

News Currents

In Brief

CMS Eyes No-Pay Rule For SNFs

Hospital Provisions Have Future Implications

The decision by the Centers for Medicare & Medicaid Services (CMS) to rescind a “forecast error adjustment” that would have cost skilled nursing facilities (SNFs) some \$770 million in payment cuts was clearly the biggest news coming out of the agency’s fiscal year 2009 SNF prospective payment system (PPS) final rule. But the voluminous text also contained a number of other noteworthy provisions.

Among them were comments from the agency regarding a new hospital regulation that precludes Medicare from paying for a selection of hospital-acquired conditions (HACs) that have been determined by CMS to be reasonably preventable. Under the provision, if a condition is not present upon admission, but is subsequently acquired during the hospital stay, Medicare will no longer pay the additional cost of the hospitalization.

The purpose of the rule is to “prevent an adverse event and improve the reliability of care [hospitals are] giving to Medicare patients.”

In the proposed SNF-PPS rule, CMS acknowledged that it was eyeing this initiative for possible applications in other settings, such as SNFs, home health agencies, end-stage renal disease facilities, and physician practices.

“The broad principle articulated in

the HAC payment provision...of Medicare not paying for these types of preventable conditions...could potentially be applied to other Medicare payment systems for similar conditions that occur in settings other than hospitals,” the proposed rule said.

In comments to the agency, the American Health Care Association (AHCA) expressed concern about the prematurity of considering the application in other Medicare payment systems and settings. “The provision has yet to be

thoroughly tested in the hospital setting, and even CMS has concerns about judging ‘preventability,’” AHCA said.

In the final rule, CMS conceded that infections, dementia, and falls—which are among the selected HACs for acute hospitals—may have different applications in the SNF setting.

CMS also agreed with comments that it would be unfair to penalize a SNF financially for a condition that developed in another setting. The agency noted that the HAC payment provision uses “present on admission” indicator data to exclude from payment those conditions that develop outside of the inpatient PPS acute care stay, and a similar mechanism would be needed to apply this type of payment provision to the SNF setting should such an approach be adopted there.

‘CMS is eyeing the initiative for possible applications in other settings.’

LTC Provider Awarded State Contract

Philadelphia-based NewCourtland Elder Services, ranked No. 47 this year on *Provider’s* list of the Top 50 Nursing Facility Chains, has been awarded a contract by the Philadelphia Corp. for Aging (PCA), the state’s Area Agency on Aging to Philadelphia County, to manage two of the 39 PCA-funded senior community centers and satellite programs that serve nearly 24,000 seniors in the city.

NewCourtland has assumed all management responsibilities of Lehigh Senior Community Center and Spring Garden Senior Community Center. Combined, the multi-service senior community centers currently serve approximately 800 seniors who receive a wide range of services, including congregate meals, recreation, transportation, education, counseling, volunteer programs, computer training, and referral resources.

“Senior community centers play a significant role in enhancing the quality of life of elderly Philadelphia residents, which is central to the vision of NewCourtland Elder Services and its network of affiliates,” said Kim Brooks, vice president of housing and community services.

—Meg LaPorte

CMS stated that it plans to work closely with stakeholders to determine which conditions could reasonably be prevented through the application of evidence-based guidelines.

Also contained in the final rule was an announcement that CMS will extend, for one more year, a payment increase add-on for SNF patients with Acquired Immune Deficiency Syndrome.

—Meg LaPorte

Education Key To Culture Change

Conference Offers Sessions For All Stages of Person-Centered Care

Nearly 1,000 people gathered recently in Washington, D.C., for the Pioneer Network's 8th National Conference on person-centered care practices.

Educational sessions were designed to cater to a range of experience, from providers just getting started to those with experience in more advanced person-directed care practices.

In a session on getting started in culture change, KaraLe Causey, a certified nurse assistant at Haven Nursing Center in Columbia, La., shared her facility's experience in transforming from a traditional medical model to a person-centered model of care.

According to DeCausey, there was some unexpected resistance to change when her facility began implementing person-centered initiatives. "Nurses and doctors will be resistant," she said.

"And they will be fearful of the change."

She noted that while a facility cannot abandon clinical practices, it is important to move away from the institutional model. Among the practices that a facility may want to consider adopting are making food accessible to residents at all times, family-style and liberalized diets, personalized rooms, empowering workers to listen and respond to residents' needs, and involving residents in all aspects of daily life, such as household work, cooking, and cleaning.

DeCausey described four stages of culture change within a nursing facility: traditional model, transitional or transformational, neighborhoods, and, finally, households or greenhouses.

She acknowledged that for those who are interested in making the leap

to culture change but feeling overwhelmed by the choices, there are several things that could help set the stage in a facility.

"Educate everyone you know," DeCausey said. "In addition, caregivers and administrators can get started by critically assessing their facilities' physical environments."

The session also included a tutorial on the positive impact of learning circles—in which any combination of 10 to 15 staff, residents, or family members gather for the purpose of solving a problem or educating staff or residents.

According to Lee Kroencke, of Americare, Sikeston, Mo., the goal of a learning circle is to "develop common ground and mutual respect among the diversity of the nursing home residents, direct caregivers, families, management, different departments, and professions."

The session also included a description of elements that make up a person-centered facility. Among the architectural features that comprise a true, resident-centered community are self-contained homes or communal apartments for 10 to 14 people; private rooms for each person; private bathrooms that include showers and sinks with grooming space, a tilted mirror, and storage space; residential hardware and finishes; driveways and sidewalks; access to outdoor space and connections with nature; and a home configuration that includes a front hall, living room, dining room, kitchen, and den.

Person-centered care policies should enable residents to choose their own bathing, visiting, and dining hours and to participate in their own care planning meetings, according to Judy Miller of Pleasant View Home in Inman, Kan.

—Meg LaPorte

Advancing Excellence Gets Funding Boost

The Advancing Excellence in America's Nursing Homes campaign has received a grant of more than \$474,000 from The Commonwealth Fund, Washington, D.C., to build on the momentum the campaign has achieved in its first two years of work.

This second round of funding is aimed at building the campaign's capacity to lead quality improvement efforts, reach out to facilities that have not yet joined, and maintain progress toward meeting improvement targets.

Led at the national level by a broad-based coalition of 28 stakeholder organizations, Advancing Excellence

now includes more than 7,000 nursing facilities. The campaign is supported by 49 local area networks that recruit providers, consumers, and frontline workers and lend technical assistance to nursing facilities.



Last year, the Commonwealth Fund supported a national field network coordinator and development of Web-based educational materials and webinars.

According to the campaign, it now has data to demonstrate that participating nursing facilities selecting one of the campaign's goals are, in fact, improving at a rate greater than nursing facilities that do not participate in the campaign.

Insurance Claims Reach \$3.5 Billion

Home Care Makes Up Majority Of Claims Paid

Some 180,000 long term care insurance policy holders received \$3.5 billion in claim payments last year, according to a recent study from the American Association for Long-Term Care Insurance (AALTCI). This year marks the first time the total number of individuals on claim was gathered.

The bulk of claims paid in 2007—43 percent—was for home care. Nearly one-third (32.9 percent) was for assisted living, and 24.1 percent covered nursing facility care.

“Most people associate long term care insurance with nursing facility care, but quite the opposite is true,” says Jesse Slome, AALTCI executive director. “The vast majority of benefits paid today cover care at home or in an assisted living community.”

AALTCI compiled data from more than 60 long term care insurers that represent 98 percent of all policies currently in force.

“Some 400,000 new policies were issued last year alone,” says Slome. “As more individuals become aware of and understand the importance of planning for long term care needs, the number of individuals and families deriving benefit from this coverage will only increase.”

More than 97 percent of long term care insurance policies sold provide some form of home care benefit (86 percent did in 2000, while 67 percent did in 1995).

The study also found that most individuals receiving benefits from their long term care insurance policies are older. Nearly one-third (32.3 percent) of new claims in 2007 began for individuals between the ages of 70 and 79, according to AALTCI.

More than half (55.2 percent) began for those aged 80 or over, but 11.5 per-

cent were for those between 50 and 69. “In 2007, the average purchase age for individual coverage was 58, a decline from the average purchase age of 67 as

recently as the year 2000,” says Slome. “An individual is far more likely to qualify for significant good health discounts offered by leading insurers ➤

AHCA/NCAL Gets Spotlight At Conventions

Although neither presidential candidate has laid out a long term care reform plan, several advocacy and health care organizations have joined forces in an effort to shine a light on health care issues during the Democratic and Republican national conventions.

The American Health Care Association (AHCA) and the National Center for Assisted

Living (NCAL) were among several organizations that sponsored a Health Care Town Hall reception during the conventions in an effort to get their message across to policy makers from both parties.

Obama’s Health Policy Advisor Dora Hughes, MD, participated in a panel discussion during the event.

O’Donnell asked panelists to answer a list of questions covering a range of health care issues that included long term care.

Attending the event were Hollywood luminaries director Spike Lee and actors Susan Sarandon, Anne Hathaway, and Angela Bassett—all of whom are members of The Creative Coalition, a nonprofit advocacy organization of the entertainment industry.

AHCA Vice Chair Bob Van Dyk represented the association at the Republican convention, where he served as a panelist at the Healthcare Innovation Breakfast. He briefed elected leaders and other participants on the association’s long term care reform proposal.

The Sept. 4 town hall reception, in St. Paul, Minn., was attended by Sens. Arlen Specter (R-Pa.) and John Barrasso, MD, (R-Wyo.)

AARP, the American Nurses Association, and the American Physical Therapy Association joined with The Creative Coalition and AHCA/NCAL in co-sponsoring the events.



Actress Gloria Reuben introduces the panel at the Democratic National Convention Town Hall Reception.

Living (NCAL) were among several organizations that sponsored a Health Care Town Hall reception during the conventions in an effort to get their message across to policy makers from both parties.

The Democratic National Convention’s town hall reception in Denver, entitled From Hollywood to the Hill: Speak Out on Health Care, was moderated by MSNBC political analyst Laurence O’Donnell. Jenny Chin Hansen, AARP president, and Sen. Barack

Bill Ross Photography

when they are in their 50s than if they wait to purchase coverage until they're in their 60s."

The five most common reasons for a long term care insurance claim, according to the association, are Alzheimer's disease, stroke, arthritis, circulatory issues, or injury.

Women comprise two-thirds of individuals who have purchased long term care insurance, and they claim and receive just over two-thirds of all claim dollars.

"Women, especially those who are divorced, widowed, or living alone, need to plan for the risk," Slome says. "More than 70 percent of nursing home residents are women, and almost two-thirds of formal (paid) home care users and informal (unpaid) care recipients are women."

Claim payments from insurers ranged in size, according to AALTCI. "Some of the largest open claims ranged from more than \$500,000 to just over \$1 million, with the claimants having received benefits for between 7 and 13 years," Slome says. "Most people will be on claim for between one and three years."

—Meg LaPorte

Group Studies Assisted Living Dementia Regs

The Alzheimer's Association has commissioned a study examining states' enforcement levels of assisted living regulations and rules pertaining to people with dementia. The study began in August and could be finished by November.

The research study's objectives include:

- Conducting a state-by-state account of enforcement codes pertaining to assisted living, which specifically involves analyzing the text defining possible consequences for noncompliance and the related appeals process;

- Determining the capacity for enforcement by ascertaining the number of investigative staff, ombudspersons, and other personnel available to monitor compliance;

- Describing the nature of enforcement across the states and categorizing states by whether they actively enforce rules and regulations (for example, routine site inspections) or passively enforce possible violations (for example, responding to resident complaints);

- Ascertaining the number of fines and penalties that have been levied against assisted living communities determined to be noncompliant with assisted living regulations; and

- Using basic statistical analyses to identify reasons for lack of enforcement.

While all states regulate assisted living—and all but a few states have enacted specific standards for assisted living communities offering care for resi-

dents with Alzheimer's and other forms of dementia—previous research shows a wide range of regulatory enforcement requirements and practices among states.

Though some states require and provide resources for annual facility surveys, others do not, according to the Alzheimer's Association.

States that do not provide sufficient resources to perform surveys as often as their statutes require them to may be vulnerable to criticism by study researchers.

—Lisa Gelhaus



Stock Check

PROVIDERS	Symbol	Where Traded	Current Price 8/29/08	Adjusted P/E Ratio	Change From 1/1/08	52-Week Range High	52-Week Range Low	PROVIDERS	Symbol	Where Traded	Current Price 8/29/08	Adjusted P/E Ratio	Change From 1/1/08	52-Week Range High	52-Week Range Low
Skilled Nursing								REITs							
Advocat	AVCA	NASDAQ	\$7.03	8.4	-36%	\$12.54	\$6.40	Care Investment Trust	CRE	NYSE	\$10.98	6.2%	2%	\$12.65	\$8.79
Ensign Group	ENSG	NASDAQ	\$16.64	7.2	16%	\$16.89	\$7.50	Health Care Property Investors	HCP	NYSE	\$36.22	5.0%	4%	\$38.75	\$26.80
Kindred Healthcare	KND	NYSE	\$30.93	8.9	24%	\$33.25	\$17.35	Health Care REIT	HCN	NYSE	\$51.87	5.2%	16%	\$53.98	\$38.35
National HealthCare	NHC	AMEX	\$49.72	7.4	-4%	\$55.75	\$42.75	Healthcare Realty	HR	NYSE	\$28.67	5.4%	13%	\$30.31	\$22.02
Skilled Healthcare Group	SKH	NASDAQ	\$15.96	9.4	9%	\$17.17	\$9.83	LTC Properties	LTC	NYSE	\$26.87	5.8%	7%	\$30.00	\$20.89
Sun Healthcare Group	SUNH	NASDAQ	\$17.19	8.5	0%	\$18.78	\$11.72	National Health Investors	NHI	NYSE	\$32.70	6.7%	17%	\$33.45	\$27.00
Assisted/Independent Living								Nationwide Health Properties							
Assisted Living Concepts	ALC	NYSE	\$7.08	10.6	-6%	\$10.07	\$5.05	NHP	NYSE	\$34.42	5.1%	10%	\$39.99	\$26.00	
Brookdale Senior Living	BKD	NYSE	\$22.05	13.1	-22%	\$41.70	\$14.06	Omega Healthcare	OHI	NYSE	\$17.84	6.7%	11%	\$19.23	\$13.67
Capital Senior Living	CSU	NYSE	\$7.87	10.8	-21%	\$10.12	\$6.32	Senior Housing Properties Trust	SNH	NYSE	\$21.68	6.5%	-4%	\$25.21	\$18.01
Emeritus Assisted Living	ESC	AMEX	\$22.22	15.3	-12%	\$33.38	\$13.29	Universal Health Realty	UHT	NYSE	\$36.69	6.4%	4%	\$39.05	\$29.75
Five Star Quality Care	FVE	AMEX	\$4.02	9.2	-52%	\$10.20	\$3.66	Ventas	VTR	NYSE	\$45.42	4.5%	0%	\$50.39	\$35.94
Sunrise Senior Living	SRZ	NYSE	\$20.33	N/A	-34%	\$39.70	\$16.27								

Quotes courtesy of www.seniorcareinvestor.com, Norwalk, CT (203) 846-6800

(1) Adjusted P/E=(market cap + total debt + capitalized leases = cash)/annualized EBITDAR based on the most recent quarter.

The rate used to capitalize the leases has been changed from 12.5% to 10.0% effective 1/31/06 to better reflect market conditions

Group Urges Use Of Care Delivery Process

Utilizing a correct, complete care delivery process is an essential tool to providing high-quality long term care, according to the Long Term Care Professional Leadership Council (LTCPLC), a group of four organizations representing administrators, directors of nursing, medical directors, and consultant pharmacists.

Although a care delivery process may sound like a basic function, LTCPLC asserts that a systematic method “reduces guesswork and helps increase the likelihood that correct, safe care will be given.”

Such a process also contributes to improved care quality, customer satisfaction, regulatory compliance, financial performance, and reduced legal liability, according to the document.

For example, it is possible to target interventions for agitated behavior, pain, and anorexia and weight loss to maximize benefit and minimize risk, according to the paper. “In contrast, interventions that skip key care process steps often become guesswork. Faithful adherence to the care delivery process enables rational medication use that maximizes effectiveness, minimizes risks and complications, and facilitates regulatory compliance.”

In addition, when all the diverse care providers and practitioners use this systematic approach to care for all residents, care delivery should become more consistent, the group asserts.

The care delivery process focuses on four main steps (*see graph*): recognition/assessment, cause identification, management/treatment, and monitoring. While specific interventions may be controversial or may change with time, these principles and processes are enduring, according to LTCPLC.

“Taken together, this information enables pertinent, individualized care plans and interventions.”

Issued as an official statement of LTCPLC, the document outlines

the steps in a question-and-answer format that explains the advantages of using a standardized process, how it relates to long term care regulations,

and how it fits with risk management practices.

A systematic care delivery process is also consistent with essential geri- ➤

CARE DELIVERY PROCESS (see original table below)

PROCESS STEP	OBJECTIVE	KEY TASKS
Recognition/assessment	Gather essential information (physical, functional, psychosocial) about the individual.	<ul style="list-style-type: none"> ■ Identify and collect information that is needed to identify an individual's situation that enables proper definition of their conditions, strengths, needs, risks, problems, and prognosis. ■ Obtain a personal and medical history. ■ Perform a physical assessment.
Problem definition	Define the individual's problems and issues.	<ul style="list-style-type: none"> ■ Clearly identify the individual's issues and physical, functional, and psychosocial strengths, problems, needs, deficits, and concerns. ■ Identify any current consequences and complications of the individual's situation, underlying condition and illnesses, etc. ■ Define significant risk factors.
Diagnosis/cause-and-effect analysis	Identify the physical, functional, and psychosocial causes of risks, problems, and other issues, and relate them to one another and to their consequences.	<ul style="list-style-type: none"> ■ Identify causes of, and factors contributing to, the individual's current dysfunctions, disabilities, impairments, and risks. ■ Identify pertinent evaluations and diagnostic tests. ■ Identify how existing symptoms, signs, diagnoses, test results, dysfunctions, impairments, disabilities, and other findings relate to one another. ■ Identify how addressing those causes is likely to affect consequences.
Identifying goals and objectives of care	Clarify the purpose of providing care, including specific interventions, and the criteria that will be used to determine whether the goals are being met.	<ul style="list-style-type: none"> ■ Clarify prognosis. ■ Define overall goals and objectives for the individual's services and care. ■ Identify criteria for meeting goals.
Selecting interventions/planning care	Identify and implement interventions and treatments to address the individual's physical, functional, and psychosocial needs, concerns, problems, and risks.	<ul style="list-style-type: none"> ■ Identify specific symptomatic and cause-specific interventions (physical, functional, and psychosocial). ■ Identify anticipated benefits and risks of treatments and services to address causes, consequences, and risk factors, and help attain overall goals for the individual. ■ Clarify how specific treatments and services will be evaluated for their effectiveness and possible adverse consequences.
Monitoring of progress	Review individual's progress toward goals; review effectiveness and adverse consequences related to treatments; adjust interventions as needed; and identify when care objectives have been achieved sufficiently to allow for discharge, transfer, or change in level of care.	<ul style="list-style-type: none"> ■ Identify the individual's response to interventions and treatments. ■ Identify factors that are affecting progress toward achieving goals. ■ Define or refine the prognosis. ■ Identify when treatment and other interventions should be modified or stopped.

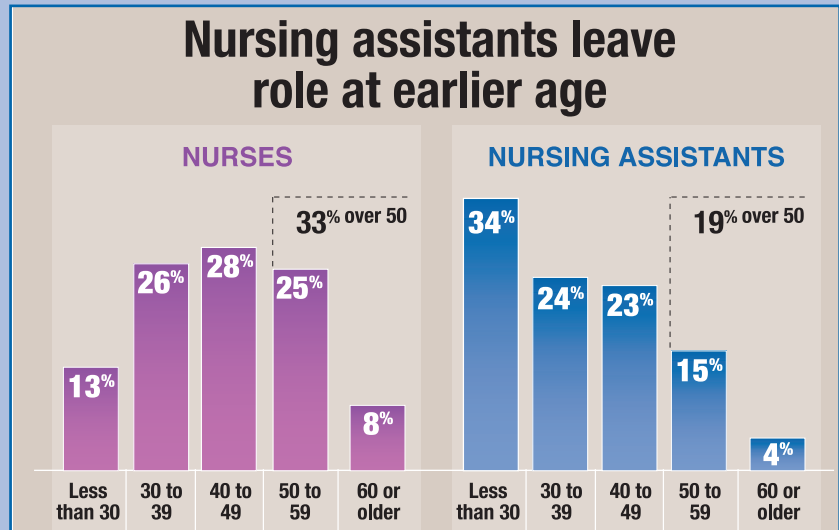
atrics and medical principles, the paper says. “Much of the care of long term care residents and short-stay, post-acute patients, especially those with complex conditions and multidimensional needs and problems, revolves around a handful of problems.”

Moreover, according to LTCPLC, a proper care delivery process helps fill the critical gap between assessment and care planning by providing a basis for process and outcome quality indicators.

LTCPLC recommends that all nursing facilities, as well as “all efforts to improve long term care” should embrace and promote the care delivery process. “A proper care delivery process has major positive effects on multiple outcomes and promotes care that meets all of the desirable attributes of quality,” the document says.

—Meg LaPorte

By The Numbers



Scores represent the percentage of nursing home caregivers — by age category — responding to My InnerView's satisfaction surveys collected during 2007.

Source: 2007 National Survey of Consumer and Workforce Satisfaction in Nursing Homes by My InnerView Inc.

LTC Insurance Costs Rise Slightly

Getting Coverage At A Younger Age Advantageous

Recent studies on the costs of long term care insurance coverage illustrate the advantages of guarding against rising costs of care by purchasing insurance at a younger age.

Long term care insurance for a 55-year-old married individual will cost \$709 per year for a base level of protection, while a 55-year-old single individual will pay \$1,095 per year, according to a 2008 price index for long term care insurance published recently by the American Association for Long-Term Care Insurance (AALTCI).

The cost of coverage has increased by a modest 4 percent, compared with last year's price index.

The annual index measures current

costs for top-selling long term care insurance policies that offer consumers approximately \$115,000 in current benefits for base-level coverage, with protection increasing yearly as the individual ages.

"That coverage will grow in value to over \$305,000 of protection in 20 years," says Jesse Slome, executive director of AALTCI. The study compares costs for plans that provide benefits for three years or longer with an annual compound inflation option that increases the available insurance benefits by 5 percent, compounded each year.

"The analysis highlights the benefits of obtaining coverage at younger ages

and taking advantage of discounts offered to those in good health as well as to couples," Slome says. "Someone seeking protection equal to today's average cost of care, about \$55,000, would pay \$1,064 a year for a policy purchased at age 55."

Costs for long term care insurance are priced to remain level throughout the life of the policy, though this is not guaranteed. "If that same person waited until age 65 and no longer qualified for a preferred health discount, they would pay \$3,221 yearly to obtain an equal level of future protection," Slome says. That assumes policy costs do not increase over the next 10-year time period. ➤

“The cost of long term care insurance is directly linked to interest rates, the anticipated likelihood of claims, as well as care costs,” he says. “When interest rates decline as they have in recent years, insurers need to increase premium costs.”

What’s more, according to AALTCI, a study of leading insurers that issued 250,000 individual long term care insurance policies in 2007 revealed that significantly more individual applicants in their 50s qualify for preferred health discounts than those who wait until their 60s to apply.

“It’s never an economic advantage to wait,” Slome says. “Costs do increase from year to year, and a change in your health could make it impossible to health-qualify no matter how much you are willing to pay. Plus, you are not protected during the years you delay.”

In order to plan for equal long term

care protection at age 75, a 55-year-old who qualifies for preferred health and spousal discounts pays \$1,064 for a “standard” plan based on a current benefit of \$150-per-day, or \$54,750 per year.

At age 75, the available benefit would be \$457,957 because the yearly benefit grows 5 percent compounded annually. If people wait to buy at age 65, they need to start with a higher level of initial protection—\$150 grows to \$240 at 5 percent compounded—to have equal protection. Today, that level of protection (\$240) costs \$3,221 yearly.

Another study, released by Fidelity Investments Life Insurance Co., estimates that a 65-year-old couple in 2008 will need \$85,000 to insure against long term care expenses.

“With the cost of certain long term care services rising by as much as 7 percent per year for the last five years,

retirees who don’t factor these future potential costs into their overall retirement plans may be surprised by the financial impact on themselves or their family members,” said Joan Bloom, senior vice president of Fidelity Investments Life Insurance.

The study recommends that consumers look for insurance policies that offer these top six characteristics:

- A policy premium that fits comfortably within a family’s financial means. Investors should carefully forecast their ability to pay the premiums year after year.

- Backing by a carrier with a strong track record of paying claims. The ability to receive policy benefits depends on the integrity of the company and its history of financial strength.

- Comprehensive coverage that covers in-home as well as facility-based care. Families want flexibility in ➤

terms of the services they opt for when facing a long term care challenge.

■ A benefit period of at least two, but no more than four years, for each person. Fidelity analyzed data on more than 6 million long term care insurance policies sold between 1984 and 2004 and found that 75 percent of all

individuals would not have exhausted benefits lasting two years. A four-year benefit period would have been adequate 90 percent of the time.

■ Five percent guaranteed annual benefit increase except for buyers older than age 75. To guard against the risk of price inflation, those under age 75

should consider purchasing a policy with inflation protection.

■ For joint policies, a “shared coverage” provision that enables each insured person to tap the other’s benefits if necessary. This valuable flexibility is usually worth the increased cost.

—Meg LaPorte

In Brief

Health Care REIT Buys 29 Sunrise Properties

Toledo, Ohio-based Health Care REIT has inked a \$643 million deal to acquire a 90 percent interest in a venture owning 29 seniors housing properties managed by Sunrise Senior Living, Health Care REIT announced recently.

Sunrise Senior Living, ranked the largest assisted living company in the country according to *Provider’s* list of the Top 40 Assisted Living Chains, will continue to manage the properties and will retain a 10 percent interest in the venture.

Health Care REIT’s purchase will be financed with approximately \$365.4 million in cash, plus a 90 percent interest in the \$309 million of existing debt held by the venture.

The communities are located in the New York City, Los Angeles, and Chicago metropolitan areas and comprise 2,082 units, with an average resident occupancy of 94 percent, company officials said.

Upon the transaction’s closing, expected in the fourth quarter of this year, Health Care REIT anticipates the private-pay mix across its entire portfolio of properties to exceed 70 percent and values the assets of the deal at \$715 million.

“This is a great real estate portfolio and an excellent market venture that should perform well over the long term,” said Scott Estes, Health Care REIT’s chief financial officer.

—Meg LaPorte