FHA SENIOR HOUSING AND HEALTHCARE FINANCE

Scott D. Brown, Ph.D.

There are fundamental differences between multifamily project finance and healthcare real estate finance. Healthcare and multifamily differ in their sources of revenue, the services provided, regulatory oversight, the kinds of principals, the use of secondary financing and the risks involved. Healthcare also uses many terms that are alien to the multifamily world.

In addition to addressing residential healthcare options, this paper also addresses **multifamily housing options for healthy elderly and disabled persons** since many of the adaptations of housing units to make them suitable in a healthcare setting also can be applicable to residential design and programming for healthy elderly and disabled persons. This discussion includes senior apartments which are an important part of the continuum of residential care options for elderly and disabled persons.

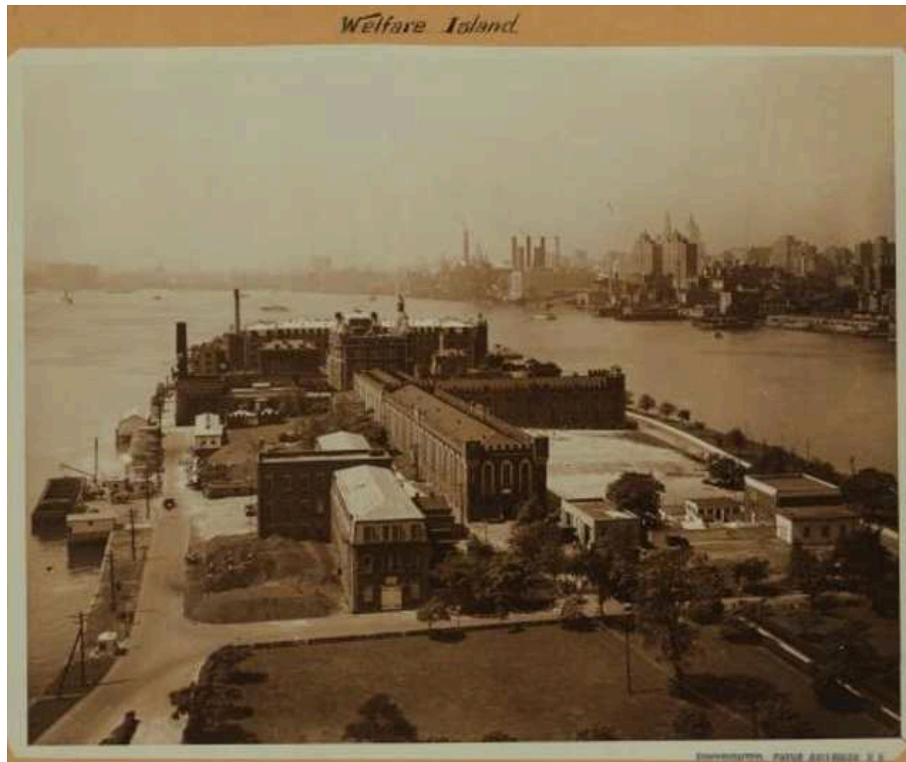
All FHA mortgage insurance programs can be traced back to the **National Housing Act of 1934**. This law has been amended many times over the years but represents the common ancestry of all HUD mortgage insurance programs. As such, there are many programmatic commonalities among FHA multifamily and healthcare lending programs. At their core, both FHA healthcare and multifamily programs are geared toward providing **safe, decent and affordable housing**.

HUD has two offices that write FHA mortgage insurance. The HUD **Multifamily Housing Division** ("**MHD**") just handles apartments. These apartments can include senior apartments (62+) and independent living subject to some restrictions. The HUD **Office of Insured Health Care Finance** ("**HCF**") handles independent living (also subject to restrictions), assisted living, skilled nursing and hospitals. OIHCF's non-hospital mortgage insurance programs are operating under the name "**LEAN**.[1]"

[1] HUD's motivation to move assisted living and nursing home finance out of the Housing Division was prompted by high default rates and inconsistent processing by field offices. HUD chose to apply a process management philosophy termed "LEAN" to facilitate the transformation of healthcare mortgage insurance processing. LEAN processing first came to prominence in the 1980's when a team at MIT studied Toyota's very successful approach to business. LEAN, in a nutshell, is a process improvement strategy aimed at lowering the cost of production through process mapping, analysis and experimentation. The process is continuous. Imbedded in LEAN is the philosophy of Kaizen, a Japanese word meaning "change for the best." Kaizen implies a work process that humanizes the workplace, eliminates overly hard work and teaches people how to perform experiments on their work to identify waste in business processes. Staff nurturing and development is integral to Kaizen. Unlike MHD, LEAN does is not divided regionally into HUBs and field offices. LEAN has one virtual office with personnel spread throughout HUD offices across the United States.

A Little History

For much of the nation's history, frail elderly persons without families to care for them often wound up in institutions called "almshouses" which were described as "halfway houses between society and the cemetery."[2] New York City's almshouses were located on what is now Roosevelt Island (then it was called Welfare Island). Along with the Almshouses, Welfare Iland was used as a site for a penitentiary, small pox hospital, insane asylum and foundling hospital. Essentially, all of the unwanted were swept up and deposited in large institutions where the quality of care was poor at best.



In response to the horrors of the almshouse, some charitable organizations established homes for the aged such as Boston's Home for Aged Women, Philadelphia's Indigent Widow's and Single Women's Society and the Hebrew Home for the Aged in Harlem. These efforts touched only a small number of people and often were restricted by religion or ethnicity.

The first real breakthrough for seniors came with the passage of the Social Security Act in 1935. In his majority opinion in support of the law, Supreme Court Justice Benjamin Cardozo proclaimed that:

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[2] http://booksage.blogspot.com/2012/04/laguna-honda-hospital-last-almshouse-in.html

"…the hope behind this statute is to save men and women from the rigors of the poorhouse as well as the haunting fear that such a lot awaits them when the journey's end is near."[3]

Prior to Social Security, seniors were the poorest group in the country.[4] Although Social Security began to lift the elderly out of poverty, it didn't ensure that suitable living environments were available for those who weren't able to live independently. Congress recognized this problem in the early 1950's and authorized Social Security to allow federal support to individuals in public facilities. The Medical Facilities Survey and Construction Act of 1954 began to direct federal funds for the development of public institutions for the neediest older adults. Nursing home development exploded with the 1965 passage of Medicare and Medicaid. Between 1960 and 1976, the number of nursing home beds grew by over 300%.[5] Medicare and Medicaid prompted nursing home development not just because they provided a funding source. Program managers saw nursing homes as a much lower cost alternative to keeping frail elderly in hospitals at government expense.

Nursing homes, in addition to providing superior housing and care compared to the almshouse, represent a far more cost-effective environment where hospitals can discharge their comparatively low acuity patients for therapy or custodial care. A similar revolution happened with assisted living in the 1970's when it became clear that many nursing home residents would fare better in a less acute, less costly and more independent setting. The next revolution in care was independent living and home healthcare. The Balanced Budget Act of 1997 opened up Medicare to home health care. Medicaid followed shortly resulting in a large number of elderly and disabled receiving long-term health and personal care in their homes.

Getting Our Arms around the Challenge

In the seventy eight years since passage of the Social Security Act, the nation has significantly upgraded the quality of care for its elderly. The federal government bears much of the cost for this care through Medicare, Medicaid, Social Security and HUD. Powerful demographic trends are pushing up the cost of these programs. If cost savings can't be found, policymakers may face hard choices between abandoning the nation's frail elderly population and bankrupting the government.

Ten thousand baby boomers are turning 65 today. Another 10,000 will turn 65 tomorrow and the day after. In fact, this trend will continue every day for the next nineteen years.[6] The

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[3] http://www.4fate.org/history.html
[4] http://www.nber.org/bah/summer04/w10466.html
[5] Ibid.
[6] http://www.pewsocialtrends.org/2010/12/20/baby-boomers-approach-65-glumly/

number of American seniors aged 65+ already is over 40 million and will exceed 55 million by 2020.

Although most seniors continue to live independently, today over five million require supportive services in a residential setting.[7] This number includes about 1.5 million in skilled nursing facilities,[8] 1.5 million in assisted living and independent living facilities, [9] [10] and 1.5 million receiving licensed home care services in their private residences.[11]

A substantial amount of the care provided to seniors is provided by unpaid caregivers, primarily family members. Unpaid caregivers provided 17.5 billion hours of care valued at more than $216.5 billion in 2012 alone.[12]

The U.S. Agency on Aging ("AOA") forecasts that, by 2020 there will be over ten million seniors with activity of daily living limitations, nearly two million of which are severely disabled.[13] The AOA goes on to forecast that, by 2030, the total number of elderly in need of nursing care could double or triple.[14] The Alzheimer's Association reports that the cost of care for Alzheimer's patients will rise to $1.2 trillion per year by 2050.[15]

Medicaid spending for long-term care totals about $127 billion annually.[16] Medicare spending for inpatient hospital services is about $140 billion annually.[17] Another $27 billion of Medicare funds are spent on skilled nursing care.[18] Supplemental Security Income goes to about two million seniors at a cost of about $13 billion annually.[19] About 2.1 million households receive Section 8 vouchers and roughly half of them are elderly or disabled. The elderly/disabled share of Section 8 voucher holders is growing.[20] The annual cost of Section 8 vouchers for elderly/disabled is about $8.25 billion.[21]

When all of the different residential care expenditures for the elderly are added up, and this list is by no means comprehensive, we quickly exceed $300 billion in federal spending annually. The

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[7] http://www.aoa.gov/Aging_Statistics/Profile/2011/docs/2011profile.pdf
[8] Ibid.
[9] Ibid.
[10] Ibid reference 2.
[11] http://www.cdc.gov/nchs/fastats/homehealthcare.htm
[12] http://www.alz.org/alzheimers_disease_facts_and_figures.asp#quickFacts
[13] http://www.aoa.gov/AoARoot/Aging_Statistics/future_growth/aging21/health.aspx
[14] Ibid.
[15] http://www.alz.org/alzheimers_disease_facts_and_figures.asp#quickFacts
[16] http://kff.org/medicaid/state-indicator/total-medicaid-spending/
[17] http://kff.org/medicare/fact-sheet/medicare-spending-and-financing-fact-sheet/
[18] Ibid.
[19] http://www.cbo.gov/publication/43759
[20] http://www.cbpp.org/files/12-2-11hous.pdf
[21] http://www.cbpp.org/cms/?fa=view&id=3145

number of seniors who require supportive residential services today is going to double to ten million in the next ten years. The government and industry challenge will be to provide safe decent and affordable care for this population without bankrupting the government.

Layering of Services to Match Resident Needs

Modern senior/disabled housing and residential healthcare facilities can be described in terms of the level of care provided. **Hospitals** and **critical access hospitals** ("**CAH's**") provide acute care, **skilled nursing facilities** ("**SNF's**") provide sub-acute care (e.g. rehabilitation and custodial care), **assisted living facilities** ("**ALF's**") provide extensive personal support and some sub-acute care**, independent living facilities** ("**ILF's**") generally provide meals and a limited amount of personal support and **senior/disabled housing** ("**Senior Apartments**") offer primarily an accessible residential component with some community activities.

Each of these facilities has key distinguishing resident care characteristics. A hospital wouldn't be a hospital if it didn't provide life-saving acute care for patients. A SNF wouldn't be a nursing home if it didn't provide rehabilitation and custodial care. An ALF wouldn't be an assisted living facility if it didn't provide extensive personal care. Independent living is distinguished by congregate meals in a setting where residents live independently in apartments. Senior apartments are distinguished by their clientele and, in most other respects, resemble normal family apartments.

A person's residential setting does not necessarily determine the level of care available to them. A frail elderly person in a senior apartment may have a **home care aide** or be attending a local **adult day health care program** that provides meals, therapy and social activities. An ALF resident may be receiving ADL's and sub-acute care services through a **licensed home care agency** or a **certified home health agency**. The key difference between the two types of home care agencies is that the certified home health agency can bill Medicare while the licensed home care agency cannot. The regulation of the two types of home care service providers is different. However, it is not uncommon to find the two types of agencies under the same parent organization such as the Visiting Nurse Service of New York.[22]

Some nursing homes provide special care units for treatment of AIDS, traumatic brain injury, ventilator beds for COPD[23] patients and psychiatric care that would be more characteristic of a hospital setting. All hospitals have patients receiving sub-acute care. Hospital discharge planners are under tremendous pressure to move sub-acute patients out of the hospital and

[22] http://www.vnsny.org/home-health-care-and-you/tools/glossary/c

[23] Chronic obstructive pulmonary disease refers to a group of lung diseases that block airflow and make breathing difficult. Emphysema and chronic bronchitis are the two most common conditions that make up COPD.

into an appropriate lower acuity setting because the hospital's reimbursement for a patient falls dramatically once that patient is no longer in need of acute care.

When considering a specific financing assignment, it is important to fully understand the levels of care provided by the facility not just to screen the deal for FHA eligibility and to determine the appropriate loan program but also to understand the robustness of its business model and available sources of revenue.

The different types of residential facilities for the elderly and disabled can be arrayed on a continuum based on the number of supportive services ("**acuity of care**") provided to the resident. The first layer of care is the **residential component** that can be identical to a normal multifamily apartment unit (e.g. senior apartments, independent living and, to a lesser extent, assisted living) or very different from an apartment unit (e.g. beds in nursing homes and hospitals). Social stimulation is included as part of the housing component since most good senior-oriented facilities, from senior apartments through acute care hospitals; include programs and activities to provide for the social and intellectual stimulation of elderly residents. Social stimulation isn't just a quality of life enhancement for seniors. The health benefits of social interaction for seniors include the reduced risk of: cardiovascular problems, some cancers, osteoporosis, Alzheimer's and other dementias and depression.[24]

The next service delivery layer is **personal care** which includes dressing, toileting, bathing, food preparation, housekeeping, transportation, administration of medications and assistance with personal finances. Together these personal services are termed "**activities of daily living**" or **ADL's**[25]. ADL's can be delivered by facility personnel (e.g. hospital, nursing home and assisted living aides and nursing staff) or by outside contractors such as licensed home care agencies. There are a number of different ways to provide supportive services to seniors (e.g. licensed home health care, adult day health care centers and outpatient therapy). Although one might be living in their own home, a senior apartment or an independent living facility, it still may be possible for them to get an appropriate level of assistance and therapy even though their condition might make them appropriate for a higher acuity (and cost) residential placement.

The next layer above ADL's is **sub-acute care**. Sub-acute care involves medical services such as physical therapy, occupational therapy, speech therapy, wound care, custodial care or hospice care. Sub-acute care can be provided to patients that are expected to have a limited nursing home stay such as people recovering from traumatic injuries. Sub-acute care can be provided to

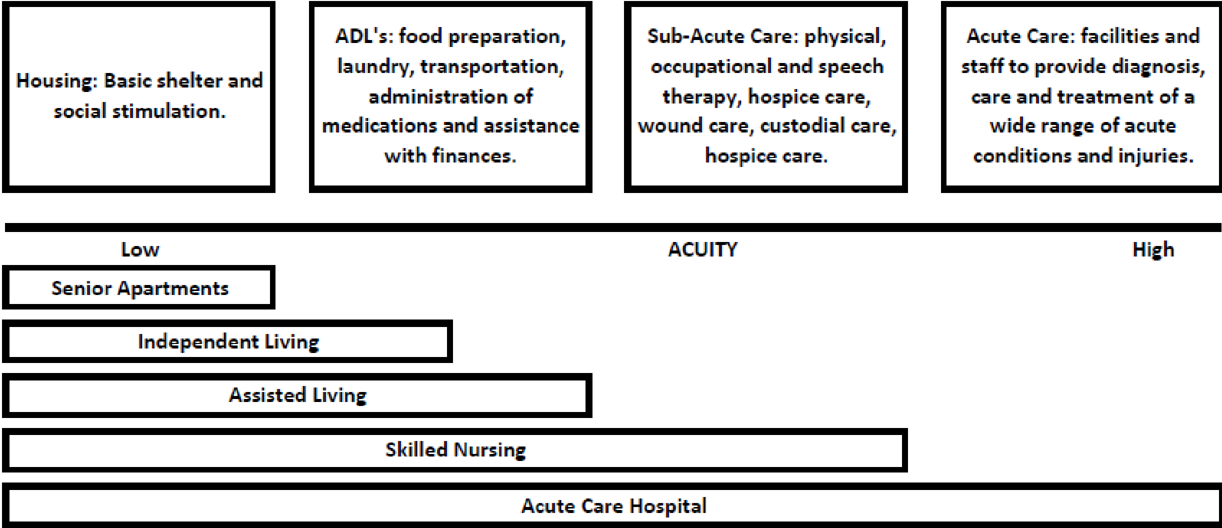
[24] http://www.urmc.rochester.edu/encyclopedia/content.aspx?ContentTypeID=1&ContentID=4513

[25] Some distinguish between activities of daily living and instrumental activities of daily living. Activities of daily living involve the most basic personal care activities (walking, bathing, and dressing, toileting, brushing teeth, eating). Instrumental activities of daily living relate to people who can take care of their personal needs but need help living independently (e.g. cooking, driving, using phone, shopping, handling finances and managing medications). For the purposes of this paper, we group them all together as ADL's.

patients that are not expected to recover such as patients with dementia or hospice patients. In nursing homes, sub-acute care involves continuous resident over-watch in a hospital-like setting. In assisted living facilities, physical therapy, occupational therapy and speech therapy are types of sub-acute care that can be administered on site or on an outpatient basis.

Finally, there is **acute care** which includes the wide range of medical diagnostic procedures and interventions necessary to diagnose and treat an immediate medical need and stabilize the patient. Because of the very high cost of acute care facilities there is a lot of focus on getting patients to the point where they can be discharged to a lower acuity (lower cost) facility to complete their recovery. Within this category, HUD distinguishes between **acute care hospitals** that provide acute care at least 50% of the time and **critical access hospitals** ("CAH") that tend to be smaller facilities serving isolated populations in rural areas. HUD allows critical access hospitals to be eligible for the hospital finance programs even though the level of critical care is less because these facilities often do not have access to skilled nursing facilities and other providers of sub-acute care.

Senior/Disabled Residential Facilities Arrayed by Acuity of Care Provided



The diagram above attempts to link the level of care provided with the relevant type of facility. As noted, there are many different ways to meet a resident's residential, ADL, sub-acute and acute care needs. This classification should be used only as a general guide.

The Continuum of Care

Placement in the lowest acuity environment is desirable from a cost standpoint and a quality of life standpoint. Even the healthiest seniors will sustain injuries and illnesses that may necessitate temporary assistance with ADL's and sub-acute care. Generally, it does not make

economic sense for a senior apartment or even an independent living facility to hire staff to provide for resident care since the level of demand won't justify staff positions. However, it is cost effective for a facility to be accessible to **licensed home care agencies** that can deliver ADL's and various forms of therapy up to skilled nursing care as needed. These specialized service providers normally are Medicare and Medicaid qualified. Through this overlay of service providers, a senior can enjoy an independent living environment while still getting appropriate higher acuity care when needed. Similarly, a senior apartment or independent living facility may contract for food services to provide a congregate meal once or twice a day. Although more of a convenience than a necessity, congregate meals in a senior apartment setting are an important opportunity for social activity and for monitoring the condition of residents.

A senior's need for ADL's and medical assistance will fluctuate but generally increases with age. Requiring a senior to relocate to a higher acuity living environment because of their changing needs can cause social disruption that is detrimental to their quality of life and possibly their health. Facilities that serve the elderly must be accessible to a network of care providers across the full range of acuity levels in order to address a resident's increasing needs and to deal with emergencies. With a proper network of caregivers available to the resident, it is possible for the senior to **age in place** in a familiar setting surrounded by friends.

Continuum of Senior/Disabled Housing and Healthcare Finance Options

Facility	Senior Apartments	Independent Living	Assisted Living	Skilled Nursing	Hospital
HUD Office	Housing	Housing	Health Care	Health Care	Healthcare
Program	223(f) & 231	223(f) & 231	232	232	241 & 242[26]
Licensing	No	No	Yes	Yes	Yes
Central Kitchen	No	No	Yes	Yes	Yes
ADL's Provided	Optional	Optional	Required	Required	Required
Sub-Acute Care	No	No	Optional	Required	Limitations
Acute Care	No	No	No	No	Required
	Low		**ACUITY**		**High**

[26] The FHA healthcare programs are overlaid on existing National Housing Act sections. A refinance of an assisted living or skilled nursing facility would be done under Section 232 pursuant to Section 223(f) or (if the loan already is in the FHA portfolio) the loan could be done under Section 232 pursuant to Section 223(a)7. The same applies to hospitals which could be refinanced under Section 242 pursuant to 223(f) or 223(a)7. For ground-up new construction or substantial rehabilitation of a skilled nursing facility or hospital, then Sections 232 and 242 respectively would apply. Section 241 is a supplemental hospital capital improvement loan program for projects already in the FHA Section 242 portfolio.

The gold standard in continuum of care is the **continuing care retirement community** or **CCRC**. A CCRC typically provides the full range of residential options from independent living (even condos or single family homes), assisted living and nursing care on the same campus. Normally, a CCRC will begin with a nursing home which will be followed by an assisted living facility and, ultimately, independent living and even senior apartments. The wide range of care givers on one site makes it possible for a resident to remain in the same residential setting for most if not all of their remaining years. A CCRC that develops gradually over time is termed a "naturally occurring CCRC." These facilities generally are very successful and are highly sought by eligible residents. In the 1980's FHA financed a number of de novo CCRC's. Most of these facilities failed because of the high cost of operation and long period of time required for the facilities to reach stabilized occupancy. It is unlikely that FHA would entertain a ground-up CCRC proposal today.

The Cost of Residential Healthcare

The drive to move residents from higher acuity settings to lower acuity settings is certainly justified on a quality of life basis. But even more, it is justified on a cost basis. Today, the taxpayer cost for Medicare and Medicaid is over $1 trillion dollars a year.[27] With the explosive growth in America's senior population, controlling the cost of care for America's seniors will be a major long-term challenge. Properly managing the acuity of care for seniors is one of the most important ways that the cost of care can be held down.

The figure on the following page compares the cost of a one-month stay across the acuity continuum from a senior apartment to an acute care hospital. Moving a senior from a hospital to a skilled nursing facility, lowers the average cost of a monthly stay by almost 90%. Moving from a SNF to an assisted living facility can almost cut the cost in half again. Moving from assisted living to independent living again cuts the cost in half. Thirty seniors can live in independent living for the cost of one senior in a hospital.

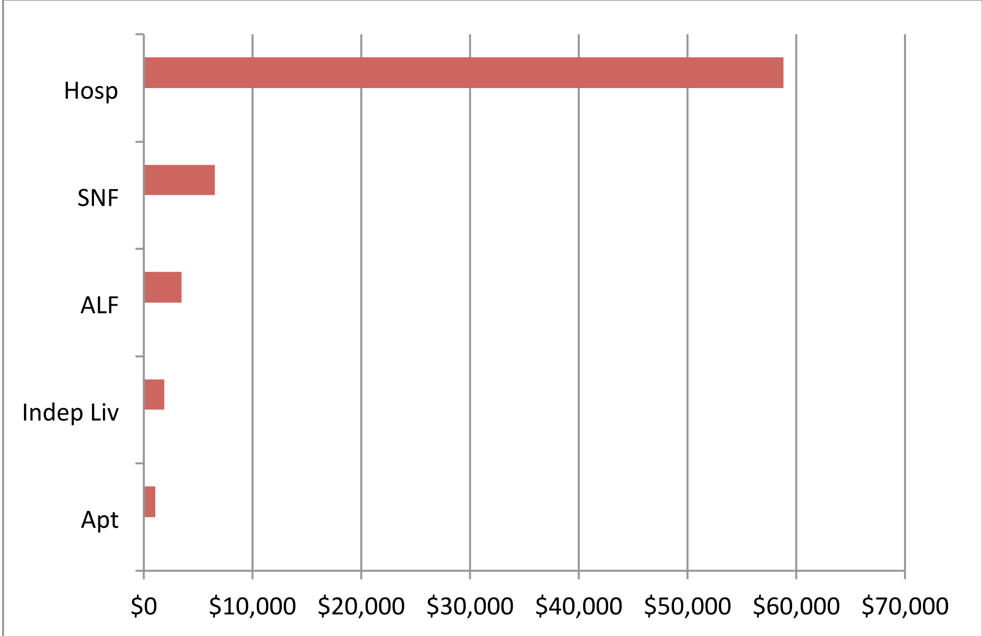
As noted earlier, lower acuity environments can provide higher acuity services by layering on home care services and home health aides. According to Genworth, the national median hourly rate is $18 for homemaker services and $19 for home health aide services.[28] Someone living in their own apartment could afford 45 hours of home care services per month before the cost of rent and care became equivalent to the cost of independent living. Similarly, someone in independent living could afford 83 hours of home care per month before the cost of rent and

[27] http://usatoday30.usatoday.com/news/health/healthcare/health/healthcare/story/2011/08/Medicare-Medicaid-tab-keeps-growing/49776998/1

[28] www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/130568_032213_Cost of Care_Final_nonsecure.pdf

care became equivalent to assisted living. Someone in assisted living could pay for 160 hours of home care a month before the cost approached that of skilled nursing care.

Typical Cost of a One Month Stay in Different Residential and Healthcare Settings[29]



Who Is Paying for Senior Care?

The vast majority of America's 40 million seniors live independently. Among the five million that require care, a significant number are living in private residences and receiving care from family members. Even these seniors are likely to be receiving one or more government benefits. What follows is a listing of different sources of payment for housing, board and care for various types of senior living arrangements.

- **Private Residence.** Private residence is used here to refer to a non-institutional setting such as a private single family home, an apartment, a senior apartment or even independent living which will have some community-based meals. All of these settings rely primarily on private out of pocket payments from residents. However, residents of any of these settings may be eligible for and use their **Supplemental Security Income ("SSI")** payments to cover some or all of their housing expense. Qualified renters also may use **Section 8 rental assistance** vouchers if the property owner will accept them. Some independent living projects may have Housing Assistance Payment Contracts that

[29] http://kff.org/other/state-indicator/expenses-per-inpatient-day/ ; https://www.metlife.com/assets/cao/mmi/publications/studies/2011/mmi-market-survey-nursing-home-assisted-living-adult-day-services-costs.pdf

will cover a portion of the rental cost for Section 8-qualified low income tenants. HUD's Section 202 Supportive Housing for the Elderly program provides over 260,000 units of affordable independent living units targeted to the elderly and disabled.[30] Some **long-term care insurance policies** may cover room and board in an independent-living residence. **Medicare** does not pay for living expenses in these settings but it will pay the cost of medically necessary in-home services (home health, home medical equipment, and personal care).[31] **Medicaid** varies on a state-by-state basis. Generally, Medicaid will cover a number of home health aide visits per week. Connecticut, for instance, will cover two skilled nurse visits per week and twenty hours of home health aide services per week.[32]

- **Assisted Living.** Higher quality assisted living facilities are often but not always **private pay**. A major source of revenue for the lower end of assisted living is **Supplemental Security Income**, the Social Security program for elderly and disabled persons. About a million Americans aged 65 or over receive SSI.[33] There are state-level variations in SSI. Many states supplement the federal payments for SSI depending on the residential setting of the senior. California, for instance, pays a single person $866.40 a month for fully-independent living, $950.40 for independent living with no cooking facilities and $1,122.00 for non-medical out of home care (e.g. assisted living).[34] LEAN views SSI as a stable source of revenue for a facility and a risk mitigant. The average monthly cost for a stay in assisted living is $3,022.[35] SSI funding is less than half of that amount. For that reason, facilities that rely on SSI tend to be of lower quality. SSI-funded facilities, often termed "adult homes" typically feature shared bath facilities and simple rooms with two or more beds. A growing source of funding for assisted living is **Medicaid**.[36] Since 1981, states have been able, on a limited demonstration basis, to use Medicaid to fund the care component of assisted living in order to developer lower cost alternatives to nursing home placement. Medicaid spending for assisted living has been growing rapidly over the past decade. Today, over a quarter of Medicaid spending on long-term care is going to nursing home alternatives such as the care component of assisted living and

[30] http://www.huduser.org/portal/publications/sec_202_1.pdf
[31] http://www.medicare.gov/pubs/pdf/10969.pdf
[32] http://kff.org/medicaid/state-indicator/home-health-services-includes-nursing-services-home-health-aides-and-medical-suppliesequipment/
[33] http://www.ssa.gov/policy/docs/quickfacts/stat_snapshot/#table1
[34] http://www.ssa.gov/pubs/EN-05-11125.pdf
[35] http://www.alfa.org/alfa/Assessing_Cost.asp
[36] http://www.ahcancal.org/ncal/resources/documents/medicaidassistedlivingreport.pdf. Congress authorized state programs to use Medicaid for personal care not covered by the state plan (home delivered meals, adult day care, personal emergency response systems, respite care and environmental accessibility adaptations that could prevent, delay or substitute for admission to an institution.

home care. Only Alabama and Kentucky do not have programs that use Medicaid funds to pay for lower cost alternatives to nursing home care. There are wide programmatic variations from state to state. A good review of Medicaid assisted living programs is Robert Mollica's "State Medicaid Reimbursement Policies and Practices in Assisted Living.[37] According to Mollica, nationally about 135,000 assisted living beds are receiving some level of Medicaid reimbursement. The Medicaid assisted living programs are currently in a demonstration phase and limits on participation are required. Medicaid reimbursement normally does not cover residential expenses. In most cases, SSI funds are used for residential "rent" with the Medicare funds being applied to ADL's and any sub-acute care. Some states award Medicaid vouchers to individuals who may then select from a list of pre-approved assisted living facilities. Other states assign Medicaid beds to specific facilities that must qualify residents for Medicaid reimbursement. Medicaid assisted living programs likely will have waiting lists. There are five principal ways that states set Medicaid reimbursement for assisted living:

- Flat per diem rate
- Rate adjusted to reflect the needs of individuals
- Case mix index approach (similar to nursing homes and hospitals rates)
- Fee for service
- Negotiated contract under managed long-term care

The most common approach is the tiered approach and the least common approaches are case mix index and negotiated contract. As long as states can reduce their Medicaid long-term care costs by shifting seniors from nursing homes to assisted living, the Medicaid assisted living program can be expected to grow. Non-Medicaid waiver assisted living facilities may have Medicaid-eligible residents who could receive home health services subject to state-specific limitations. Some **long-term care insurance policies** may cover room and board in an assisted living facility. **Medicare** does not pay for living expenses in assisted living but it will pay for the covered costs for medically necessary in-home services (home health, home medical equipment, and personal care).[38]

- **Skilled Nursing.** Medicaid normally represents the largest share of a SNF's revenue. Nationally, 63% of nursing home revenues come from Medicaid, 14% from Medicare and the remaining 23% come from VA benefits, long-term care insurance and other insurance, private payments and other sources.[39] One of the reasons that so many SNF

[37] http://www.ahcancal.org/ncal/resources/documents/medicaidassistedlivingreport.pdf
[38] http://www.medicare.gov/pubs/pdf/10969.pdf
[39] http://kff.org/other/state-indicator/residents-by-primary-payer-source/

residents receive Medicaid benefits is that the cost of nursing care can quickly bankrupt an individual and result in their qualification for Medicaid benefits. For this reason a very small portion of skilled nursing revenue is private pay.

- **Hospital Revenue.** According to the National Hospital Discharge Survey, Medicare accounted for 40.9% of hospital revenues, Medicaid accounted for 17.2%, Blue Cross Blue Shield and other private insurance accounted for 16.5%, HMO's and PPO's accounted for 14%, Self-pay accounted for 4.9%, Worker's comp and other government programs accounted for 2% and other accounted for 1.2%.[40] Medicare, as the leading source of funding for hospitals, generally takes the lead when it comes to rate-setting methodology. Medicaid and the Private insurers usually fall in line.

Classifying Types of Senior/Disabled Housing and Healthcare Facilities

Although each type of senior/disabled housing and healthcare facility may have the characteristics of others, the focus here is on each major category to provide insight into their distinguishing characteristics, functions and business model.

Senior Apartments. Senior apartments, also known as retirement communities, senior living communities or independent retirement communities are designed for residents who generally do not require ADL's but may benefit from accessible residential units, convenient services, senior-friendly surroundings and increased social opportunities. There aren't good statistics for senior apartments currently in service. Given that 10,000 baby boomers are turning 65 every day, if even a small number of them opt for senior apartments; this could spur construction of millions of new elderly-oriented apartments over the next several decades.[41] Market research indicates that seniors value proximity to shopping, walking/jogging trails, hospital/doctor's office, church, community centers, golf course and accessible public transportation as being desirable features for senior apartments.[42]

HUD MHD will provide mortgage insurance for senior apartments in which a resident is disabled or aged 62 or greater. Younger or non-disabled family members are allowed to live in the apartment with the qualified resident. Senior apartment projects typically provide common areas for social functions and some may even provide congregate meals. The layering of meal service and other ADL's is allowed by MHD so long as the services are not mandatory and not included in the rent. It must be possible to underwrite the transaction as a multifamily rental apartment project. The revenue from meals and other ADL's are not included in the underwritten project revenue. HUD will want to see an analysis of rental housing demand and

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[40] http://www.beckershospitalreview.com/racs-/-icd-9-/-icd-10/americas-payor-mix-by-region.html
[41] http://www.bdcnetwork.com/8-trends-shaping-today%E2%80%99s-senior-housing
[42] http://www.csa.us/docs/StateoftheSeniorHousingIndustryReport.pdf

supply for the targeted 62+ population to ensure that the project will be supported by its target clientele. The projects can be acquired or refinanced under Section 223(f) and built or substantially rehabilitated under **Section 231 Housing for Elderly Persons**. The Section 231 program is very similar to 221(d)4. It does appear that there will be flexibility to design units that are more appropriate for seniors than traditional family apartments.[43]

Independent Living Facilities. Sometimes you will see the terms "senior apartments" and "independent living" used interchangeably. For our purposes, independent living is assumed to offer full kitchens in apartment units but also a congregate meal. Some senior apartments will offer optional meal services. All independent living facilities will offer at least one daily meal service. Independent living facilities typically will offer private apartment units with private kitchens and baths with an overlay of ADL's that can be tailored to the changing needs of individual residents. These ADL's could be provided by a contractor that is not part of the independent living operation. The number of ADL's provided by senior apartments would be considerably less or even none. Showers and baths in independent living facilities will have grab bars. Emergency call capabilities are appropriate but continuous over-watch services would push the facility to the level of assisted living. Generally, independent living facilities will offer housekeeping, central meal services, social programming and transportation. The meals and social programming are designed to ensure that the elderly person does not become isolated and enjoys an appropriate level of social and intellectual stimulation. The ultimate goal of independent living facilities should be to maximize the resident's independence and self-determination in a safe and appropriately stimulating environment. The Society of Certified Senior Advisors has estimated that there are 3,840 independent living facilities in the nation that are providing 812,500 housing units.[44]

In order to qualify under Section 223(f) or Section 231, the independent living facility should have private baths and full kitchens. Meal service and other ADL's must be completely optional and not included in the rent. If the facility does not have private baths, full kitchens or congregate food preparation is done at the facility or if the facility must be licensed by the state; it should be processed through LEAN as an assisted living facility under Section 232 pursuant to 223(f). HUD MHD will be interested in the supply and demand of comparable apartments to determine the likely long-term success of the project but they will not give credit for the higher rents and ancillary income in the valuation or net operating income for loan underwriting purposes. LEAN will not accept a transaction that is exclusively independent living. LEAN will consider projects in which 25% or less of the units are independent living. LEAN's considerations with the independent living units will involve the occupancy history for established projects and the penetration and capture rate for planned new construction or

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[43] MAP Guide 3.8 A. 1. B. (3).

[44] http://www.csa.us/docs/StateoftheSeniorHousingIndustryReport.pdf

substantial rehabilitation. A developer will have two options when considering independent living: (1) to plan senior apartments with sufficient optional service overlays to serve a more acute population as needed (MHD housing model); or (2) to plan an assisted living facility in which the units have sufficient amenities to attract independent living tenants but with sufficient ADL's and medical services to support an assisted living population (LEAN assisted living model). LEAN will allow up to 25% independent living units in a 232 assisted living project but they will impose a debt service reserve requirement.

Assisted Living. Assisted living facilities can range in design from private apartments with limited kitchen facilities (refrigerator, sink and microwave) to facilities with shared baths and rooms with multiple beds. Assisted living facilities will have a congregate dining area and other shared spaces for social activities, therapy and personal care. The typical assisted living resident is a woman about 87 years old who is mobile but needs assistance with approximately two to three ADLs. She would have two to three of the top chronic conditions (high blood pressure; Alzheimer's disease or other dementias; heart disease; depression; arthritis; osteoporosis; diabetes; cardio-pulmonary disease and allied conditions; cancer; and stroke).[45] The typical length of stay in assisted living is 22 months with 59% of residents moving to nursing care, 33% of residents dying and the balance moving to another location. As a rule, patients need to be ambulatory, not require oxygen on an on-going basis and be able to comply with simple instructions.

Every state has regulations for the licensing of assisted living facilities.[46] Licensing requirements address the necessary qualifications of key personnel and condition of the facility to serve a resident population with a certain level of acuity. As the acuity of care required by the residents increases, the qualifications of key personnel will increase. The Society of Certified Senior Advisors estimates that there are 6,315 assisted living properties in the country that are providing 475,500 units.[47]

A key problem with private pay assisted living is that it is expensive and, in many cases, can be an optional living choice for many elderly persons who, in a pinch, could move back in with the kids. For this reason, existing assisted living facilities should have well-established operating histories with low turnover and robust debt service coverage ratios. LEAN will not process an application from an unlicensed facility. LEAN will want to see recent facility compliance reviews by the licensing authority.[48] However, LEAN will allow up to 25% of the units in an assisted living

[45] http://www.ahcancal.org/ncal/resources/Pages/ResidentProfile.aspx
[46] http://www.alfa.org/alfa/State_Regulations_and_Licensing_Informat.asp
[47] http://www.csa.us/docs/StateoftheSeniorHousingIndustryReport.pdf
[48] State regulatory authorities establish standards for admission policies, physical environment, sanitation, safety, staff/resident ratios, staff training and supervision, staff supervision, resident rights, medical administration, use of restrictive interventions, incident reporting and provisions of or arrangement for necessary health services. Rather

facility to be unlicensed independent living.[49] LEAN will require a twelve month debt service reserve for projects offering independent living.

If a planned facility has more than 25% independent living beds, LEAN suggests that the transaction be split into two projects with the assisted living wing using Section 232 and the independent living wing using Section 221(d)4. For planned projects, HUD will be very cautious about the market and will insist on a significant operating deficit reserve because new private pay assisted living facilities take so long to achieve stabilized occupancy. The marketing plan should be carefully reviewed to determine that the facility has a workable plan for attracting residents. In all cases HUD will scrutinize the qualifications and experience of the professionals designated to administer the facility. HUD will not approve a new construction or sub rehab application where the operator can't show prior successful experience with the rent-up and stabilization of a similar assisted living facility. Operating manuals should be reviewed to ensure proper procedures for resident care and safety.

It is extremely common for multifamily and other commercial real estate developers to fixate on assisted living as an attractive development opportunity because the revenue per square foot is so much higher than multifamily or other commercial uses. If the development team doesn't include an experienced assisted living operator with skin in the game, their chances of getting a loan are slim to none.

Skilled Nursing Facilities. SNF's resemble hospitals more than apartment houses. SNF's sometimes are termed "**rehabilitation centers**" or "**convalescent homes**." A SNF provides the full range of ADL's plus 24-hour over-watch by professional medical staff. On top of the ADL service layer, SNF's provide a layer of sub-acute medical care which is normally supervised by a physician and implemented by the facility's staff of nurses and other healthcare professionals. As noted earlier, some specialized SNF's may provide services more characteristic of hospital care (e.g. burn unit, AIDs unit, brain trauma unit). Nursing home residents don't differ greatly from assisted living residents in terms of age or gender. Nursing home residents, however, are much more dependent on help with ADL's and are more likely to have a medical condition requiring therapy or continuous care. Some patients are in nursing homes to rehabilitate a specific condition such as a broken hip, a burn or stroke. Once their rehab is completed, these residents return to their homes. Other nursing home residents have custodial care needs that necessitate that they stay in the SNF. Over half of SNF patients have Alzheimer's or some other dementia. Over a third is severely incontinent. Over a third has heart disease. Nearly a third is

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than establish its own detailed standards for unlicensed facilities, LEAN simply requires that, for a facility to be eligible for FHA mortgage insurance, it must be licensed.

[49] LEAN Email Blast December 18, 2009 "Independent Living Units in a Section 232 Project."

suffering from depression. Over a quarter of nursing home residents are taking antipsychotic medications.[50] [51]

Typically, nursing home residents live in simple rooms with one or two beds. Facilities with four or more beds per room are becoming less common. Rooms typically contain their own bathroom. The facility is divided into multi-room units generally with a central nursing station that allows for visual oversight of all hallways. All beds and bathrooms should have call chains that can alert the nearest nursing station. SNF's will offer common areas for social activities, therapy and personal care. Meals can be provided in central dining areas or be delivered to rooms for residents that are confined to bed. More modern facilities may have highly specialized capabilities such as burn care and the treatment of patients that are dependent on mechanical ventilation.

In order to be eligible to receive Medicare or Medicaid, all nursing homes must be licensed by their respective states. The administrator of the nursing home must be licensed. In order to obtain a license, the nursing home facility must meet strict construction standards and safety requirements. To obtain a license, the facility must demonstrate the staff qualification and experience to safely operate the facility. The Society of Certified Senior Advisors estimates that there are 10,975 nursing homes in America today that are providing 1,491,000 beds.[52]

The balance of SNF revenue that does not come from Medicare and Medicaid will come from private long-term care insurance, Tricare (the military's dependent managed care program) and direct payments by individuals. SSI generally is not applicable to nursing facilities unless they are not eligible for Medicaid. SSI recipients will continue to receive a small monthly allowance ($30 per person and $60 for couples).[53]

Because the federal government is a very reliable payor, a high portion of Medicaid patients in a facility is viewed favorably by LEAN. Nursing homes that are primarily private pay will be viewed less favorably. As the technology for skilled nursing care has advanced, older facilities are put at a serious disadvantage. Older facilities also may be at a competitive disadvantage to more modern facilities and may need to be underwritten with higher vacancy assumptions. Older facilities with stable operating histories may be eligible for financing but the appraiser is likely to assign them a fairly short useful life which will adversely affect both the valuation and the debt service constant. Older projects may pencil with loan terms so short that the

[50] http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/nursinghomedatacompendium_508.pdf

[51] http://www.healthnewsobserver.com/articles/detail/ten-most-common-medical-conditions-among-nursing-home-patients-uncovered

[52] http://www.csa.us/docs/StateoftheSeniorHousingIndustryReport.pdf

[53] http://www.disabilitysecrets.com/resources/disability/about-disability/how-does-ssi-disability-work-

amortization rate renders the loan infeasible. Depending on state regulations, it may be better for the owners of older facilities to seek approval for a replacement facility or to consider substantial rehabilitation of the facility.

SNF's are subject to regular reviews. These state reviews are called **surveys** and are available from the state department of health. These surveys aren't involved with reimbursement. The periodic survey will identify problems with patient care and regulatory compliance. If the survey has findings, the facility is required to quickly remediate the problem. An example of a problem would be patients exhibiting **decubitus** ulcers or bed sores. Leaving patients alone in their beds for long periods can cause these pressure ulcers. Decubitus ulcers vary in severity from red bruised patches of skin to deep open wounds that are life-threatening. The prevalence of bed sores in a SNF is indicative of poor patient care.

LEAN will look carefully at the qualifications of the nursing home operator. The SNF administrator must be licensed by the state. LEAN will look for a clean track record with the state regulator. LEAN also will review the insurance loss histories not only of the subject facility but of all other facilities under the control of the operator group. Often, the real estate entity (mortgagor) and the SNF operator are different entities that could be related or arm's length. If the operator or the principals of the operator are active in more than one facility, LEAN will want to see a summary review of all the facilities to ensure that they are all healthy. LEAN does allow for portfolio financings with cross collateralization of multiple facilities. As noted, the reimbursement mix is important to LEAN. SNF's with high percentages of Medicaid are viewed most favorably.[54]

It is very common for SNF's to be organized into two entities: a real estate or mortgagor entity and an operator entity. The operator leases the facility, on a triple net basis, from the real estate owner and pays a net rent to the owner. The lease is triple net because the tenant pays the (1) real estate taxes; (2) building insurance and (3) maintenance costs. LEAN actually prefers that the operator entity, the tenant, make the mortgage payment directly to the mortgagee. The mortgagor or real estate entity simply receives their net rent each month. The separation of the real estate entity from the operator entity reflects the reality that the worlds of commercial real estate and nursing home operations don't share very much in common. By having two entities, commercial real estate experts can run the real estate entity and health care experts can run the operator entity.

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[54] The amount of Medicaid reimbursement is a function of the acuity of care provided. If the SNF operator overstates the acuity of care provided and is overpaid for the care given, the state will discover this when they do their audit of the facility. Typically, the state will require that the facility reimburse the state for the amount of overpayment. Where there is a persistent pattern of overbilling and the state is two or three years in arrears on its audits, it is possible for a facility to suddenly have a huge payable due to the state. Unscrupulous operators may seek to inflate the NOI of a facility by overbilling and then attempt to refinance or sell the facility before the state discovers the overbilling. This is why significant increases in facility revenue unaccompanied by state audits should be looked at skeptically.

As noted, Nursing homes depend on Medicaid reimbursement to fund a large share of their operations. The timing delay between incurring reimbursable costs and being reimbursed by the Medicaid and Medicare can create a cash crunch for facilities that do not have significant working capital reserves. Due to a favorable judicial decision in the mid-1980's it became possible for healthcare facilities to pledge their Medicaid and Medicare receivables for a working capital line of credit.

LEAN allows **accounts receivable ("A/R") lines of credit** but there are strict requirements. The maximum A/R loan should not exceed 85% of Medicare and Medicaid accounts receivable. Other risk factors are multiple facility lines, multi-state lines, identity between A/R lender and A/R borrower and accounts receivable more than 90 days old.

LEAN requires Deposit Account Control Agreements ("DACA") and Deposit Account Instructions Service Agreements ("DAISA") for A/R lines. These agreements are used to perfect a lender's security interest in and control the use of an operator's deposit accounts. This requirement has delayed some LEAN closings as these agreements must be agreed to in advance by the A/R banking institution involved. Some community banks have been unable, or, in some cases, unwilling to enter into these agreements because they do not feel they have the capability to facilitate blocked account agreements. In practice, some borrowers have found themselves in the undesirable position of having to change A/R banks in order to comply with this new requirement, which invariably delays closing the FHA loan.

Under the terms of the Deposit Account Instructions and Service Agreement ("DAISA"), the operator must deposit into a lockbox account all payments received from government health insurance programs. Private receivables are not deposited into the lockbox. Each month the FHA mortgagee notifies the A/R lender of the amount of the aggregate lease payment that is due on the 14th of the month. The A/R lender, subject to the A/R line being fully drawn down, will ensure that the lockbox account contains sufficient funds to cover the monthly lease payment. On the 14th of the month, the FHA mortgagee sweeps the account for the full monthly lease payment. The FHA mortgagee applies the lease payment to the monthly principal, interest and escrow payments and returns any balance (net rent) to the Lessor (the owner of the nursing home).

The A/R line security agreement grants the A/R lender a primary security interest in all Medicaid and Medicare receivables until the operator's obligations to the A/R lender are satisfied at which time the senior interest returns to the FHA lender. The FHA mortgagee continues to maintain a primary security interest in the assets and licenses of the healthcare facility.

In 1964, New York created the first **Certificate of Need** ("CON") program to control the development of healthcare facilities. In 1974, legislation was passed to link federal healthcare funding with implementation of a CON program. The federal mandate for CON's was repealed in 1987 and 14 states elected to operate without CON's (AZ, CA, CO, ID, IN, KS, NM, ND, PA, SD, TX, UT, WI, WY). The original purpose for the CON program was to slow the proliferation of nursing facilities and ensure that the supply of nursing beds was in line with the demand. Many of the states that eliminated their CON requirements have developed other ways to control the proliferation of skilled nursing beds.

Critical Access Hospital. The key distinguishing feature of a hospital, compared with other healthcare facilities such as nursing homes, is the provision of acute care to patients. Acute care generally involves treatment of a brief but severe episode of illness resulting from disease or trauma (including recovery from surgery). An acute care hospital should have the facilities and medical staff to provide diagnosis, care and treatment of a wide range of acute conditions including injuries.[55] To be eligible for FHA financing, hospitals normally must devote at least 50% of their patient days to acute care. Ineligible patient days would include skilled nursing care, intermediate care, convalescent care, rehabilitation and psychiatric care. HUD provides a method for counting outpatient acute care in the 50% test.

By requiring hospitals to provide at least 50% acute care beds to be eligible for FHA mortgage insurance, FHA ruled out a large number of smaller hospitals in rural areas. In conjunction with other changes to the national healthcare delivery system to improve healthcare services in rural areas, HUD now allows these smaller hospitals to be eligible for FHA mortgage insurance irrespective of the 50% acute care requirement. HUD's CAH initiative dovetails with Medicare's push to improve funding for rural acute healthcare facilities. Participation in the Medicare CAH program provides for cost-plus reimbursement and inclusion of capital costs in determining Medicare reimbursement.

CAH's, according to HUD, are facilities designated as Critical Access Hospitals by Medicare.[56] These hospitals provide an emergency room and ambulance coverage as well as a wide variety of acute care capabilities. But because they are in relatively isolated areas, they are required to handle their own sub-acute care needs which can result in the number of acute care patient days falling below 50%. CAH's must have at least one physician but that physician is not required to be on site. Midlevel practitioners can be an active, independent part of the CAH medical staff. Medicare requires the CAH to have no more than 25 inpatient beds and an average length of stay of no more than 96 hours for acute inpatient care. As of June 2013, Medicare had certified 1,332 critical access hospitals in the United States.[57] Critical access hospitals ("CAH's") must be over 35 miles from another hospital or 15 miles from another hospital in mountainous terrain or areas with only secondary roads.

[55] http://www.ct.gov/dph/lib/dph/ohca/hospitalstudy/HospToday.pdf
[56] HUD Hospital Mortgage Insurance Program Handbook May 2013. Subpart A 2.
[57] http://www.raconline.org/topics/critical-access-hospitals/faqs/#whatis. For intrepid originators who actually read footnotes: the link here has an Excel spreadsheet with information on every CAH in the nation.

Medicare pays CAH's for most inpatient and outpatient services to Medicare patients at 101% of reasonable costs. Medicare also will pay 101% of reasonable costs for ambulance services if the CAH is the only provider of ambulance services within a 35-mile drive of that CAH. Medicare Part A and Part B deductibles do apply. The Affordable Care Act provides bonuses for certain health care professionals to work at CAH's.

HUD allows the acquisition, refinance and moderate rehab (up to 20%) of CAH's under Section 242/223(f) program. Ground up new construction of a CAH ("Greenfield CAH") would be handled under Section 242. Refinance of CAH's already in the HUD portfolio would be under Section 242/223(a) 7. For more information regarding the underwriting of CAH Section 242 transactions, refer to the Section on Acute Care Hospitals.

Acute Care Hospitals. Hospitals provide a residential care component, a comprehensive ADL component, a sub-acute care component plus the diagnostic and intervention capabilities to address a wide range of chronic and traumatic conditions that may be life-threatening. Because of the high acuity of care provided, hospital stays are very expensive. In 2010, the average cost of a hospital stay in the U.S. was $9,700.[58] The aggregate cost for all hospital stays that year totaled $375.9 billion. Although inpatient hospital services account for only seven percent of health care utilization, they make up 29% of all healthcare spending.

Acute care hospitals, to be eligible for FHA financing, must provide over 50% of their patient days for acute care. Ineligible patient days include convalescent, epileptic, mentally deficient, mental, nervous and mental and tuberculosis care. For hospitals that provide significant outpatient services, outpatient acute care can be included in the computation of acute care days.[59]

HUD allows the acquisition, refinance and moderate rehab (up to 20%) of acute care hospitals under Section 242/223(f) program. Ground up new construction of acute care hospitals would be handled under Section 242. Properties with FHA mortgages requiring capital improvements can get financing under Section 241. Refinance of CAH's already in the HUD portfolio would be under Section 242/223(a)7. Other key screening criteria for HUD Section 242, 242/223(f) and 241 hospital applications include:

- **90% LTV.** The loan can be no more than 90% of total estimated replacement cost of the hospital.
- **Cash to Close.** The hospital must have cash on hand to meet any closing equity requirement for the loan. For Section 241 loans, an upfront equity contribution of 10% of the mortgage amount is required.
- **Special Start-Up Hospital Requirements.** Section 242 Start-up hospitals must demonstrate sufficient start-up capital, fill a market need and has a viable physician recruitment plan. In general, OHF discourages start-up hospital transactions.[60]

[58] http://www.hcup-us.ahrq.gov/reports/statbriefs/sb146.pdf

[59] HUD Hospital Mortgage Insurance Program Handbook May 2013. Appendix 1.

[60] In a recent training program, a HUD official indicated that they would be looking for approximately $50 million in working capital for a planned 300 bed hospital.

- **Minimum Aggregate Operating Margin.** This is calculated by computing the operating margin for each of the past three full years (operating income/operating revenue). If the sum of the three full year operating margins is less than zero, OHF won't do the deal. If the hospital is showing signs of improvement, there may be exceptions to this rule.
- **Minimum DSCR.** The minimum debt service coverage ratio for 242/241 transactions is 1.25. The minimum DSCR for 242/223(f) transactions is 1.40. The hospital must be able to show that it has met the minimum DSCR requirement for each of the past three years.
- **State and Local Support.** If a hospital is receiving revenues from government, the nature of the support needs to be described to establish that the support is reliable enough to be included for underwriting purposes.
- **State and Federal Compliance**. The hospital should be in compliance with their state and federal regulators and not under investigation for violations.
- **Two-Year Rule.** Debt associated with structures completed fewer than two years prior to submission of the application is not eligible for refinance.
- **Limit on Construction.** For 242, a minimum of 20% of loan amount must be used for hard cost of construction. For 242/223(f), not more than 20% of loan amount can be used for hard cost of construction.
- **Need for Refinancing.** There is no requirement for 242. For 242/223(f), the refinancing must be shown to be necessary so that the hospital can continue to provided needed healthcare services to its community. Only in rare cases will Section 241 loans include a debt refinancing requirement.
- **Physician Ownership.** Any application by a physician-owned hospital must include an attorney's opinion of compliance with the Anti-Kickback Statutes and the Federal Physician Self-Referral Prohibition Act.
- **First Lien.** The hospital must be able to grant a first lien on hospital property, plant, equipment and receivables to Rockhall. OHC severely discounts the value of the property if it is a leasehold estate. OHF also will be concerned about governmental restrictions on granting a lien, the existence of any A/R financing program or any other thing that could limit the placement of a first lien on the hospital's property, plant, equipment, receivables and revenue.
- **Commencement of Construction.** Construction should not begin until after closing.
- **CON**. If the hospital is in a CON state, it must have a CON or a CON must be in process.
- **Identify Mortgagor and their Qualifications.**

Federal Healthcare Reimbursement: Medicaid and Medicare

Senior apartments, independent living and assisted living primarily rely on a monthly rent payment from the resident.[61] Unlike facilities that charge by the month, nursing homes and hospitals charge by the **patient** day for services provided to a patient with a particular diagnostic classification. The diagnostic classification system and the amount to be paid are set by the payor. By billing on a **per diem** basis, the facility can set a billing rate that corresponds to the rate-setting methodology proscribed by the **payor** (e.g. private pay, Medicare, Medicaid, private health insurance).

Nursing homes and hospitals normally are subject to a **prospective case-mix payment system**. The system is prospective because reimbursement rates for different average patient acuity levels are set in advance. The system assumes that there is a characteristic mix of residents across a range of diagnostic categories. The cost of care goes up as the acuity of care goes up. If the actual acuity mix of patients varies from the established norm for a particular facility, adjustments to reimbursement can be made once audits are completed. The amount that will be paid to a nursing home or hospital for a particular activity can be bounded by minimum and maximum amounts and adjusted for inflation over time. The assignment of new patients to specific diagnostic categories is subject to audit to ensure that the health care facility isn't over-classifying patients in order to receive higher reimbursement than is justified.

Medicaid. Medicaid, which is jointly funded by the federal government and the states, is administered by the states. Because each state administers its own Medicaid program, there are variations in Medicaid rate-setting methodology from state to state. This doesn't mean that you need to be an expert in Medicaid reimbursement for every state in which you are underwriting a nursing home loan. For the most part, you will be relying on the appraiser and other expert consultants to provide you with a detailed analysis of the revenue sources for a skilled nursing of hospital facility. For existing facilities, you will be able to rely on audited historical data. For new facilities you will have pro forma revenue and expense assumptions associated with the **certificate of need** ("CON") process or other state licensing process.[62]

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[61] This could be changing for assisted living. As previously noted, assisted living is increasingly relying on Medicaid as many states are increasing the number of Medicaid assisted living spaces in an effort to manage costs. There are some assisted living facilities in operation today that have a prospective rate-setting process that is more akin to nursing homes and hospitals than traditional private pay assisted living.[61]

[62] Certificate of need ("CON") programs involve a state-level evaluation of the need for new nursing home or hospital beds. The aim of CON programs was to prevent the unnecessary proliferation of health care facilities. In states like New York, the award of a CON for a nursing home or hospital carries with it a commitment from the state to include a capital reimbursement component in the Medicaid rate. Although once a federal requirement for Medicaid eligibility, this requirement was repealed in 1987 and today only 36 states have active CON programs. Opponents of the CON program have argued that it is anti-competitive and favors established facilities and operators.

Although you won't be the reimbursement expert for the transaction, it is important to have a working understanding of the program so that you can interpret financial reports and know what questions to ask the client or third party report contractor.

Medicaid per diem reimbursement rates are intended to provide an appropriate level of funding to cover the share of a SNF's costs associated with a one-day stay in that specific facility. For instance, if a facility had 100 beds, it would have the capacity to provide a maximum of 36,500 bed-days of service. Reimbursement methodologies assume a vacancy rate. For instance, if the vacancy assumption were 10%, then there would be 32,850 resident days (36,500 X .90 = 32,850) to use for setting rates ("**base year resident days**"). For our example, the Medicaid daily rate ideally would represent 1/32,850th of the cost to operate that facility including a reasonable return on the capital investment. This rate-setting methodology assumes that Medicare, Medicaid, long-term care insurance, private payments and any other reimbursement that the facility receives in addition to Medicaid will be at least equivalent to the Medicaid per diem rate. Some states will place a cap on the Medicaid rate to keep it from being higher than other forms of reimbursement.

The challenge in setting Medicaid rates is that no two facilities have the same operating and non-operating costs and no two facilities serve exactly the same patient population. For that reason, the rate setting process must be able to accurately reflect the unique characteristics of each facility.

The process of establishing a Medicaid rate breaks down a particular SNF's costs into four categories:

- **Direct Costs:** These are the costs of providing patient care including salaries and benefits for nursing, nursing assistants and therapists, social services as well as laboratory, radiology and ancillary service providers. This is the largest component of a nursing home's costs. The higher the acuity of care provided, the higher the direct cost component of the Medicaid per diem rate.
- **Indirect Costs:** These costs include food service, housekeeping, facility maintenance, supervision and administration, utilities and insurance. Assuming the facility has stable occupancy, these costs will remain fairly stable with minor adjustments for inflation.
- **Capital Costs:** Some states include the capital cost of the facility in the Medicaid rate. In New York, a percentage of the approved capital costs for a new facility are used to establish a mortgage amount with a term of 30 years and a rate based on the level of long-term Treasury bonds plus a margin. The annual cost of debt service on the resulting mortgage is divided into the number of patient days times an occupancy factor to arrive at the per diem capital cost for the facility. In New York, capital cost is a one-time thing.

Once the initial thirty year period is over, the facility's capital cost component of its Medicaid rate is zero.

- **Non-Comparable Costs:** These are costs for staff or services that are beyond the basic direct costs such as salaried physicians, dentists, hearing/audiology services, psychologists and nurse practitioners. Utilities and real estate taxes also are included here. Like indirect costs, Non-comparable costs are expected to remain fairly stable.

In order to establish the various costs associated with a stabilized, operating nursing home, some operating history must be monitored. This monitoring period is known as the **Rate Basing Period**. Typically, this monitoring period is a year. In the case of newly built facilities, rate basing can't begin until the facility has reached stabilized occupancy, typically 90% occupancy. During the rate basing period, the facility is paid an **interim rate** based on averages for nursing homes in the area. Once the final rate is set, the facility is reimbursed for any underpayment or must return any overpayment if the interim rate differs from the **final rate**. Some states require a facility to go through rate basing at periodic intervals and others don't rebase until there has been a change in ownership.

Indirect costs, capital costs (if that state pays for capital) and non-comparable costs are fairly straightforward. The facility reports indirect, capital and non-comparable costs incurred during the **base year** in a **cost report** submitted to the state. The total cost for each of these three categories is divided by the appropriate number of patient days (32,850 in our example) to establish the per diem component of the Medicaid rate for each cost category. The state may impose maximum per capita limits within these categories. Some states may allow adjustments to indirect and non-comparable costs based on case mix. Each of these cost components can have adjustments for inflation.

Pricing the direct care component is a little more involved. The computation of direct costs assumes that the cost of care will fluctuate with the acuity of the patient population being cared for. Direct care reimbursement adjustments require that each patient day of service have a **Resource Utilization Group (RUG)** category assigned to it. There are a number of RUG categorization methodologies with the number of diagnostic categories ranging from 16 to 52. New York, for instance, uses a 16 category scale and Vermont uses a 48 category scale. The distribution of patient days across the total available bed days is termed the **case mix.** Each clinical category is assigned a **case mix weight**. The case mix weight for a particular diagnostic group, for instance, can range from 0.50 (Reduced physical function) to 3.00 (Extensive Services). The RUG weightings assume a linear relationship between the weight and the cost of a particular service. For instance, if a diagnostic classification has a weight of 2.0, that per diem cost will be twice the per diem cost of a diagnostic classification with a weight of 1.0. The higher the case mix weight, the higher the cost of care. The case mix weights for all patient days during

the base year are added up and divided by the number of occupancy-adjusted patient days in that year to yield the patient day weighted **average case mix score** or **case mix index.**

The case mix index is multiplied by the base year resident days and divided into total base year direct cost to arrive at the **direct care cost per case-mix point**. This calculation computes the facility-wide average cost for a patient with a RUG score of 1.

Below is an example of a 100 bed facility with 90% occupancy and 32,850 base year resident days. The case mix index is computed to be 1.25. The base year direct costs are $4,000,000. The base year direct costs are divided by the base year resident days weighted by the case mix index to yield the direct cost per case mix point.

Example Calculation of Direct Cost per Case-Mix Point

A	Number of Beds	100	
B	Occupancy	90%	
C	Base Yr Resident Days	32,850	(A X B X 365)
D	Case Mix Index	1.25	
E	Base Yr Direct Cost	$4,000,000	
F	Direct Cost Per Case-Mix Point	97	(E / (D*C)))

The direct cost case-mix point is set during rate basing and can be adjusted for inflation but normally remains relatively unchanged until the next rate basing. Determination of the direct cost component of the Medicaid reimbursement rate is a function of multiplying the direct cost per case-mix point ($97 in our example) times the case mix index for the facility times the number of Medicaid patient days in the period being assessed.

Example of Medicaid Reimbursement Calculation

G	# of Medicaid Patient Days In Period	2,700	
H	Case-Mix Index	1.35	
I	Direct Cost Per Case-Mix Point	97	
J	Medicaid Reimbursement	353,565	(G X H X I)

As we continue this example for a one-month period, we see that 90 beds were occupied by Medicaid patients for a period of 30 days (2,700 patient days). The facility reports an average case-mix index of 1.35 which, when multiplied by the case-mix point of $97 and the number of Medicaid patient days, results in a $353,565 payable from Medicaid. If, on subsequent audit, it turns out that the actual case-mix index was higher or lower than that presented for billing, a correcting payment will need to be made.

The facility will provide cost reports to the state to demonstrate the acuity of care provided. The state will audit these reports and also review the paperwork involved with the diagnostic classification of patients to ensure that they are assigned to the proper RUG classifications.

There may be a time lag of one or two years between when Medicaid costs are incurred and when the cost reports submitted by the facility are audited. As noted, facilities that overbill Medicaid will be required to reimburse Medicaid. Generally, Medicaid will allow facilities that have overbilled to repay them over a period of time. In reviewing a SNF's financial history, it is important to check to see if there is a pattern of overbilling that may overstate the facility's revenue and also set the stage for costly reimbursement down the road.

During the base year, it is not uncommon for nursing home operators to seek ways to increase their operating costs and to seek the lowest acuity patients possible. In this way, they are obtaining the highest direct cost per case-mix point. Once the rate setting period is over, the operator will seek to drive down costs and increase the acuity of patients as much as possible in order to maximize reimbursement.

It is very common for SNF residents to be discharged to a hospital or other therapeutic setting for temporary care. In these cases, the facility may hold the bed of this resident and continue to receive Medicaid payments ("**Bed Hold Payments**") as if the resident is still in the SNF. In New York, SNF's are eligible to bill for bed hold only when the vacancy rate in licensed beds is less than or equal to five percent.

Hospital reimbursement used to resemble the process used by nursing homes. Hospitals set a per diem rate based on a retrospective analysis of hospital operating and non-operating costs. Under this fee-for-service system, there was no incentive for hospitals to manage their costs. In fact, hospitals had a built-in incentive to increase the services provided. Not surprisingly, hospital costs soared.

Medicare also can be applied to nursing home stays but it does not cover custodial care. Medicare only pays for skilled care. Medicare pays the full cost for covered services up to twenty days in a SNF. After twenty days and up to one hundred days, Medicare requires a fairly significant copayment which may or may not be covered by **Medigap insurance**. After one hundred days, Medicare pays nothing.[63] Medicare reimbursement also is based on RUG categories but is not facility specific. The Medicare category price is expected to cover all direct, indirect and non-comparable costs for that resident.

[63] http://www.medicare.gov/Pubs/pdf/10153.pdf

Pressure to control rising hospital costs resulted in a new **prospective payment system** ("**PPS**") being implemented by Medicare in 1983.[64] PPS systems are geared to **pay for performance** rather than simply by head count. The states adopted PPS for Medicaid in 1986 and private insurers got on board in the late 1980's. PPS is based on **diagnostically-related groups** ("**DRG'S**")—a patient disease classification system that adjusts for acuity differences. If actual costs exceeded the pre-approved costs, the hospital suffered a financial loss. The prospective or case-based payment system replaced the cost-based reimbursement system and continues to this day to be the operant payment system in the country. The DRG concept is founded on the theory that patients in each category or DRG have the same clinical and resource needs. The DRG system has been refined over time. Today, there are 746 separate **MS-DRG** classifications.[65]

MS-DRG classifications are assigned an **acuity weight**. For example, a patient or "case" with a weight of 2.0 is deemed to be double the intensity and cost (and payment) of a case with a weight of 1.0. A particular hospital's actual cost of treatment is not involved in this determination. Hospitals generally seek to increase their **case-mix intensity** to generate higher revenues.

Each hospital is assigned a **base rate** which is the reimbursement rate for a case with a weight of 1.0. A national base rate is established and then adjusted for regional and local differences such as higher wage rates. In the case of teaching hospitals, there are adjustments to cover the cost of medical education. There also are adjustments to reflect the use of capital.

The base rate is reviewed annually by a **financial intermediary** ("**FI**") on behalf of Medicare and Medicaid. The FI reviews a twelve-month cost report provided by the hospital to determine if the base rate properly reflects the facility's operating and non-operating costs. The FI also delves into the coding of individual cases and the appropriateness of case documentation. Any overstatements of the base rate due to misrepresentations will mandate refunds by the hospital to the paying agencies. When hospitals are required to make refunds for overbilling, this item is not always clear on their financial statements and often is shown as an "unusual item."

Length of stay ("**LOS**") is used to measure the duration of a single episode of hospitalization. LOS is measured in whole days on a per patient basis and is computed by subtracting the day of admission from the day of discharge. Each MS-DRG classification has an associated LOS. **Average length of stay** ("**ALOS**") is the average number of days patients stay in the facility. ALOS is calculated by dividing the total number of days all patients stayed in the hospital by the number of patients discharged for the same period of time. ALOS is a key indicator of hospital efficiency and utilization. Because of pressures to reduce costs, ALOS has been falling steadily from 8 days in 1975 to 5.6 days in 2006. If a facility can treat and discharge patients with a lower LOS than the indicated MS-DRG, they are increasing their capacity utilization. If a facility

[64] Most of this section is pulled whole cloth from A Primer on Hospital Accounting and Finance for Trustees and other Healthcare Professionals. Fourth Edition. Felix Kaufman, Ph.D., CPA. Kaufman, Hall & Associates. http://dhss.alaska.gov/ahcc/Documents/meetings/201306/PrimerHospAcctFinance4thEd.pdf

[65] I think the name change to MS-DRG was due to revisions made by the Centers for Medicare and Medicaid Services ("CMS") but I am just guessing.

must keep a patient longer than the MS-DRG indicated LOS, then they aren't reimbursed for the extra time and they lose the bed availability for a new admission during the time the bed is occupied.

Both Medicare and Medicaid are turning to **private managed care organizations** ("**MCO's**") that agree to procure health services for participants for a set per capita payment. This way government can lock in the cost of care and the incentives for efficient management (e.g., pay for performance, lie with the private manager). Today, two thirds of Medicaid beneficiaries are enrolled in some form of managed care mostly from **private health maintenance organizations** ("**HMO's**") and **primary care case management organizations** ("**PCCM's**"). Medicare Advantage, the managed care version of Medicare, originated with the Balanced Budget Act of 1997. Of the 50.7 million Americans receiving Medicare coverage, 13.1 million are Medicare Advantage beneficiaries. Participation in the Medicare Advantage program continues to grow rapidly because of the better coverage than conventional Medicare.

The **Affordable Care Act**, also known as **Obamacare**, expands the use of pay for performance approaches in Medicare and encourages experimentation to identify designs and programs that are most effective.[66] Under Obamacare, hospitals are eligible for financial incentives or penalties depending on specific patient health outcomes. The objective is to further push hospitals to focus on patient outcomes rather than delivering services to increase revenues.

[66] http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=78