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*Serving Senior Living Clients For Over 37 Years
There Is No Substitute For Experience*

“You’ve Got Questions . . . We’ve Got Answers”

2009

ASSISTED LIVING COST CREEP IS A FATAL BUSINESS DISEASE

*Many Owner/Operators Are
Experiencing a \$1 Million-Plus Wake-Up Call*

Keeping monthly fees reasonably affordable for seniors is a crucial part of survival, success and profitability for assisted living providers. But equally crucial is the other end of that economic balancing act, ensuring that increasing resident acuity and the resulting creeping costs do not infiltrate your profit margin, leaving your bottom line depressed and possibly bleeding red ink.

We now know that assisted living costs constantly shift. Containing these costs at acceptable levels has become one of the most significant challenges of the industry. It is generally recognized that initial fill-up and turnover rates are difficult to predict. Obviously, the typical assisted living resident suffers from chronic conditions that gradually – but predictably – deteriorate with time. This can result in significant cost creep and profit margin erosion *if* higher levels of care are provided *without* corresponding increases in pricing. In order to compensate for 45 to 50 percent annual resident turnover, many operators have modified their admission and discharge policies in an attempt to extend the average length of stay. Dealing with incontinence and dementia has become an accepted operating policy for most assisted living operators.

Both public companies and private assisted living operators are chasing the elusive optimum operating profit margins in excess of 30 percent. Identified as Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA) by public companies, this critical ratio is defined as net operating income divided by net revenues.

The Real World of Cost Creep

The following scenario is being played out hundreds of times *daily* in assisted living communities all across the U.S.:

Resident aide or Housekeeper: “*Let me give you some additional help today, Mrs. Jones.*”

Mrs. Jones: “*Oh, thank you – I just love living here at The Gardens of Westridge.*”

Resident aide or Housekeeper: “*No problem, Mrs. Jones, I’m sure you’ll feel better tomorrow.*”

There are two big problems with this scenario:

1. Mrs. Jones *may* feel a little better tomorrow – but she has a *chronic medical condition* with gradually declining health that will require increasing assistance with the activities of daily living (ADLs). This will also increase the average direct care minutes (and cost) per 24-hour day for Mrs. Jones.
2. There are many residents like Mrs. Jones in almost every assisted living community.

Cost creep is the most serious *chronic business disease* afflicting both for-profit and not-for-profit assisted living operators. But proper analysis, pragmatic cost accounting and sound pricing policies can be the miracle drugs that prevent a catastrophic epidemic.

Calculating the Financial Impacts of Cost Creep

Many new assisted living communities market themselves as offering a fixed monthly service fee of approximately \$2,700 to \$3,000. Let’s now take a look at the arithmetic of cost creep. Figure 1 lays out this arithmetic in a simplified financial template format. You can use your own input assumptions to fit your specific community and market. Here are the assumptions that I’ve used for this realistic cost creep model:

- **Base Rate for CNA/Resident Aide** – The average hourly rate around the United States is approximately \$8.50 to \$10.00 per hour; you can insert your own prevailing wage rate for these types of workers.
- **Fringe Benefits** – This includes your share of payroll taxes, health care benefits and other direct fringe benefit costs. This typically ranges between 20 to 30 percent of direct payroll costs.
- **Indirect Time** – Workers need coffee breaks and lunch breaks. This means that direct care personnel are unavailable to serve residents approximately 20 percent of the time in a typical 8-hour day. Because the residents’ needs are frequently *very* time sensitive, this indirect (lost) time must usually be completely covered by someone else, and therefore must be factored into a pragmatic cost creep model.

- **Overhead Allocation** – Regardless of whether you’re selling widgets or staff time by the hour, you should allocate a portion of your existing overhead to each element of additional “product” that you’re selling.
- **Desired Profit/EBITDA Margin** – This can be a controversial issue, especially for not-for-profit organizations. I feel very strongly that each element of the “product” you offer should be assigned a target profit margin.

FIGURE 1

COST CREEP ARITHMETIC

INPUT ASSUMPTIONS:	
Base CNA/Resident-Aide Hrly \$:	\$8.50
Fringe Benefits @	25.0%
Indirect Time @	20.0%
Overhead Allocation:	15.0%
Desired Profit/EBITDA Margin:	30.0%

I. Direct Care Cost and Tiered Pricing			
<u>Direct Care Cost:</u>			
* Base Salary CNA/Resident-Aide		\$8.50 /hr	
* Fringe Benefits @ 25.0%		\$2.13	
Subtotal - Direct Costs		\$10.63 /hr	
<u>Other Cost Allocations:</u>			
* Indirect Time @ 20.0%		\$1.70	
* Overhead @ 15.0%		\$1.28	
TOTAL COST		\$13.60 /hr	
Profit/EBITDA Margin @ 30.0%		\$5.83	
Target Cost Recovery Per Hour		\$19.43 /hr	
<i>Or</i>			
<i>Tiered Pricing for direct care time & cost in excess of 60 minutes PRD is typically already included in the base monthly service fee.</i>	\$9.71 for a 30 additional minute segment	\$14.57 for a 45 additional minute segment	\$19.43 for a 60 additional minute segment
	<i>Or</i>	<i>Or</i>	<i>Or</i>
	<i>An Additional Price Tier of:</i>		
\$295 /mo	\$443 /mo	\$591 /mo	
<i>or</i>	<i>or</i>	<i>or</i>	
\$3,546 /yr	\$5,319 /yr	\$7,091 /yr	

Note: The following is the direct care impact (minutes/day) above and beyond the average/baseline level of direct care for each resident in your community.

Assuming that you have either accepted my input assumptions or inserted your own, we can now proceed with the cost creep arithmetic. In my example, the direct care cost is \$10.63 per hour. When the cost allocations and loading discussed above are added, this increases to almost \$14.00 per hour. Assuming that you add a profit margin of 30 percent, the total *loaded* cost for a typical CNA or resident aide grows rapidly to over \$19.00 per hour!

Now, let's assume that one of your residents requires direct care over and above the industry average of 45 to 60 minutes per resident for a 24-hour day. An additional 30-minute segment (half an hour) results in an additional cost incurred by that resident of approximately \$9.71 per day, \$295 per month, or \$3,546 per year (see Figure 1).

What you must decide is how many minutes of direct care per resident per 24-hour day is included in your *base monthly service fee*. The industry norm is approximately 45 to 60 minutes per resident per 24-hour day. Then, you must develop reasonably accurate measuring systems to determine which residents are consistently receiving higher levels of care each day. As Figure 1 clearly demonstrates, the additional cost can range from approximately \$3,546 per year to over \$7,091 per year. Note that this is real cash; money that must either come out of your pocket *or* be fairly and equitably passed on to the resident and/or their families.

Why Cost Creep Can Easily Become a \$1 Million Problem!

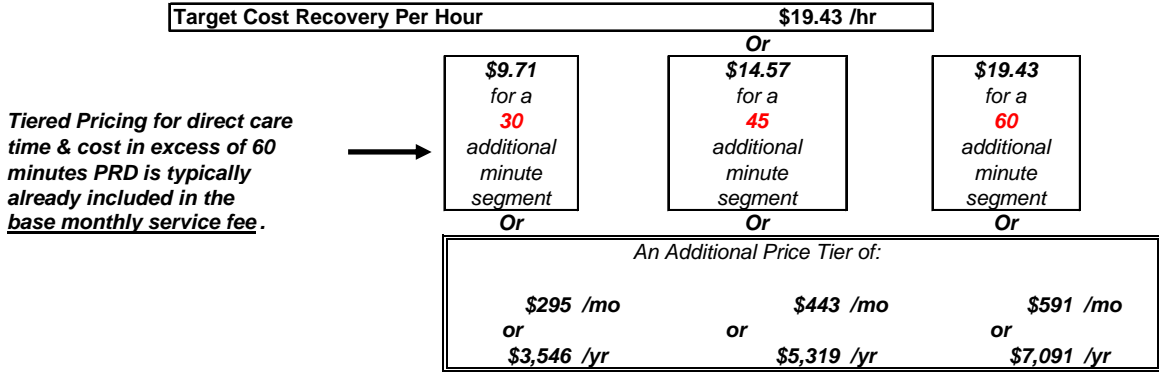
Figure 2 continues the analysis that was summarized in Figure 1. Note that the cost creep impact for an individual resident is now extended to approximately 30 percent of the total residents in a typical 80-unit assisted living community operating at 93 percent occupancy.

So if, eventually, 25 of the residents of your 80-unit community operating at 93 percent occupancy receive a range of 30 to 60 extra minutes per day of *uncompensated care*, the results will be financially devastating from two perspectives:

1. ***Total net income shortfall and lost cash flow*** from those 25 residents is \$132,964 per year (Figure 2).
2. ***A decrease in the imputed economic value of your community.*** While one can easily understand the lost cash flow monthly or annually in *operations*, it is sometimes difficult to realize this could only be the tip of the iceberg. If you are considering an exit strategy or refinancing, a buyer or appraiser will “capitalize” that lost cash flow at approximately a 9.0 percent capitalization rate which is used to determine value. This results in a loss in the economic value of your community ranging of approximately \$1.5 million! This is certainly significant if you ever intend to sell your property, but it can also have a serious impact if you choose to refinance at approximately 75 percent of the *appraised value* of your community.

As Figure 2 indicates, these loss figures continue to escalate rapidly as the resident's direct care time increases.

FIGURE 2
WHY COST CREEP CAN EASILY BECOME A \$1 MILLION PROBLEM!



Tiered Pricing for direct care time & cost in excess of 60 minutes PRD is typically already included in the base monthly service fee.

Impact If Cost Creep Grows to 25 Residents:	30 additional minute segment	45 additional minute segment	60 additional minute segment
<u>Impact if Cost Creep grows to 25 residents:</u>			
Estimated Mix of Care Levels	25.0%	50.0%	25.0%
Residents per Care Level	6	13	6
Cost Creep per Resident	<u>\$3,546 /yr</u>	<u>\$5,319 /yr</u>	<u>\$7,091 /yr</u>
Equals Lost Annual Cash Flow of -	<u>\$21,274 /yr</u>	<u>\$69,141 /yr</u>	<u>\$42,549 /yr</u>
TOTAL ANNUAL LOST CASH FLOW	\$132,964 /yr		
AND			
Reduces Community Value by - (Impact @ 9.0% Cap Rate)	<u>\$236,381</u>	<u>\$768,238</u>	<u>\$472,762</u>
TOTAL REDUCTION IN COMMUNITY VALUE	\$1,477,381		

Answer Seven Tough Questions and Take Appropriate Action

Figure 3 outlines seven critical questions that must be continually addressed. An investment in a comprehensive operations analysis and cost creep software will typically result in very high returns.

Some would say this type of pragmatic analysis is insensitive and not appropriate. And it's true that we can't walk in the shoes of your dedicated front-line professionals who provide endless love, care, and patience to the residents; much of it accomplished in a time-sensitive, stressful environment. However, the cost creep problem is surfacing as a major productivity and financial issue for many operators. In the future, we must strike a delicate balance between increasing direct care productivity while sustaining high standards of care, quality of life, employee morale, and workplace satisfaction.

FIGURE 3

ANSWERING SEVEN QUESTIONS LEADS TO INCREASED PRODUCTIVITY . . . THE KEY TO THE FUTURE

1. Does your increasing resident acuity result in increased care and uncompensated cost creep?
2. Do you really know how many minutes per 24-hour day your direct care staff is actually spending with each resident?
3. How efficient is your direct care staff?
4. Are they spending at least 75% of their time delivering (hands on) assistance with activities of daily living?
5. How many direct care Full-Time Equivalents (FTEs) employees do you really need?
6. How many direct care FTEs do you have?
7. Finally, is there a direct, quantitative link between the output of your resident evaluation scoring methodology and the specific number of direct care minutes (24/7) for each resident?

Obviously, answering these questions will likely identify both expense reduction and revenue enhancement opportunities.

*Jim Moore is president of Moore Diversified Services, Inc., a national Senior housing and health care consulting firm based in Fort Worth, Texas. He has written several books about assisted living and Senior housing, including **Assisted Living Strategies for Changing Markets**. A new book titled **Independent Living and CCRCs** will be available soon. Jim Moore can be reached at 817-731-4266 or jimmoore@m-d-s.com.*

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