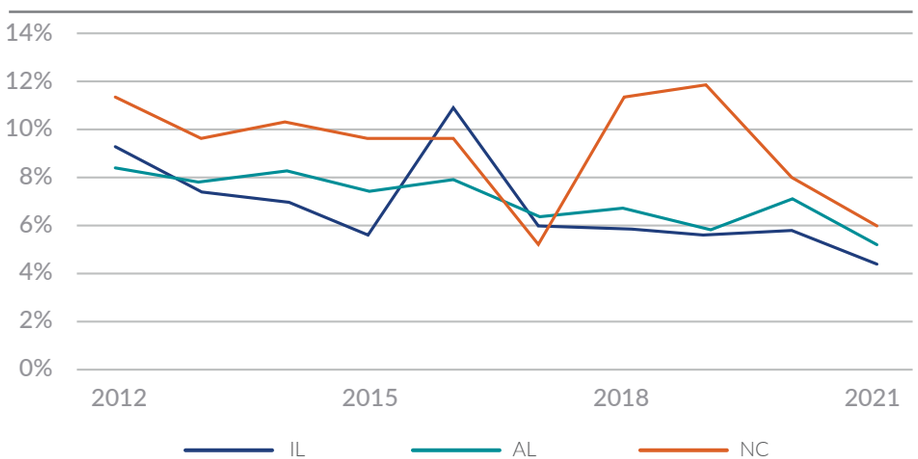
Asset planning in the age of the pandemic is complex, at best, for senior care and living providers struggling with occupancy and staffing challenges. As congregate living has faced considerable scrutiny, private rooms have evolved from a social desire to a medical need. A comprehensive review of research by consulting firm Health Management Associates on the impact of single-resident rooms versus multiresident rooms found that single-resident rooms are associated with decreased risk of facility-acquired infections, medication errors, resident anxiety, and incidence of aggressive behavior, as well as improved sleep patterns, sense of privacy, and satisfaction.

But transitioning to single-resident rooms takes capital that many struggling providers simply don't have. According to a Plante Moran analysis of 2019 data from two multifacility long-term care organizations, transitioning to single-resident rooms entailed operating cost increases of $16 to $25 per patient day, and ongoing capital cost increases of anywhere from $20 to $40 per patient day. Even in today's low-interest-rate environment, these added costs are out of reach for the average provider.

The good news is that those who can weather the immediate disruption and make strategic decisions for the future will benefit from favorable long-term demographic trends, which are attracting considerable investor interest in the senior care and living industry — especially at the lower end of the acuity scale.

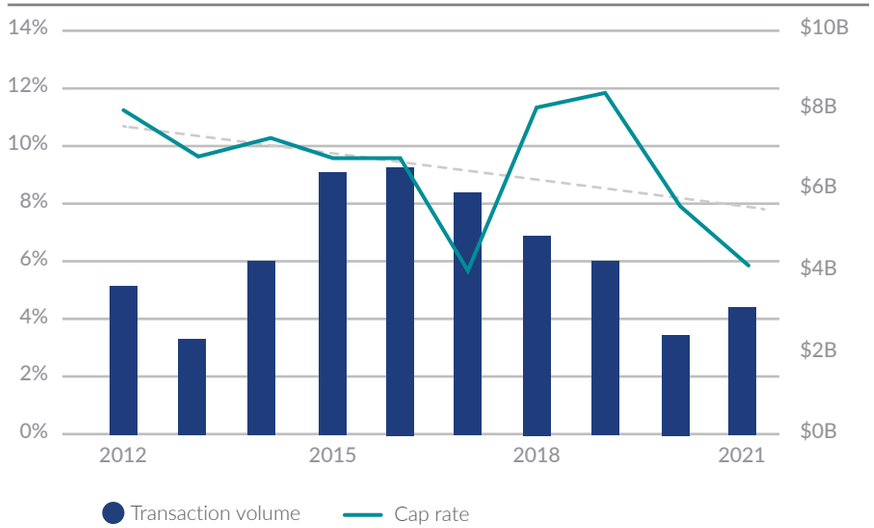
Investor sentiment continues to chase lower acuity senior housing, which is less dependent on healthcare operations and more dependent on services. Independent living has been the favored asset class for roughly the past decade, as can be seen in the relatively low capitalization rates. *(See charts, below.)*

#1: Cap rates for IL, AL, and NC, 2012–2021

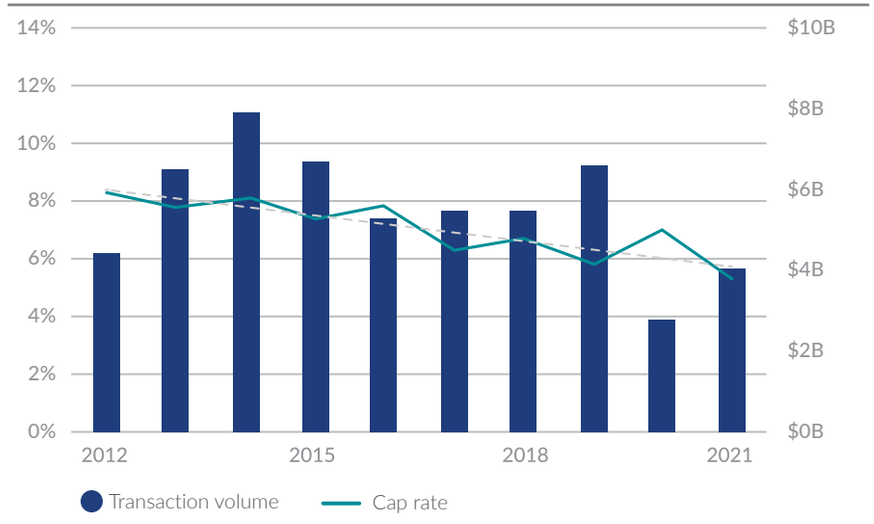


Source: NIC MAP Data, Powered by NIC MAP Vision

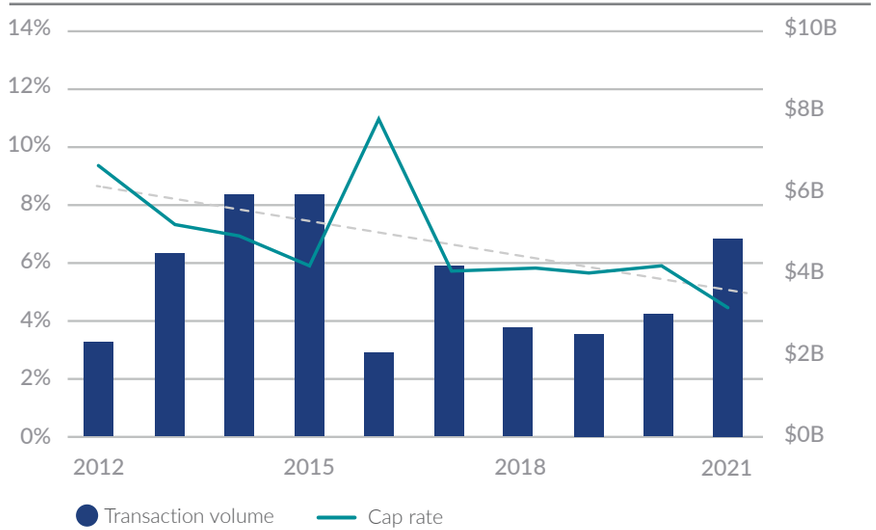
#2: Skilled nursing trends in cap rates & transaction volume, 2012–2021



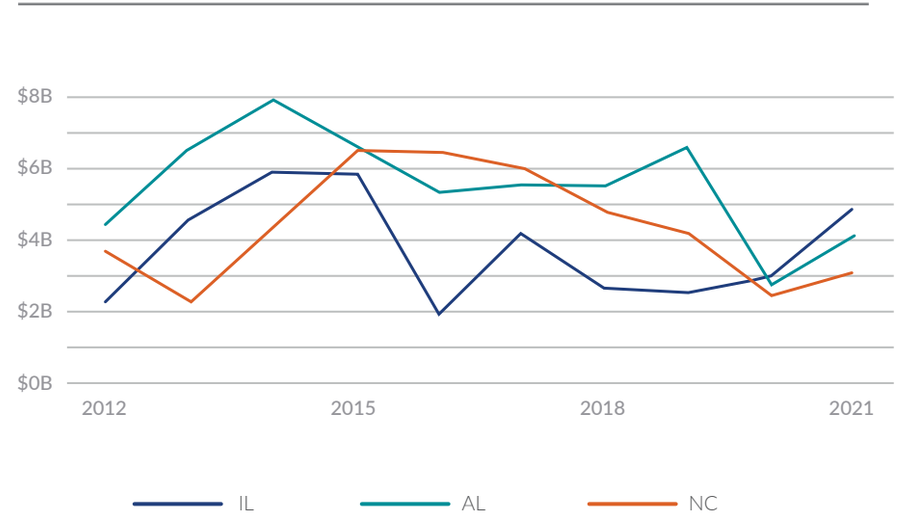
#3: Assisted living trends in cap rates & transaction volume, 2012–2021



#4: Independent living trends in cap rates & transaction volume, 2012–2021



#5: Transaction volume for IL, AL, & NC, 2012–2021



Source for graphs: NIC MAP Data, Powered by NIC MAP Vision

Independent living also has experienced more rate compression than the other asset classes over the past decade (note the converging grey and orange lines), indicating that pricing for IL facilities is increasing faster than the decline in the overall risk-free rate. This trend shows no signs of reversing. In fact, a new and even lower acuity asset class has emerged in the last few years. The active adult (senior age-restricted apartments) segment is already priced even more aggressively than independent living.

While many senior living owners are taking advantage of this growing investor appetite by putting their own properties up for sale, others are reticent to sell, fearing that a consolidator will change the culture and lead to detrimental effects for residents and staff. While dedication to staff and residents is commendable, owners should keep some things in mind:

- Selling might, in fact, be the best way to fulfill the organization's mission, since well-capitalized groups are better positioned to make the kinds of investments that will result in more consistent staffing, better care, and improved quality of life for residents. Sell-side due diligence typically includes evaluating the purchaser's operating philosophy and expertise to maintain quality of care. *(See the list of questions to the right.)*
- You remain in the driver's seat until a transaction is final. Even if you ultimately decide not to sell, there's nothing quite like collecting actual offers to discover what your facility is actually worth. But there are downsides as well, especially if staff and residents prematurely get wind of the M&A discussions.

Before approaching the negotiating table, both buyers and sellers of senior living properties are wise to consider the following key questions:

- To what degree has deferred maintenance created underlying liabilities?
- What are the market conditions (demographics, level of competition, hospital relationships)? Consider undertaking a market study to determine demand for and supply of senior living in the local market area.
- How healthy is the facility's revenue cycle? Does it have any problems with collections?
- How heavily is the facility relying on staffing agencies?
- Does the acquirer have the operational expertise to maintain quality of care?

Opportunities in strategic asset planning

In addition to exploring potential combinations or divestitures, senior living owners and operators are finding creative ways to use existing space to enhance resident socialization and offer more options while keeping residents safe. These were among the most important issues for residents in a recent COVID-19 sentiment survey conducted by Plante Moran Living Forward™ and Retirement Dynamics. (Learn more about senior living facility improvements arising from the pandemic.)

Following are just a few opportunities for senior care and living communities to reimagine existing space:

The strength is small

As demand for skilled nursing beds has dropped and providers struggle to staff the census that they do have, some providers are consciously choosing to operate at a lower census. Turning semiprivate rooms into private rooms is far more affordable than building new units and has the added benefit of operational efficiencies. In some cases, providers are even permanently de-licensing those beds.

Creating discrete neighborhoods

While the benefits of Green House communities are well documented, few providers have the capital to undertake a major expansion at this time. Another approach that achieves many of the same benefits involves dividing up an existing building into smaller, discrete areas. For example, some providers make each wing of a building its own neighborhood housing a dozen or so residents. While one RN might oversee multiple neighborhoods, residents and most staff would stay in the neighborhood. This approach addresses infection control concerns while meeting residents' needs for social interaction.

Repurposing existing space to generate new revenue streams

Given the shift away from large group dining and activities, some providers are repositioning underused dining and activities spaces to accommodate smaller units or neighborhoods. Others are repurposing this space to provide additional services that can offset some of the financial losses stemming from declining occupancy and rising labor costs. Assisted living communities, for example, that are experiencing rising levels of resident acuity might consider turning some of these common spaces into **dedicated therapy rooms**.

Another opportunity to repurpose dining and activity space might include offering adult day care. With caregivers increasingly going back to work, they seek opportunities for their parents and grandparents to have some social interaction during the day in a safe environment. The light clinical requirements of adult day care can make it an ideal option for burned-out nurses looking for less demanding, first-shift work.

As occupancy continues to be a significant issue, following are additional ways to use unoccupied units or wings:

- **COVID-19 patients.** Hospitals are struggling with their own staffing, and many are looking to post-acute care options for long-haul COVID-19 patients or shorter-term COVID-19 patients that require ventilator or respiratory therapy.
- **Hospice or respite care.** Residential hospice or respite care can be very attractive to families if done appropriately so that the unit feels separate from the rest of the population. For example, providers might combine two private rooms to create a suite with a sitting area for family to gather outside the patient's room.

The bottom line is that status quo isn't an option for long-term care providers anymore. Start planning now for how you envision transforming your asset, even if that transformation must happen incrementally over a period of several years. Start with that purposeful vision, and then create a plan for bringing in the resources to make it a reality — even if that means selling to another owner group that's better positioned to implement and execute on that vision.

Reimagining the future of senior care

Demand for senior care services will continue to build, even if the pace of recovery remains uncertain. Organizations that remain agile will be prepared to respond to the long-term demographic boom of seniors, while those that cling to status quo will be left behind. Now's the time to future-proof your senior care organization with strategies that balance the needs of today with the long-term care landscape of tomorrow.

Let's work together to reimagine the future of senior care and find ways to thrive amid uncertainty.

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