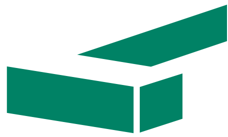

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Senior Living Business INTERACTIVE

Financial News, Growth Strategies, and Best Practices for Providers and Suppliers

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Memory Care: (Unfortunately) A Hot Market
Our feature article summarizes the discussion at our October 24, 2013, webcast of the same name. Panelists included Michael J. Smith, Executive Director, Alzheimer's Research Center of Connecticut (moderator); Michelle Egerer, Senior Vice President of Operations, Silverado Senior Living; Letitia Jackson, Vice President od Health Services/Programs, Senior Star; Curtis King, Vice President, Herbert J. Sims & Co.; and Eric McRoberts, AIA, Partner, RLPS Architects.

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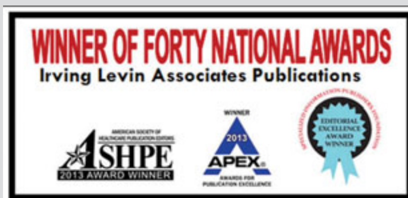

Memory Care: (Unfortunately) A Hot Market

More than five million Americans age 65 and older are living with Alzheimer's disease, a number expected to increase to more than seven million by 2025, according to the **Alzheimer's Association**. Currently, one in three elderly Americans die with some form of dementia. The highest risk factor for Alzheimer's disease is and continues to be age, according to Michael Smith, Executive Director of the **Alzheimer's Research Center of Connecticut**. Half of those over age 85 will experience some form of dementia and will need support once their lives are affected by changes in cognition and physical ability.

Yet the existing memory care inventory is a fraction of the assisted living and independent living available today. Senior care developers and providers alike recognize this as an opportunity for growth while also fulfilling the greatly increasing needs of those with dementia who can no longer live in their own homes.

Memory care in a continuum

Shortly after **Senior Star** entered the senior housing business more than 25 years ago, the prevalence of some form of cognitive impairment among many of its residents—and the impact of that impairment on those residents and their families—became quite obvious. "We saw the need for memory care support and were compelled to respond," said Letitia Jackson, Vice President of Health Services/Programs. "Moving into the memory care arena was a clear next step for us."

Senior Star, based in Tulsa, Oklahoma, manages 12 independent living and assisted living communities in six states. Seven of those communities now provide memory care services, although all Senior Star employees, including independent living staff, regularly receive training to address the needs of residents with dementia. "We chose long ago to provide staff education and resident and family support across our continuum," Jackson added.

Prior to embarking on this new business segment five years ago, Senior Star did in-depth research to identify and clarify an operational and philosophical approach to providing the absolute best memory care. It became immediately clear that the focus must be on recognizing the resident as an individual rather than as an individual with dementia—on providing opportunities for those individuals to experience purposeful moments throughout their day—and on providing them with moments of success, purpose, and, as often as possible, joy.

Family members who care for those with dementia work hard to help their loved ones remain in their own homes until the physiological, behavioral, or safety needs become either too difficult to manage or have

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(203) 846-6800 Fax (203) 846-8300
info@seniorlivingbusiness.com
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a negative impact on the medical and /or emotional health of the caregiver. Most often, the decision to move someone into a memory care community—a decision often fraught with guilt and fear—occurs when the person reaches the mid-level stages of dementia.

Family members certainly look for an environment where their loved one will be safe and receive quality personal care. Perhaps more importantly, they seek an environment where residents have a wonderful quality of life experience, according to Jackson. Senior Star developed its comprehensive memory support program with that focus in mind.

According to “The State of Seniors Housing 2012,” published by **American Seniors Housing Association**, the median number of units or beds in an assisted living community providing Alzheimer’s care is 81, with a median unit size of 367 square feet. Of those units, 84% are studios, 12% have one bedroom, and 4% have two bedrooms. The median annual occupancy of Alzheimer’s units in assisted living with memory care is 92%, according to the report, and median revenue per occupied unit/bed is $4,500+ per month. Median annual revenue per occupied unit/bed is $55,313, and median operating expenses per occupied unit/bed are $37,342 (53% to 48% labor-related).

Even though 84% of memory care apartments throughout the industry are studios, Senior Star chose to provide shared units for its residents. “That model is both financially desirable and beneficial to people with dementia, who may find a studio to be too socially isolating,” said Jackson. The Senior Star model also incorporates a common space design, which promotes activities and programs that meet the diverse individual, small group, and large group needs of these residents and their families. The activities and programs range in nature from stimulating and productive to calming and relaxing. Just as importantly, the memory care environments have lounges where staff members can take a break and relax during the day, allowing them to return to their caregiving duties refreshed and engaged.

Everyone with a stake in the resident’s care—including the resident—participates in Senior Star’s care planning process. The individual’s care plan promotes a sense of self-determination and encourages free movement rather than a sense of confinement. Team members manage the sensory environment in order to provide cueing that supports individual choice and involvement while, at the same time, limiting overstimulation. Each memory

care environment has a Snoezelen® multisensory room to stimulate the person's various senses, as well as Wii systems—which also are a great way for grandchildren to connect with the resident—and iPod music systems that have an "amazing ability to awaken people who were previously not communicative or engaged," said Jackson.

The median monthly rental rate for residents in memory care (private room) nationwide is $5,000, according to **Genworth**'s "2013 Financial Cost of Care Report." That compares with $3,450 per month for single occupancy in an assisted living community and $210 to $230 per day (or $6,300 to $6,900 per month) in a skilled nursing facility.

Nearly all (98.5%) assisted living and memory care communities are structured as rental only; the remaining 1.5% require an entrance fee in excess of $20,000. About 41% of memory care communities are structured with an all-inclusive rate, while 59% use care levels or other forms of fee-for-service billing. Very little reimbursement is available for either assisted living or memory care. Some people have long-term care insurance, veteran's benefits may apply, and some states offer a Medicaid wavier. Memory care is primarily private pay.

"Helping families remain connected through the many losses associated with dementia was important to us. We provide many opportunities for families to comfortably interact with their loved ones."
—Letitia Jackson

Freestanding memory care

Caring for people with dementia is quite unique, because the daily struggles of residents, family members, and staff differ broadly from the general geriatric care provided in most long-term care communities. **Silverado | Memory Care Communities** specializes in memory care. It is described as a "purpose-driven company" by Michelle D. Egerer, Senior Vice President of Community Operations. Based in Irvine, California, Silverado operates 29 communities in eight states. All but one were acquired or repurposed for memory care; one was purpose-built from the ground up. Silverado is currently building six additional memory care communities in various states.

"Our purpose is to change the world...to change the way memory care is provided and to help organizations as they develop memory care either within their continuum or as a freestanding community," Egerer explained. From its inception, the focus of the Silverado model of care has been

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"An unintended consequence of our intergenerational program is that we now have third-generation caregivers who came to the community as children, with a parent, and then became caregivers themselves or, based on the experience, have earned advanced degrees in gerontology, become a social worker or nurse, or studied neurology in medical school to try to find a cure for this disease."

—Michelle Egerer

to dramatically improve the quality of life for its residents by creating "normal" living environments that include pets, plants and gardens, outdoor spaces with walking paths and areas for residents and families to enjoy, intergenerational programming where staff members bring their children to the community, and, perhaps most importantly, an ability for residents to have a sense of control or purpose.

Beyond that social model, all Silverado communities have a strong medical component led by a medical director with geriatric expertise, particularly memory impairment, and a university or other research affiliation. In addition, each community has a full-time director of health services (a registered nurse) and licensed vocational or practical nurses on site 24/7. The nurses continually assess the residents and their prescribed medicines for changes in behavior and other clinical measures.

Dealing with people with dementia can be very difficult, though, so finding staff members with the "heart" to work in the memory care environment and then nurturing, inspiring, and recognizing those staff members is key. "We always hire for the heart," said Egerer. "The skill set can be acquired through training, buy they have to feel passionate about improving the quality of life of our residents." In fact, the caregivers receive extensive training—orientation, monthly, and annual training that exceeds state requirements—and consistent resident assignments to help them acquire the level of expertise required to deal with challenging behaviors.

A staff social worker is available to assist families with the decision to place their loved one in the community, as well as with end-of-life decisions. Because dementia is a chronic, progressive disease, 98% of Silverado residents live out their lives in the community, 85% as hospice patients. It's important, therefore, to provide a "good death" as much as to provide a good quality of life.

Silverado communities are restraint-free: no bedrails, no geri-chairs, and no other furniture that prevents a resident from moving around. And reducing psychotropic medications as much as possible encourages ambulation, self-feeding, continence, and communication. "Keeping everyone moving, lively, and engaged improves their muscle mass, cognitive ability, and general quality of life," noted Egerer. In its newer communities, Silverado has large central courtyards and secure outside areas where residents can walk around freely throughout the day. All doors remain open from early in the morning until evening.

Planning/designing a memory care community

There's no single formula for building memory care environments, according to Eric McRoberts, AIA, partner with **RLPS Architects** in Lancaster, Pennsylvania. "We've done many, many different types," he said. "And if you compare one community to another, a lot of things are very different—mainly the size."

For years, the thought was that memory care should be delivered in small neighborhoods of 10 to 16 residents. Yet some communities today have as many as 80 or 90 residents in one dedicated area, and it works beautifully. In any case, memory care must be a dedicated program, with staff who can provide discrete services, state-of-the-art therapies, and integrated technology.

Consumers expect memory care neighborhoods to be safe and the environment to be respectful, healing, supportive, and nurturing. "We generally don't think of memory care as being healing," said McRoberts, "since someone with dementia won't be 'healed' unless a cure is found. With environmental therapy, however, we have seen residents who really do come back to life."

For many years, private rooms were considered the most appropriate accommodation for memory care—and, for the most part, that's still the case. Private rooms tend to be 230-240 square feet—very similar to a nursing care room—with private in-room bathrooms, according to McRoberts. Many residents might feel isolated in a private room, though, and could actually benefit from a one-to-one social connection with a roommate. Each of Silverado's new 90-bed, purpose-built memory care projects, for example, will have 40 "companion" and 10 private rooms.

One design element to definitely avoid in memory care environments is dead-end hallways or hallways that end in a doorway. Those can frustrate people with memory issues, as they want to get through the doors. Instead, it's important to create positive distractions at each end of a hall such as an activity room, a sitting room, a sunroom or

garden, a dining room or kitchen, or a residential foyer. In fact, contextual cueing—placing visual or recognizable things or places within the community so that residents have a sense of where they are—is an important aspect of memory care design.

Bringing as much daylight into the building as possible is also very important. Positioning the common areas so they don't darken late in the afternoon, as the sun tracks from east to west, avoids having residents feel the urge to go back to their rooms and go to sleep.

"As much as possible, we try to design a residential setting—a sense of separate rooms with different types of places to go and a strong connection to the outside," said McRoberts. "We want it to feel like home. We want residents to go about freely on their own, both inside and outside in secure areas." At the same time, staff members must be able to keep an eye on what's going on, although new technology (e.g., closed-circuit TV) is making direct visibility less important than in the past. And the most effective courtyard or secure garden spaces will have visible destinations—seating or a pavilion—to attract a resident's attention.

"The trend now is to introduce adult day care into the memory care program by increasing the social space in the neighborhoods so that a certain number of residents can be dropped off in the morning and picked up again at the end of the day. The programs provided in adult day care are often the same as those provided in the actual neighborhood."

—Eric McRoberts

The green house or small house design, initially a skilled care alternative, is a flexible type of building that is easily separated into zones: private (bedrooms), common (living/dining/kitchen), and service (office, laundry, housekeeping, storage). And because of that flexibility, the model is now being used for many other levels of care—including memory care—across the country.

Another successful approach is the cluster design, where a neighborhood of individual resident rooms (perhaps a dozen units) each have a private entry from the hallway—a foyer or veranda type of "in-between" space—that separates a perimeter of private accommodations from a central social or activity space. "That tends to work very well for memory care, where a certain percentage of the residents will be wanderers," McRoberts said.

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Then there's the Main Street approach, which is the design concept of **The Village at Waveny Care Center** in New Canaan, Connecticut. The memory care neighborhood is patterned after a person's typical day. A private bedroom with bath, along with a small kitchen and dining area for preparing and eating breakfast, opens onto Main Street, a long corridor that mimics the local downtown in terms of the façades, light fixtures, canopies, even a clock tower and "cobblestone"-design carpet. Skylights create an environment that appears to be outdoors.

Various organized activities, including adult day care, take place on Main Street during the day. There's also a bistro, shops, gardens, beauty/barber shops, and more. Residents return to their rooms at the end of the day on Main Street, just as they might have done years ago, and relax, perhaps watch a little TV, and then go to bed. The environment creates a natural experience that can essentially change the lives of those with dementia in rather extraordinary ways. Some residents that had closed down in other types of memory care environments have actually opened up and begun to participate in activities.

People with dementia may still have a very sharp long-term memory, even though their short-term memory is probably no longer there. So the Main Street approach does a very effective job of replicating their lifestyle during their working years many years ago.

Again, there isn't a single way to go about designing memory care communities, according to McRoberts. "Every community will be a little different and have a different set of criteria; it's definitely not one-size-fits-all."

Financing memory care development

In general, the current appetite for memory care financing is "really, really strong," according to Curtis King, Vice President at **Herbert J. Sims & Co.** in Fairfield, Connecticut. It's a "need-driven" product, and both lenders and investors alike realize that the aging demographic and a growing incidence of dementia diseases will result in pent-up demand—particularly as consumers become more educated about their options.

New memory care inventory—particularly freestanding memory care communities—is growing rapidly, as experienced CCRC and assisted living operators, along with some new entrants to the market, have focused on memory care expansion. Across the country, penetration of the market can be as low as 1%, on average, for memory care compared to 10% for other types of senior living; hence, the bullish outlook for this market sector. That said, investors and lenders are very cautious about overheating the market in certain areas, making sure that the area isn't being overdeveloped.

Financing acquisitions and recapitalizations:

A variety of capital sources are available to senior living borrowers for first-mortgage financing of acquisitions and recapitalizations:

- Agency financing (**Fannie Mae** and **Freddie Mac**) for stablized or primarily private pay communities;
- **FHA/HUD** for facilities that rely more on Medicaid;
- Tax-exempt bonds for not-for-profit providers; and
- Banks and other financial institutions for recently stabilized communities and those with "a story."

A number of mezzanine debt and equity providers are also helping with acquisition and recapitalization financing.

"The underwriting parameters for memory care acquisition or recapitalization financing are different from other care types," King emphasized. Fannie Mae and Freddie Mac, for example, require debt service coverage of 1.45x for memory care, whereas it's 1.35x for independent living and 1.40x for assisted living. Also, Fannie Mae requires at least 60 units of memory care; below that size, they will cut the occupancy estimate to 90% regardless of the actual occupancy of the community.

Unique underwriting considerations for memory care acquisition/recapitalization financing include:

1. Operator quality. Certainly important for any investment, operator quality is a strong underwriting characteristic for memory care, in particular. Real estate, for example, is not nearly as important as the overall level of service, whereas real estate may be a relatively larger factor when underwriting an independent living facility. "Partnering with good operators that provide great service is pretty important," King emphasized.

2. Narrowly drawn markets. Largely due to the prevalence of and lack of education about Alzheimer's disease, combined with the low penetration rates, markets are generally narrowly drawn and subject to a more critical eye when being evaluated.

3. Small community size. Particularly with freestanding memory care, communities are comparatively small. Appropriately sizing a facility to its market is important,

as building more than the market can handle risks fill up. On the other hand, losing a single resident in a very small facility will put cash flow at risk—and investors and lenders don't like that kind of volatility.

4. Pricing resistance. Memory care is more expensive to provide than assisted living or other care types, because it requires a lot more services and staffing. It's important to ensure that the market can afford—and is willing to pay for—quality service. That can be an issue in select markets.

5. Programming and services. Tied into operator quality, investors and lenders want to see that the services improve the residents' quality of life, provide value to consumers, and differentiate the operator from its competitors.

6. Continuum of care. The benefit of adding a memory care component to the continuum is taken into account when underwriting for both a new expansion and as an investment enhancement to the existing community.

7. Facility design. Two aspects are considered: 1) a facility design that allows the provider to deliver the best care and the most value to residents; and 2) particularly for older facilities, the design's effect on staffing ratios—which may make the facility more difficult to operate at the necessary profitability level.

Financing renovations:

Financing renovations is somewhat different from—and has fewer options than—financing acquisitions and recapitalizations. For smaller deals, the borrower can often rely on the facility's existing cash flow to finance the renovation. Other options—depending on the borrower's existing leverage, the potential financial benefit from the expansion, and any interruption in cash flow in the meantime—include:

- Supplemental loans from existing lenders;
- Tax-exempt bonds (for not-for-profit borrowers)
- A new subordinate or mezzanine debt lender;
- Preferred equity from an existing equity partner; or
- Recapitalization that builds in the necessary proceeds for the renovation.

Financing expansions:

The same financing sources for renovation financing apply to expansion financing, particularly for smaller projects. An additional option for larger expansions, however, is

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HUD financing. If HUD financing is already in place, supplemental financing may be available but subject to the new construction or substantial rehabilitation queue. A bank loan or some other form of capital funding could potentially be refinanced with HUD under Section 223(f), with a portion of those proceeds (up to 15%) used to finance the expansion.

Financing new freestanding projects:
While there's a lot of interest in new freestanding projects, development capital is harder to secure. For first mortgages, the major issues are loan to value and guarantees. "It's very difficult to get the same leverage as it was five, six…even eight years ago," King said. "In addition, most conventional financing options require at least some type of limited personal guarantee—which, for some borrowers, is a nonstarter."

HUD is an attractive option for those that don't want the recourse or don't want to provide any sort of personal guarantee. While HUD offers low-rate, long-term construction financing, the difficulty is the long queue, which can be as long as 18 months, and the prevailing-wage requirement for construction that, for certain areas, greatly increases construction costs.

Tax-exempt bonds are available to not-for-profit projects. In some states, 142(d) multifamily housing bonds may be available to proprietary providers subject to certain limitations in design and to income restrictions on residents.

REITs are another option for freestanding projects. As with HUD, however, the availability of construction capital is very, very limited. "REIT capital is more focused on acquisitions or recapitalizations once the project has been built," King said. "Only 3% to 5% of REIT balances are tied up in development at any one time."

Some REITs are doing construction, though, and some have also done forward purchasing programs in which they fund a limited equity amount up front and provide a guarantee, subject to certain conditions being met, that they will purchase the project upon stabilization or upon opening. "That often allows you to get attractive financing for development," he added.

There are other sources of equity and subordinate debt, but they also depend upon the strength of the team and of the project—and the unique underwriting characteristics mentioned above.

Contact information...

Michelle D. Egerer
Senior Vice President of Operations
Silverado | Memory Care Communities
6400 Oak Canyon, Ste. 200
Irvine, California 92618
(949) 249-7200
megerer@silveradocare.com
www.silveradocare.com

Letitia Jackson
Vice President, Health Services/Programs
Senior Star
1516 S. Boston, Ste. 301
Tulsa, Oklahoma 74119
(918) 704-2832
ljackson@seniorstar.com
www.seniorstar.com

Curtis King
Vice President
Herbert J. Sims & Co.
2150 Post Road
Fairfield, Connecticut 06891
(203) 418-9016
cking@hjsims.com
www.hjsims.com

Eric McRoberts, AIA
Partner
RLPS Architects
250 Valleybrook Drive
Lancaster, Pennsylvania 17601
(717) 560-9501
emcroberts@rlps.com
www.rlps.com

Michael J. Smith
Executive Director
Alzheimer's Research Center
of Connecticut
1261 South Main Street
Plantsville, Connecticut 06479
(860) 628-9000
msmith@arc-ct.org
www.arc-ct.org