

Assisted Living Reports Healthy Revenues In 2007 Report

A majority of the assisted living residences participating in the “2007 State of Seniors Housing” survey reported a median per resident, per day revenue of \$125, slightly lower than continuing care retirement communities (\$129) and \$50 more per day than independent living communities (\$75) reported.

The “2007 State of Seniors Housing” summarizes data collected from 807 seniors housing properties located throughout the United States. Respondents were asked for operating results for the 12-month period ending nearest to Dec. 31, 2006. The report is a joint project of the American Seniors Housing Association (ASHA), the American Association of Homes and Services for the Aging, and the National Investment Center for the Seniors Housing & Care Industry (NIC). This is the 15th year the report has been published. The report’s authors discourage year-to-year comparisons because different providers respond to the survey each year.

The 65-page report contains various operating and key financial indicators. Assisted living communities comprised nearly one-half (44.7 percent) of the survey sample, followed by independent living communities, (36.4 percent), and continuing care retirement communities (CCRCs) 14.1 percent.

Among the findings are that median occupancy rates exceeded 90 percent across all community types, yet many facilities saw almost half or one-third of their resident population turn over. The median annual resident turnover was highest for assisted living residences (54.2 percent), followed by independent living communities (31.1 percent), and CCRCs (18.3 percent). Assisted living communities that were exclusively for individuals with Alzheimer’s disease reported the highest median annual resident turnover at 59.6 percent.

A majority of the assisted living residences also reported the highest net operating income (NOI) per occupied unit across the categories. Assisted living residences recorded the highest median NOI per occupied unit at \$14,972. CCRCs followed with \$11,270 and independent living at \$10,831. NOI per resident per day was

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National Benchmarks Not Applicable for Rural Assisted Living, Report Finds

National benchmarks used to analyze large assisted living markets may not be applicable to study feasibility of an assisted living community in a rural area that has fewer than 5,000 people, says a new report.

“Based on the findings of this study, it appears that approaches often used to analyze assisted living markets may not be appropriate for rural communities,” concluded the authors of “Assisted Living In Rural Markets,” a report published by NCB Capital Impact, Arlington, Va., in conjunction with the Robert Wood Johnson Foundation.

The study evaluates the efficacy of applying standard market study methodologies and benchmarks for assisted living to rural assisted living communities and identifies factors that would contribute to the success of an assisted living residence located in a rural area.

For this study, rural areas were defined as having fewer than 5,000 people. Nine out of 10 of the communities studied had fewer than 2,500 people. The rural assisted living communities were located in Oregon and Washington.

Market analysts typically use the national benchmark that 20 percent of the residents who move into assisted living are from the residence’s secondary market—residents who move into the facility from outside of the primary market, which is typically defined as the geographic area from which the majority of the facility’s residents are drawn.

“A larger secondary market—perhaps up to 30 or 35 percent—than is typically used by analysts may be reasonable for rural markets,” the researchers said.

Many rural communities have large numbers of seniors who face many obstacles to accessing health care services and long term care, from socioeconomic factors to lack of available services. In addition, most assisted living is built in higher population areas, and there is a major undersupply of assisted living in rural areas—considering that 25.4 percent of people who are 85 years or older live in a rural area.

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Medicare Prescription Drug Plan Enrollment Ends Dec. 31, 2007

The Centers for Medicare and Medicaid Services (CMS) encourages all Medicare Part D Plan beneficiaries to compare their current plans with other plans during the open enrollment period. The Medicare annual open enrollment period for prescription drug plans ends Dec. 31, 2007.

Assisted living residents who have not enrolled in Part D can consider whether the Medicare drug benefit is right for them, and if so, can select and enroll in a drug plan. Residents who already have Medicare Part D coverage can also review their current Part D plans, and if they wish, can switch to another plan during the open enrollment period. If residents are satisfied with their current Part D drug plan, they do not need to do anything in order to maintain coverage.

For those individuals considering enrolling in a Medicare drug plan, CMS suggests that they review their prescription drug needs and then compare the performance of the plans. NCAL's "Medicare Part D Essentials for Assisted Living/Residential Care Facilities," suggests that to make the best decision, individuals will need to know at least four factors:

- Whether they have existing health coverage for prescription drugs that is at least as good as Medicare Part D (called "creditable" coverage in Part D jargon).
- Whether they qualify for a low-income subsidy.
- The names of the prescription drugs they take and whether these drugs are listed in a plan's formulary.
- Whether the prescription drug plan provides access to the pharmacies the individuals need.

In addition, the NCAL guide reminds assisted living administrators and staff that they can provide objective education, outreach materials, and information to residents and their families on Part D but may not take any steps that could steer beneficiaries toward particular Part D plans. CMS has stated that the beneficiary, legal guardian, or other persons with durable power of attorney may complete the application or request a plan change.

CMS says it is conducting an outreach effort to get more individuals eligible for low-income subsidies (LIS) to enroll in the program. For those LIS-eligible Medicare beneficiaries who may not have enrolled in Part D in the past, CMS is waiving the fee for late enrollment to make it easier to get the help they need. Recently CMS mailed letters on blue paper notifying low-income beneficiaries that they have been re-assigned to new Medicare drug plans for 2008.

To help beneficiaries compare plans, CMS enhanced the Medicare Prescription Drug Plan finder options available on its Web site at www.medicare.gov. The enhanced features offer information on available drug plans, including out-of-pocket costs and pharmacy networks. One section of the Web site, titled "Review 2008 Choices," is for individuals who have a current Medicare Part D plan and want to investigate whether it is still the best plan for them. The other section of the Web site, titled "Start with 7 Simple Steps," is for individuals who are looking to join a plan.

Another feature allows individuals to determine a plan's quality rating. Plans get a star rating for each category

**NCAL
Seeking
Quality
Award
Applicants:
Step I
Deadline Feb. 28**



NCAL is encouraging members to apply for the 2008 Quality Awards program and earn recognition for their residences' continuous quality efforts.

The Quality Awards program is a progressive three-step program that encourages continuous learning and development of integrated, quality systems to achieve performance excellence. Organizations are able to apply for recognition and awards at three levels—Steps I, II, and III—each of which requires a more detailed and comprehensive demonstration of quality integration and performance. These award levels are based on criteria adopted from the Malcolm Baldrige National Quality Award Health Care Criteria for Performance Excellence.

The deadline for Step I applications is Feb. 28, 2008, a month earlier than Step II and III. Step II and III applicants have until March 31, 2008, to submit applications. Visit www.ncal.org.

and every measure within the categories. A plan can get a rating between one and five stars, with one star symbolizing poor performance and five stars representing excellent performance.

For more information on the Medicare Prescription Drug Plan, visit www.medicare.gov.



Assisted Living Rates Virtually Unchanged

The MetLife Mature Market Institute's annual survey of assisted living rates in the U.S. also found that rates for assisted living units in 2007 remained relatively unchanged compared with 2006.

The 2007 national average monthly base rate for a one-bedroom apartment with a private bath is \$2,969, or \$35,628 annually. In 2006, the national average for the same unit was \$2,968, or \$35,616 annually. In 2005, the cost was \$2,905 or \$34,860 annually.

The 2007 national average monthly base rate for Alzheimer's and dementia care in facilities is \$4,270, or \$51,240 annually.

The study found significantly more

facilities provided Alzheimer's care (59 percent), compared with 48 percent in 2006. Assisted living providers charge

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Source: Met Life

additional fees for dementia care, and of the 54 percent of the communities charging additional fees for dementia care, the average additional fee totaled \$1,110 monthly.

Washington, D.C., registered the most expensive market rates in the country for Alzheimer's assisted living, with an average monthly base rate of \$5,031, with Manchester, N.H., at \$4,866, and the Stamford, Conn., area at \$4,860, following close behind.

The most inexpensive market areas are Indianapolis, at \$1,963, and North Dakota, at a \$1,964 average monthly base rate.

Survey data from 881 assisted living facilities, ranging in size from seven to 320 beds, were included in the sample; the average number of beds per facility was 63, while the median number of beds was 60.

To obtain a copy of the report, visit: www.maturemarketinstitute.com.



HUD Assisted Living Conversion Grants Awarded In Seven States

The U.S. Department of Housing and Urban Development (HUD) recently awarded \$22.2 million in grants to convert apartments into assisted living facilities in seven states.

HUD's Assisted Living Conversion Program awarded grants on a competitive basis to private, nonprofit groups that will use the funds to renovate existing multifamily units into assisted living facilities for low-income seniors and people with disabilities.

The Assisted Living Conversion Program does not cover the costs of supportive services; the project owners must provide the service funds either directly or through a third party. Supportive services include personal care, housekeeping, meals, and transportation. Properties that recently won grant funding are providing the services portion through a number of sources, including their respective state's home health care programs, assisted living services funds, congregate housing service program funds, service coordinator funds, private grants, and donations. Social Security income, Medicaid, or state or area aging agencies can also provide funding for the services.

The projects will reconfigure apartments, create common and service areas, and conduct any necessary remodeling that is consistent with HUD or state statute or regulations, whichever are more stringent. The grant also requires that the building have sufficient community space to accommodate a central kitchen or dining facility, lounges, recreation, and other multiple areas available to all

residents of the project, or office and staff spacing in the assisted living facility.

HUD's Office of Multifamily Housing is responsible for administering the Assisted Living Conversion Program.

Applicants for the program must submit an application in response to the annual Notice of Funding Availability (NOFA) published in the Federal Register. The NOFA will be issued during the first quarter 2008, according to HUD. Applicants that apply for the Assisted Living Conversion Program will compete for program funds allocated to each individual Multifamily Hub Office.

During the competitive review process, items taken into consideration include:

- The extent to which the conversion is needed by the persons that the project is intended to serve;
- The quality and effectiveness of the proposal in addressing the proposed conversion, including the meals and supportive services that the project intends to provide;
- The ability of the project owner to secure other community resources that can be combined with the grant to achieve the program's purposes; and
- The capacity of the project owner to carry out the conversion in a timely and effective manner.

Eligible applicants are private, nonprofit owners of Section 202, Section 8 project-based (including Rural Housing Services' Section 515), Section 221(d)(3) BMIR, and Section 236 housing developments that are designated primarily for occupancy by

ALC Grant Awards For Fiscal Year 2007

Project	Location	Award
Christian Care Manor IV	Mesa, Ariz.	\$4,019,569
Christian Care Manor II	Phoenix, Ariz.	\$1,315,303
Bonnie Brae Terrace	Belmont, Calif.	\$4,276,091
AuSable Valley Apartments	Fairview, Mich.	\$1,960,361
New Hope V.O.A.	New Hope, Minn.	\$2,430,264
Elderly Housing Trent Center	Trenton, N.J.	\$2,271,953
Bernardine Apartments Phase VII	Syracuse, N.Y.	\$3,754,850
NCR of Northern Columbus	Columbus, Ohio	\$2,194,899

Source: HUD

the elderly for at least five years. A private nonprofit of an unused or underutilized commercial property is also eligible, according to HUD.

To learn more, visit www.hud.gov/offices/hsg/mfh/progdesc/alcp.cfm

To sign up for e-mail notification of HUD's NOFA visit, <http://www07.grants.gov/index.jsp>



Initial Assessments Including Memory Screenings Beneficial To Providers

The Alzheimer's Disease Screening Discussion Group recently issued a consensus statement recommending that memory screenings be conducted when a person is admitted to an assisted living residence.

While the discussion group is one of two national groups promoting increased utilization of memory screenings, assisted living providers already using memory screening are assured their residents are receiving the proper care in the right setting.

"It's a good clinical practice to have," says Jeanne Jaekels, corporate housing director for Tealwood Communities, a Bloomington, Minn.-based company. Jaekels oversees 22 assisted living facilities in four states: Iowa, Minnesota, Nebraska, and South Dakota.

The memory testing is part of an initial screening done by a Tealwood registered nurse before a person moves into a Tealwood community.

"Our registered nurses are trained to do cognitive testing, it's part of our overall initial assessment," she says. Cognitive testing can not be mandated, but Jaekels says they offer it for free and encourage

people to take advantage of the screening. "It's a win-win for the resident and us," she says. "It gives us a baseline of where the person is at, and helps place the person in the right setting with the right amount of care."

Collecting initial assessment data can often uncover those families who may minimize their loved one's memory impairment because they want to place the resident in the less expensive, regular assisted living section of the community.

Another reason supporting the use of cognitive screening is that national statistics reveal even of those people who are concerned about their own potential memory impairment aren't getting tested or even discussing the issue with their physician.

A recent survey indicated that an overwhelming majority of Americans (73 percent) have memory concerns, says the Alzheimer's Foundation of America (AFA), a nonprofit organization based in New York City. Last year, the foundation conducted a study of 1,902 participants in its 2006 National Memory Screening Day.

More than 80 percent of the survey
Screenings, continued on page 7

Determining Who Should Be Screened

The AFA says memory screenings makes sense for anyone concerned about memory loss or experiencing warning signs of dementia, whose family and friends have noticed changes in them, or who believes they are at risk due to a family history of Alzheimer's disease or a related illness.

The following questions might help someone decide. If an individual answers "yes" to any of the questions, he or she might benefit from a memory screening.

1. Am I becoming more forgetful?
2. Do I have trouble concentrating?
3. Do I have difficulty performing familiar tasks?
4. Do I have trouble recalling words or names in conversation?
5. Do I sometimes forget where I am?
6. Have family or friends told me that I am repeating questions or saying the same thing over and over again?
7. Am I misplacing things more often?
8. Have I become lost when walking or driving in a familiar neighborhood?
9. Have my family or friends noticed changes in my mood, behavior, personality, or desire to do things?

-Source: Alzheimer's Foundation of America

Memory Screening: The Process

A memory screening is a simple and safe evaluation tool that assesses memory and other intellectual functions and indicates whether additional testing by a qualified health care professional is needed.

Various types of health care professionals provide memory screenings, including social workers, pharmacists, physician assistants, nurse practitioners, and doctors. The face-to-face screening takes place in a private setting; only the individual being tested and the clinician are present.

A screening consists of a series of questions and/or tasks designed to test memory, language skills, thinking ability, and other intellectual functions. Screening tools include a Mini-Mental Status Exam, a Seven-Minute Screen, and a clock drawing.

The person who administers the screening will review the results with the individual and suggest whether the person should follow up with a physician or other qualified health care professional for more extensive testing.

Results of the memory screenings are confidential. Typically, the individual will receive the screening results to bring to his or her health care professional or, with the individual's permission, the clinician at the screening will send the results to the physician.

For more information, contact the Alzheimer's Foundation of America at (866) AFA-8484 or www.alzfdn.org.

Note: A memory screening is not used to diagnose any particular illness and does not replace consultation with a qualified physician or other health care professional.



Provider Offers Rural Franchise Opportunities In Seven States

Assisted living provider Country Place Living, Grapevine, Texas, recently became the first seniors housing company to offer franchise opportunities in the rural communities of seven states.

Jack West, founder and chief executive officer of Country Place, drew upon his experience as a former Kentucky Fried Chicken franchisee to bring the idea to fruition, with the ultimate goal of expanding to more than 400 locations nationwide, according to Cynthia Gartman, Country Place chief operating officer.

The company is offering two assisted living concepts for sale in Colorado, Iowa, Kansas, Missouri, Nebraska, Oklahoma, and Texas: Country Place Senior Living, an 18-apartment assisted living residence, and Country Place Home Plus, an eight-bedroom group home residence.

The smaller size of the residences

makes them more amenable to franchising, says Gartman, who notes that “the typical franchisee isn’t capable of supporting a large investment level, but you can build a Country Place Home Plus for \$600,000 to \$1 million.”

Since launching its novel enterprise, the company has received approximately 10 “good leads,” Gartman reports, including one call from a city administrator in a small Kansas community, “who said he desperately needs seniors housing.”

Becoming a franchisee means that the prospective owner must buy into and agree with the Country Place philosophy, says Gartman, which says that “you can really do well for yourself in a financial and business manner while doing good for the larger community.”

Gartman notes that interested parties should be “altruistic by nature, honest, and full of integrity—someone that has some business or financial knowledge or

acumen, someone that wants to be part of the team.”

The company also has “very, very strict” standards of care, she says, including a required 12-day “very intensive training session.”

While she expects single, “mom and pop” franchises to be the most popular, Gartman points out that the company also has the ability to work with larger area developers or similar entities. “If someone came to us and said, ‘I’m interested in doing the state of Colorado,’ for example, that’s something we would consider, but build up slowly,” she says.

Although Country Place franchises are not currently set up to take Medicaid, the company is investigating the possibility of incorporating it into the model.

Initial growth will focus on the central United States, to be followed by a second growth phase aimed at the Eastern seaboard.

Screenings, continued from page 6

participants who had memory concerns had visited their physicians within the prior six months, yet fewer than 10 percent of them had discussed the memory issue with the physician.

In addition, another statistic reveals that many physicians are not trained to pick up the earliest stages of Alzheimer’s disease. Physicians miss at least half of the cases of mild and moderate dementia, according to J. Wesson Ashford, a physician and senior researcher of Stanford University’s Veterans Affairs Aging Clinical Research Center in Palo Alto, Calif., and a member of the Alzheimer’s Foundation of America screening advisory board. Ashford co-authored an article containing the statistic and stated that often physicians recognize dementia only when the brain

disorder is at least moderately advanced.

Despite their importance, memory screenings cannot diagnose Alzheimer’s disease. The AFA emphasizes that memory screenings are not used to diagnose any illness and recommends that those who score poorly on the screening should be referred to qualified health professionals.

Jaeckels says Tealwood uses professional services to conduct the more thorough testing needed to diagnose Alzheimer’s disease. Medicare Part B covers a portion of this service. In addition, Jaeckels says professional therapists will often provide training to staff and family members regarding care and services.

“We do a general initial screening to assist us in making the decision regarding

their safety,” says Jaeckels.

Ashford stated that early diagnosis has considerable potential benefits, including lifestyle choices such as proper nutrition and mental stimulation, which also help delay progression of symptoms.

“Memory screening is one of the best tools to detect Alzheimer’s disease and other problems that are causing memory loss,” said Ashford. “Impaired memory can be an indicator of other conditions as well. The key is to find the root of the problem.”

The Alzheimer’s Foundation of America offers several tools that providers can use to help determine who may be at-risk. See side bars, “Determining Who Should Be Screened” and “Memory Screening: The Process.” Or visit www.alzfdn.org



2007 Report

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highest in a majority of the assisted living residences at \$40 per day, with for-profit CCRCs at \$32 and independent living at \$29.

Regarding staffing ratios, the report said, "It is noteworthy that the median number of [full time employees] in assisted living (39.0) is actually higher than independent living (23.0) despite having fewer residents, on average."

In the "Same-Store" analysis chapter, the report examines key financial results of 102 communities that participated in both the 2007 and 2006 reports. Assisted living registered an increase of 7 percent in total revenue; total labor expenses were up by 6.9 percent, employee benefits increased 6.8 percent, and NOI 5.5 percent.

To purchase a copy of the report, contact ASHA at (202) 237-0900 or visit www.seniorshousing.org.

Rural Assisted Living

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While the assisted living communities studied resembled those in national studies, they generally had more permissive admission policies and were more dependent upon Medicaid financing. In addition, rural assisted living communities may serve residents with more impairments than those in larger markets because of the lack of alternatives located nearby.

Therefore, lenders, developers, and others interested in building an assisted living community in a rural area should consider a more acute resident profile, a more Medicaid-based payment mix, and a higher market capture rate, the researchers concluded.

To obtain a free copy of the report, contact Candace Baldwin at (703) 647-2352 or cbaldwin@ncbcapitalimpact.org.

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