ADAMS AND REESE LLP

LOOK BEFORE YOU LEAP
Lessons Learned From CCRC Bankruptcies

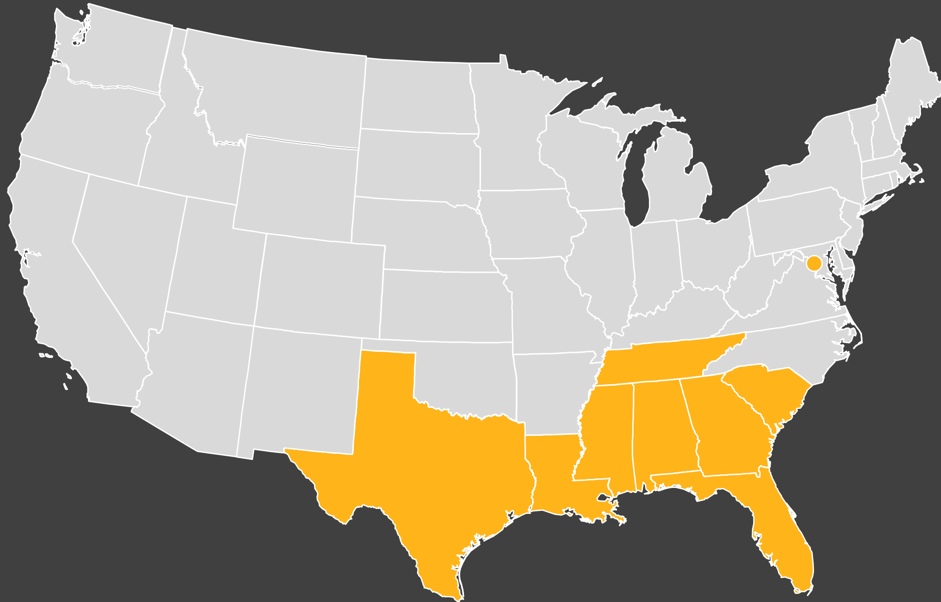
Click to add text

Panelists:
Demetra Liggins
Daniel Bleck
James Feltman
Richard Mikels

Moderator:
Richard Carmody

April 1, 2022

ADAMS AND REESE LLP



ATLANTA
BATON ROUGE
BIRMINGHAM
CHARLESTON
CHATTANOOGA
COLUMBIA
HOUSTON
JACKSON
JACKSONVILLE
MEMPHIS
MOBILE
MONTGOMERY
NASHVILLE
NEW ORLEANS
SARASOTA
ST. PETERSBURG
TALLAHASSEE
TAMPA
WASHINGTON, D.C.

Right where you need us.

Nearly 300 attorneys and advisors strategically located in 17 offices.

What are CCRCs (Also called Life Plan Communities)?

- CCRCs offer housing, meals, transportation, activities, and provide a continuum of care including assisted living and nursing home care, usually in one location, and usually for the individual's lifetime. Increasingly, CCRCs have health clinics, wellness programs, and specialized dementia care services.
- Non-Profit (many religious organization sponsors).
  For-Profit (many subsidiaries of hospitality and healthcare companies).
- Regulated (75% states) and unregulated (25% states).
- Average size mmm residents

Personal Considerations

Common Reasons to Consider a CCRC

- Highly Subjective – Priority Access to care is very important.
- Peace of mind that comes from meeting one's long term care needs in a single setting.
- No longer maintaining a house.
- Proximity of family.
- Relieves concern of being a burden on friends and family.
- Couples can age together in a community or on a campus.

CCRC Community Culture

- More institutional environment.
- Relatively homogeneous population.
- Everyone is eventually “aging out.”

Location, Facility Characteristics & Ownership

- Near or with friends. Near family?
- Age of the facility.
- Downsizing. “Your kids don’t want your stuff.”
- Non-profit or for-profit?
- Quality of management.

CCRCs from an Economic and Financial Perspective

Presented to the American College of Bankruptcy

April 1, 2022

KROLL

Table of Contents

1. **CCRC Macro & Market State**
    - Macro Outlook
    - Public Equity
    - Public Debt
2. **Cases of Distress**
    - Personal Anecdote
    - Business Anecdote
3. **Appendix**
    - Industry Regulations
    - Florida State Regulations
        - MLRR Calculation Excerpt
    - Actuarial Issues

CCRC Macro & Market State

KROLL

Macro Outlook

The COVID-19 pandemic burned many CCRCs from a financial point of view, particularly due to rapid drops in occupancy rates from to illness within facilities across the country. More recently, and primarily attributable to an aging population and a nearing cessation to COVID, senior-care facilities have begun to make a financial come-back. However, in no sense have all issues been resolved by the macroeconomic environment.

Move-ins remain well below pre-COVID levels, meaning that there is less revenue in the sector coming in the form of entrance fees, which make up a substantial portion of CCRC revenue.

Non-profit CCRCs had an 87% occupancy rate in the third quarter of 2021, down from 93% in the first quarter of 2020.

The tight labor market is currently causing additional hardship for these facilities as they struggle to both find and fund labor.

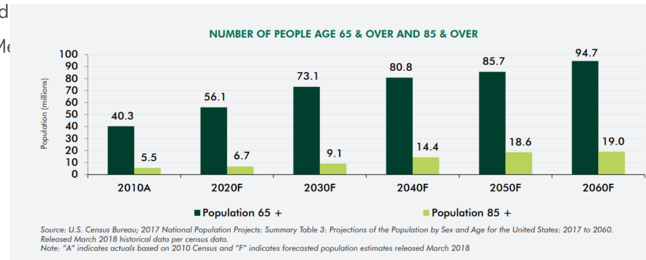
Exacerbating this situation is the fact that the market for qualified healthcare professionals has been evaporating for some time.

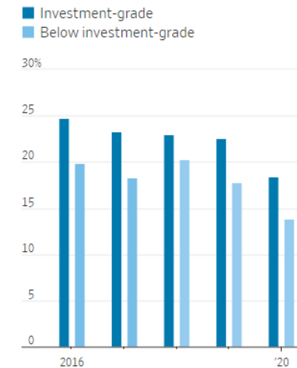
While recognizing that the COVID-19 pandemic has upended the Senior Living industry, CBRE believes the outlook for senior-living facilities is robust. Reasons for that outlook include:

i. Increasing demand as the U.S. 85+ population is forecasted to grow 177% to 18.5MM by 2050

ii. Increasing demand for need-based care (as the average lifespan increases and medical issues become more complex)

iii. Increasing generational und units/beds in the top 140 Me





Source(s): "Q22021 Senior Housing Market Insight". *CBRE*. Q22021.
Gillers, Heather. "Retirement Communities Lose Residents, Attract Muni Investors". *WSJ*. 4 January 2022

Macro Outlook Cont'd

Deaths tied to nursing homes and other long-term care facilities represent about a quarter of all COVID deaths in the U.S. Coupled with the current historic staffing shortage the industry is facing, facilities across the country are experiencing a COVID hangover that few other industries in the U.S. are feeling.

Industry reports have estimated that nursing homes and assisted living facilities together have lost more than 250,000 jobs since the start of the pandemic.

These staff shortages did not start with the pandemic: "we know that even before the pandemic, two years ago, there were already staff shortages," said Susan Reinhard, executive director of AARP's Public Policy Institute, referring to labor in the industry as "a perennial problem."

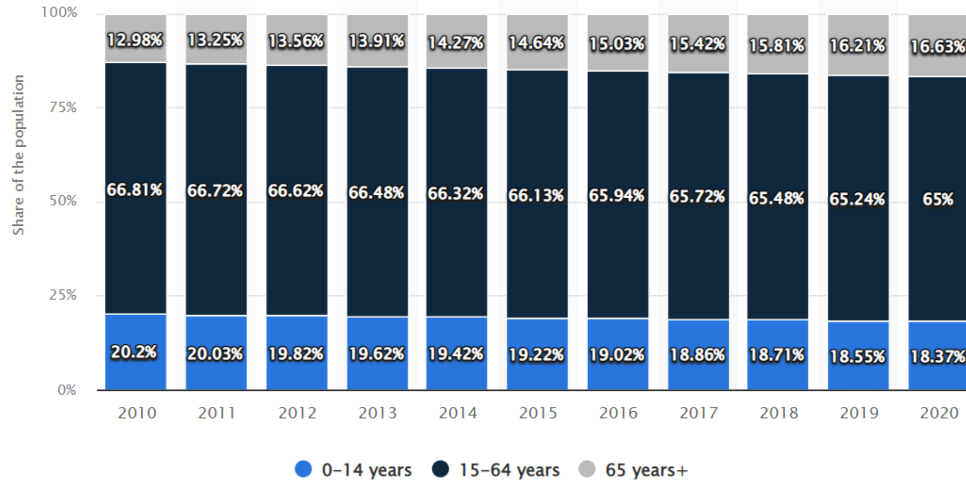
With numerous staff out due to COVID infections, many reporting for duty experienced burn-out as they fulfilled the day-to-day duties that needed to be completed for the health and well-being of the residents.

Staffing shortages have caused some operators, such as the Good Samaritan Society and Tabitha, to close facilities, which has caused backups in hospitals unable to release patients requiring long-term care. With this abrupt shortening of supply, ageing population, and inflation, the prices attached to these already expensive facilities are expected to increase. To attract workers, facilities will have to naturally pay for them, but this cost would of course be passed-on to the residents.

Source(s): Chatterjee, Rhitu. "The Pandemic Pummeled Long-Term Care—It May Not Recover Quickly Experts Warn". *NPR.* 22 February 2022.

U.S. Age Trends

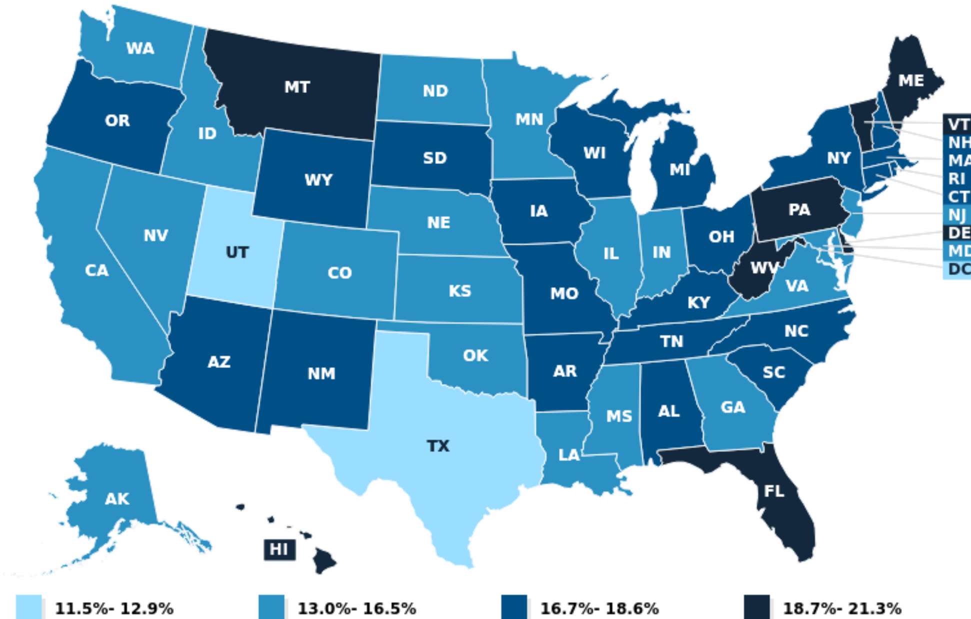
The 65+ population in the U.S. witnessed a 2.96% CAGR from 2008 to 2019, compared with a 0.27% CAGR for the rest of the population.



Source(s): "Age Distribution in the U.S. from 2010 to 2020". *Statista*. 2 February 2022. (https://www.statista.com/statistics/270000/age-distribution-in-the-united-states/)

U.S. Age Geography

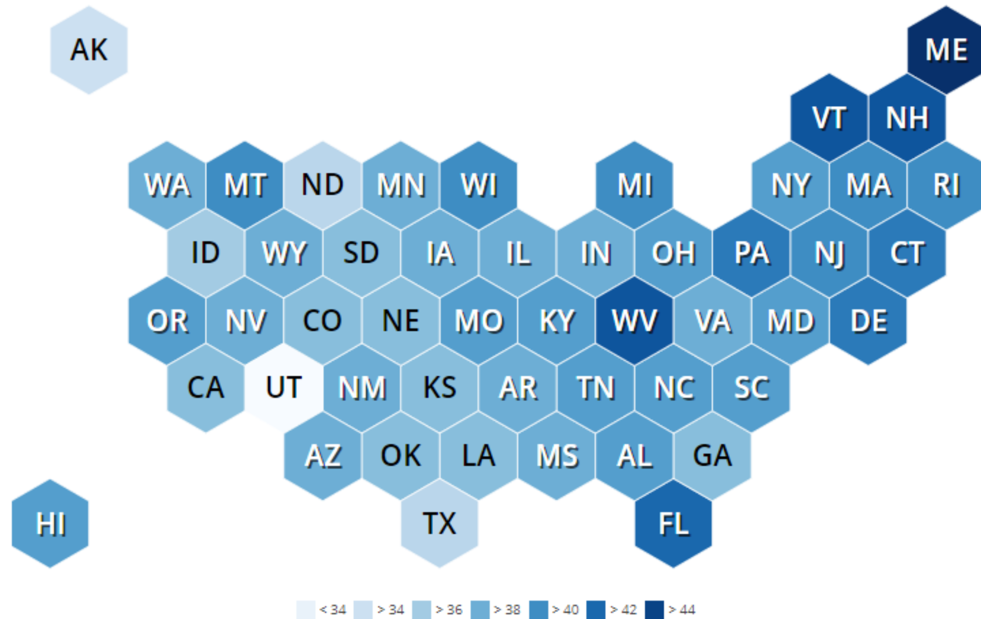
The below map details those states that had high relative 65+ populations in 2019.



U.S. Age Geography Cont'd

The dark colored states below will require robust assisted-living infrastructure if that is not already the case. Florida's expansive state regulations regarding the senior-living industry are detailed in later slides.

2022 Median Age by State



Source(s): *World Population Review*. (https://worldpopulationreview.com/state-rankings/median-age-by-state)

Public Equity

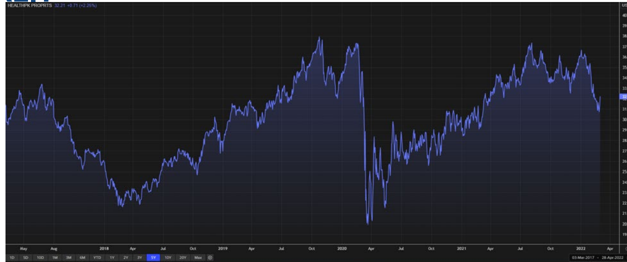
5-Yr Price Performance of Sector ETF (NASDAQ:OLD)[1]

With the objective to track the Solactive Long Term Care Index, the ETF invested in companies, globally, that position themselves to profit from providing long-term care to the aging population.

5-Yr Price Performance of Largest Sector REIT welltower

Welltower invests in senior housing, post-acute communities, and outpatient medical properties, in the U.S., Canada, and U.K.

5-Yr Price Performance of Second-Largest Sector REIT



Healthpeak holds and has developed over $20Bn of real estate assets in the segments of life sciences, medical offices, and CCRCs across the U.S.

It is obvious to say that the industry took a massive blow in the wake of, and during the worst of, the Coronavirus pandemic. Though, the market has since begun to find a renewed attraction in these notoriously difficult-to-operate CCRC assets. Healthpeak is currently trading at a 3x LTM P/BV and 23x LTM EV/EBITDA, while Welltower is at a 2x LTM P/BV and 30x LTM EV/EBITDA. These are strong multiples but not extraordinary in the current market.

Source(s): Refinitiv & Bloomberg

1. This ETF was closed and liquidated on October 11, 2021, for no reason provided by the sponsor (Source: Business Wire).

Public Debt

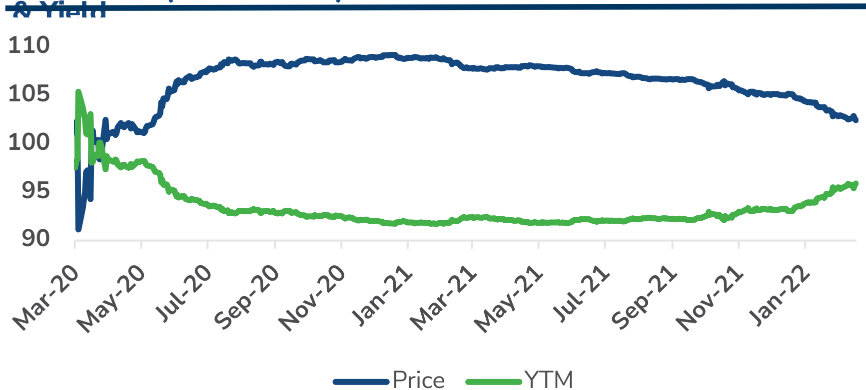
The demand is strong for muni-bonds sold by senior-care facilities despite record default rates, pandemic-related revenue losses, and labor shortages.

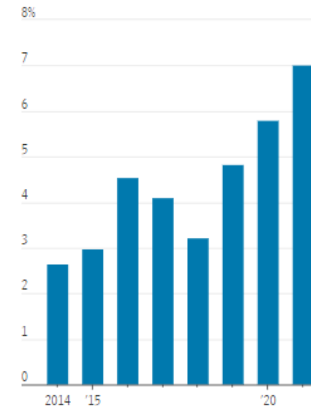
Senior-care facilities (nursing homes, assisted-living, and CCRCs) are permitted by federal law to sell tax-exempt debt (municipal) because they are perceived to have a public benefit.

~8% of the $41Bn in outstanding senior-care facility bonds were in default as of December 2021: the most since tracking began in 2009.

The industry now accounts for almost one-quarter of defaulted debt in the muni market.

- Senior-care facilities sold $7.4Bn in new bonds in 2021—21% more than they had in 2019.
- According to David Hammer, head of muni-bond portfolio management at PIMCO, "the operations have not fully recovered, even though, in some places, bond prices have."





Source(s): Gillers, Heather. "Retirement Communities Lose Residents, Attract Muni Investors". *WSJ*. 4 January 2022.

Cases of Distress

- Business cases of distress in this sector are especially precarious and have a truncated time-line due to the reality that the residents of these facilities are in often fragile, vulnerable states that require the utmost care. This is irrespective of the personal cases where people become buried by debt issued to fund their, or a relative’s, care,

Personal Anecdote

CCRCs are notoriously expensive, and the current macroeconomic factors (inflation) has augmented this reality. Most facilities charge an entry fee which varies widely in range (from $40,000 to greater than $2MM), of which the average is $402,000, according to AARP. Once residents move-in, there are monthly service fees. The average monthly service fee in the third quarter of 2021 was $3,555, according to AARP. It is easy to imagine how average Americans how pummeled by these fees. Americans are left with few options, as the at-home cost of caregiving is rarely any cheaper. In 2019, AARP's own caregiving expert filed personal bankruptcy after becoming awash with the costs of elderly care.

Caregiving is becoming more expensive because of increasing life expectancy and labor costs.

- The median annual cost of in-home care increased to $54,912 in 2020, an 18.5% increase from 2016. By comparing this in-home cost with the average $3,555 monthly service fee above and roughly spreading the average entrance fee, one can see how the cost of in-home care is approximate to that of facility care.

Amy Goyer, AARP's "Caregiving Expert", had to leave her personal life and career behind to care for her aging parents.

- Goyer initially put her parents up in a CCRC where monthly fees were $4,000 for the two of them. Her parents had long-term care insurance, Social Security, and her father had a pension, which were able to cover the monthly fees. But personal-care services, "including someone to help her mother bathe and dress", were additional and had to be covered by Goyer.
- When 24hr care was needed, Goyer moved her parents to her home and hired

Source(s): "How Continuing Care Retirement Communities Work". *AARP*. 27 January 2022.
Ansberry, Clare. "Caring for Older Relatives Is So Expensive That Even AARP's Expert Filed for Bankruptcy". *WSJ*. 20 February 2022.

Business Anecdote

An ongoing case in the assisted living/CCRC space is that of Gulf Coast Health Care's District of Delaware joint (including ~60 affiliates) Ch. 11 free-fall, case no. 21-11336 filed October 15, 2021. Judge Karen Owens approved the Debtor's first amended disclosure statement on March 4, 2022.

Case Background & About the Debtor

- As of the petition date, the Debtor operated 28 skilled nursing facilities in FL, GA, and MS. At its height, the Debtor operated upward of 50 facilities, but has divested 22 since that time, 20 of which were divested in November of 2020.
- At the petition date, the Debtor recorded 3,343 licensed beds, 2,244 residents, and 3,100 employees for a mere 67% occupancy rate.
- As for the crux of the distress, the CRO in their declaration cited "decreased resident occupancy levels, crippling staffing and employee retention issues, and increased operating expenses associated with PPE, labor pressures, and other associated costs." All of which have been the collective bane of contemporary CCRCs.
- State government aid was depleted in the ordinary course of business, while the recoupment of Medicare Accelerated and Advanced Payment Program ("MAAP") funds by the Centers for Medicare and Medicaid Services ("CMS") added greater pressure to the already strained liquidity.
- As is typical in the industry, the Debtor was involved in certain Intercompany Arrangements and agreements with Affiliated Service Providers, which in combination facilitate the day-to-day operations and achievement of "…economies of scale by consolidating certain key functions…".
- Debtor had simple prepetition capital structure with $280.3MM total secured debt of which 77% ($217MM) was in the form of leases.
- Since facilities are leased, primary collateralized assets are cash and AR.

Case Facts

- Debtor voluntarily filed after it entered an RSA designed to transfer the operations of all the debtor's facilities to new operators and subsequently wind down debtor operations.
- Debtor sought and attained $25MM of DIP funding, which was provided through an indirect affiliate of its largest landlord, Omega Healthcare.
- "Narrowly tailored" third-party releases are being contemplated under the plan and given the current landscape of these releases, Judge Owens said she would like "her 'hand-held' by the Debtors" when it comes to understanding to claims subject to releases.
  - Joseph McMahon for the UST has pointed-out that there is specific concern surrounding the nonconsensual third-party releases of abuse claims, or "PLGL Claims".

Source(s): "CASE SUMMARY: Skilled Nursing Operator Gulf Coast Health Care to Wind Down, Transition Facilities to New Operators Under RSA With Master Landlord Omega and Secured Lender New Ark Capital". *Reorg Research*. 15 October 2021.
"Declaration of M. Benjamin Jones in Support of Ch. 11 Petitions and First Day Pleadings". Doc 16, Case No. 21-1136 in re: Gulf Coast Health Care, LLC, Filed 14 October 21.
"Judge Owens Approves Gulf Coast's Amended DS After Debtors Resolve Outstanding Objections…". *Reorg Research*. 4 March 2022.

Appendix

KROLL

Industry Regulations

Because CCRCs essentially depend upon Medicare and Medicaid redemptions, it is imperative that the facilities meet the requirements of these government programs. The bulk of these requirements revolve around certifying that elderly care meets some level of adequacy, while some are aimed at improving the working environment for the facility staff. CCRCs and other like-operations are highly scrutinized by regulators. For instance, the CMS inspects the granularities of the cleanliness and safety of the facilities, the ways in which the staff assists patients in daily care and will inspect the facilities' ability to prevent accidents/hazards/disease. In addition to these federal regulators, facilities must comport with state regulators.

Table 4 | US Skilled Nursing Facilities Regulations

Organization or Legislation	Regulatory Actions
Centers for Medicare & Medicaid Services (CMS)	Inspects nursing facilities to see if they meet government standards Places facilities that do not meet standards into the Special Focus Facility (SFF) Initiative in an attempt to encourage suitable improvement; facilities that do not achieve improvement in the set amount of time risk funding termination
Patient Protection & Affordable Care Act (ACA)	Requires CMS to maintain a national system to collect and report payroll data on direct care staffing Requires background checks on all job applicants who will potentially have access to residents or recipients of long-term care services
Nursing Home Transparency & Improvement Act	Requires nursing facilities to clearly identify owners, managers, and the organizational structure of the facility, including how funds are spent
National Partnership to Improve Dementia Care in Nursing Homes	Sets yearly targets for the reduction of the use of antipsychotic medications in nursing facilities
US Drug Enforcement Administration (DEA)	Limits who can lawfully deliver controlled substances for disposal to three groups: the ultimate users, those entitled to dispose of the decedent's property, and long-term care facilities on behalf of their residents
US Occupational Safety & Health Administration (OSHA)	Inspects nursing facilities with high worker injury rates in an attempt to reduce the physical and mental stress of workers

Source: The Freedonia Group

Source(s): "Skilled Nursing Facilities: U.S.". *Freedonia Reports*. October 2021.

Florida Regulations

Florida has one of the eldest populations in the U.S. and elderly care is consequently a key sector to its economy. State regulation, specifically through the Florida Office of Insurance Regulation (FLOIR), regarding the finances of these care providers is continual and adaptive as the state seeks to keep all facilities in firm financial health. Florida, along with the rest of the country, aims to avoid any systemic distress in the assisted living industry.

Financial & Operating Requirements

The laws that encapsulate the CCRC industry in Florida (§651 of the FL Statutes) speak to the remedial steps that must occur if a CCRC (the "provider") is to become *impaired*. Per the state definitions outlined in §651.011 of the FL Statutes, "impaired" means that either of the following has occurred:

1. A provider has failed to maintain its Minimum Liquid Reserve Requirement (MLRR) as detailed under §651.035, unless the provider has received prior written approval from the office for withdrawal pursuant to §651.035 and is compliant with the approved payment schedule; or
2. Having begun Jan. 1, 2021:
   a. For a provider with mortgage financing from a third-party lender or a public bond issue, the provider's DSCR ratio is less than one **AND** the days cash on hand is less than 90; or
   b. For a provider without mortgage financing from a third-party lender or public bond issue, the provider's days cash on hand is less than 90.

If a provider is deemed impaired, the governing body (the "office") must:

1. Require the provider to prepare and submit a corrective action plan or, if applicable, a revised corrective action plan;
2. Perform an examination pursuant to §651.105, as the office considers necessary, of the assets, liabilities, and operations of the provider, including a review of the corrective action plan. Examinations pursuant to §651.105 are discussed on the next slide; and
3. After the examination, issue a corrective order, if necessary, specifying any corrective actions that the office determines requisite.
   a. The office may use members of the Continuing Care Advisory Council, individually or as a group, or may retain actuaries, investment experts, and other consultants to review a provider's corrective action plan or revised corrective action plan; examine or analyze the assets, liabilities, and operations of a provider; and formulate the corrective order with respect to the provider. The cost of which must be borne by the affected provider.

- An impairment is sufficient grounds for the office to be appointed as receiver, except when the office's remedial rights are suspended pursuant to §651.114(11)(a). When the remedial rights are suspended, the provider must make available to the office copies of any corrective action plan approved by the third-party lender or trustee to cure the impairment and any related required report.

Source(s): The 2021 Florida State Statutes, Title XXXVII, §651.034, "Financial & Operating Requirements for Providers".

Florida Regulations Cont'd

Examination

The office may at any time (at least once every three years), examine the business of any provider engaged in the execution of care contracts or engaged in the performance of obligations under such contracts. The written report of each examination must be filed with the office and such report constitutes a public record. The representative or examiner designated by the office may at any time examine the records and affairs and inspect the physical property of any provider, whether in connection with a formal examination or not. Relatedly, any duly authorized officer, employee, or agent of the office may, upon presentation of proper identification, have access to, and examine, any records, with or without advance notice.

The office must notify the provider and the executive officer of the governing body of the provider in writing of all deficiencies in its compliance and shall set a reasonable length of time for compliance by the provider. Additionally, the office shall require corrective action or request a corrective action plan from the provider which plan must demonstrate a good faith attempt to remedy the deficiencies by a specified date. If the provider fails to comply within the established timeframe, the office may initiate action against the provider in accordance with the provisions of this chapter.

All providers are required to respond to written correspondence from the office and

To some, the examinations and dominant position held by the office may seem intrusive and stringent. The position conferred to the office makes clear the gravity with which the state considers the protection of residents, albeit indirectly through the close monitoring of providers' financial health.

Source(s): The 2021 Florida State Statutes, Title XXXVII, §651.105, "Examination".

Florida Regulations Cont'd

Minimum Liquid Reserve Requirement (MLRR)

The MLR requirement consists of the following reserves which must be maintained in escrow, as detailed in §651.035:

1. **Debt Service Reserve:** Each provider must reserve the aggregate amount of all principal and interest payments due during the fiscal year on any mortgage loan or other long-term financing of the facility, to include property taxes and leasehold payments. If a provider does not have a mortgage loan or other financing on the facility, the provider must make monthly escrow deposits equivalent to one-twelfth of the annual property tax liability as indicated in the most recent tax notice provided.
2. **Operating Reserve:** Each provider must maintain an unencumbered reserve equal to 30% of the total operating expenses projected for the first 12 months of operation. After that initial 12 months, the reserve lowers to 15% of total operating expenses, where operating expenses are calculated annually by averaging the total operating expenses reported in the three most recent annual financial reports filed pursuant to §651.026.
3. **Renewal & Replacement Reserve:** Each provider shall maintain a reserve equal to 15% of the total accumulated depreciation based on the annual financial reports filed pursuant to §651.026, not to exceed the value of the Operating Reserve. For a provider who does not own any of its facilities and so depreciation is not a component of the financial reports, the

Source(s): The 2021 Florida State Statutes, Title XXXVII, §651.035, "Minimum Liquid Reserve Requirements".

MLRR Calculation Excerpt

Below is an excerpt for the required annual operating reserve calculation that can be found in the Florida Office of Insurance Regulation's MLRR document required to be filled-out annually be each CCRC in the state. The MLRR document is meant to be annexed to each CCRC's Annual Financial Report.

Facility Name: Enable Calculations

If the Facility has operated **less than 12 months**, the annual operating reserve is calculated below:

(13) x (.30) x (15) / (16) = (17)

13. Net Operating Expenses (Line 12D)
14. Operating Reserve Factor (.30)
15. CCRC Residents (Line 5A)
16. Total Residents (Lines 5A + 5B)
17. Total Operating Reserve

CALCULATION: ________________ X .30 X ________________ / ________________ = ________________

If the Facility has operated for **12 or more months**, the annual operating reserve is calculated below:

(18) x (.15) x (20) / (21) = (22)

18. Net Operating Expenses (Line 12D)
19. Operating Reserve Factor (.15)
20. CCRC Residents (Line 5A)
21. Total Residents (Lines 5A + 5B)
22. Total Operating Reserve

CALCULATION: ________________ X .15 X ________________ / ________________ = ________________

Source(s): Florida Office of Insurance Regulation. "Minimum Liquid Reserve Requirement (MLRR) Calculation". (https://www.floir.com/siteDocuments/OIR-A3-477.pdf)

Actuarial Issues

Specifically when considering the structure of Type A contracts, the majority of CCRCs implicitly include a multitude of long-term care obligations. The issue with these implied insurance contracts is that they were not actuarily underwritten and CCRCs generally do not keep enough reserves on hand to cover these contractual obligations. Rather than establishing appropriate actuarial reserves, CCRCs rely on the cash-flows derived from entry fees and access to the tax-exempt (muni) bond market. With that, many CCRCs are "actuarily insolvent" and exposed to high risk in the face of market-based disruptions to their fee structures.

Bondholders of these facilities typically have first liens on the assets, so the residents become the most vulnerable class of unsecured creditors.

According to the Commission on Accreditation of Rehabilitation Facilities (CARF), the bottom 25% of operators issuing Type A contracts:

i. Are unable to cover more than 23% of debt service from ongoing operating revenue;
ii. Have negative operating cash flow before entry fees; and
iii. Have either little or no equity cushion in their capital structures

Further increasing the cash flow risk of CCRCs is how many operators have created "refundable entry fee plans", albeit for higher sticker prices than non-refundable fees. These refundable fees increase current cash flow for a delayed potential liability. These unsecured promises are generally fulfilled only after death or departure from the facility, and no cash exchanges hands until a new resident takes the prior's position and replaces the prior's entry fee.

Regulators have historically been far more focused on quality of care within these facilities over the financing structures and financial health.

As discussed in prior slides, Florida has taken steps to address the risks by having adopted legislation in 2017 that requires operators to hold actuarial reserves that aim to match future incurred liabilities. Other states have followed suit and have begun to adopt similar legislation.

In the absence of equity cushions or actuarial reserves, state regulators will require cash reserves (measured by days cash on hand) or a "cushion ratio" equal to unrestricted cash on hand divided by annual debt service.

Source(s): Barker, Peter. "The Looming Crisis in CCRCs". *TopTal.com*.

CCRC Affordability

Can You Afford a CCRC?

- Entrance Fees
  - One time, upfront. Usually at or above median house values in the area
- Monthly Fees
  - Variable depending on levels of amenities and care required and type of contract. Indexed to inflation. Compare to homeowner expenses.
- Adequacy of Income Analysis
  - CCRC will fully vet each applicant's financial disclosures. Also calculate an actuarial age (life expectancy).

Continuing Care Contracts

What is a Continuing Care Contract?

- Promise of Care for a Period of at Least One Year or More.
- Offers independent living and continuum of care.
- Tend to protect the provider.
- Usually not subject to negotiation.

Key Elements of Continuing Care Contract

- Disqualifying Conditions
  - Start at independent living.
  - Pre-existing health conditions.
  - Upper age limit.
- Contract Termination
  - Trial period?
  - Prohibit divestment of assets?
  - "For good and sufficient cause?"

Key Elements of Continuing Care Contract (cont.)

- Refundable Entrance Fees
  - Subject to negotiation
  - Paid to heirs
- Ownership
  - Unusual
- Improvements to Independent Units
  - Require approval
  - Become CCRC property

Basic Contract Types – “Type A”

- Life Care Contract
  - Care for life for a fee
  - Most expensive option
  - Non refundable
  - CCRC assumes risk
  - No longer prevalent

Basic Contract Types – "Type B"

- Modified Contracts
  - Entrance fees, monthly fees, guarantee of access to higher levels of care
  - Potential refunds
  - There might be options for full, partial or proportional refunds of entrance fees
  - Less costly upfront
  - Future risk sharing

Basic Contract Types – “Type C”

- Fee-for-Service Contract
  - Entrance fees, monthly fees, guarantee of access to higher levels of care
  - Potential refunds
  - Prevailing market rate for more care
  - The resident assumes the risk of future level of care costs directly

Assessing the Availability/ Quality of Services and Care

Quality of Care Concerns

- Ask about the years of experience and the track record of ownership / management in operating both independent living units and higher levels of care
  - e.g. – assisted living and nursing homes
  - Check all levels of care

Independent Units

- Housekeeping
- Food plans and food variety
- Quality and meal schedules
- Transportation
- Recreational and activity costs
- Accessibility features
- Options/restrictions for receiving assisted living services in independent units, and associated costs
- Incidence of relocation to higher levels of care
- Consequences of one spouse in assisted living

Assisted Living

- Availability when needed
- On-site
- Dementia and hospice care
- Emergency evacuation
- Qualifications and training of staff
- Ratio of staff to residents at each shifts

Nursing Home & Primary care

- Experience of managers
- Turnover rates
- Acceptance of innovation

Evaluating Administrative Practices

Atmosphere of Respect

- Not patronizing
- Accepting of constructive criticism
- Rapport with administrators

Residents’ Self-Determination & Independence

- Are you consulted on decisions affecting your level of care?
- Ask residents about:
  - How decisions are made
  - How residents’ input is sought by administration
  - How decisions are communicated to residents
- Is there a functioning resident association?
- Can residents air grievances?

Administration’s Transparency & Experience

- Process for informing residents of fee increases?
- Experience of administration in aging services?

Plans for Renovation / New Construction

Renovation / New Construction

- Can affect enjoyment of the independent living residence or otherwise disrupt the campus.
- For older complexes, find out about their history of renovations and if any renovations or new additions are planned in the next 3 to 5 years.

Renovation / New Construction (cont.)

- For new CCRCs, find out at what stage the assisted living and nursing home care levels are planned to be in place, as you are buying into a continuum of care. Will appropriate care levels be available when you might need them?
- How will monthly rates be affected over the next 3 to 5 years?
- How will common areas be improved?

Financial Soundness

Financial Soundness of the CCRC

- Providers should share audited financial statements and different forms indicating their financial soundness prior to the signing of a contract.
- Review these documents well in advance of contract signing.

Occupancy Rates

- Occupancy rates should not on average go below 90%
- Occupancy rates are the single most important indicator of the CCRCs fiscal viability because high occupancy generates entrance fees, and amortized fees are used for maintaining moderate annual rate increases and providing funds for facility reserve funds.

Operating Income & Expenses

- Expenses should not exceed operating income as a historical pattern.
- Relying on investment income to cover operating expenses might be a vulnerable position, especially in volatile economic times.
- Check the philosophy of investment, risk monitoring procedures, and actual performance for funds invested by the corporation.

Assets, Liabilities, Reserves & Legal Obligations

- CCRCs should maintain an excess of assets over liabilities.
- Is the CCRC deeply indebted?
- Contingency funds should cover at least 6 months of operating expenses.
- Are the reserves adequate?
- Has the CCRC been sued, and, if so, why?

Size of Corporation

- Smaller entities may be more vulnerable.
- Are there any plans for future mergers with other CCRCs?
- For multi-facility entities, consider overall strength and performance record.
- Can they, or have they, shifted funds between entities?

Actuaries

- Does the CCRC rely on actuaries to price contracts, conduct regular studies, and certify satisfactory actuarial balance? These matters affect financial viability.

Additional Resources

- https://www.wsj.com/articles/caregiving-costs-expensive-11645282825
- https://www.kiplinger.com/article/retirement/t037-c000-s004-ccrcs-raise-financial-questions-for-retirees.html
- https://thechesapeake.org/blog/top-10-questions-to-ask-a-retirement-community/

Additional Resources

- https://mylifesite.net/blog/post/key-questions-the-ultimate-ccrc-checklist/
- https://mylifesite.net/blog/post/8-questions-to-consider-before-you-decide-to-age-in-place/
- http://www.canhr.org/publications/PDFs/CCRCGuide.pdf

ADAMS AND REESE LLP

Panelists

Demetra Liggins
McGuire Woods
Houston

Daniel Bleck
Mintz
Boston

James Feltman
Kroll
Miami

Richard Mikels
Pachulski Stang
Boston

Moderator

Richard Carmody
Adams and Reese
Birmingham