THE FEASIBILITY OF CONVERTING RESIDENT CARE
FACILITIES INTO ASSISTED LIVING FACILITIES

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Abstract

The purpose of this study is to determine if it is both feasible and attractive for Massachusetts Resident Care Facilities (RCFs) whose central mission is to serve the poor to convert to Assisted Living (AL). Unlike RCFs who have historically served low- and moderate-income elders, a competitive model, AL, has recently developed in a number of states primarily as a private-market, upper-income model of housing with services. In late 1992, Massachusetts policy makers began drafting AL legislation they contend will include low-income persons as well as offering the option to RCFs to convert to AL.

RCFs face several potential obstacles in converting to AL. Whether RCFs will be able to meet physical plant changes necessary to qualify as AL providers, and whether conversion will assist RCFs in attaining and maintaining long-term financial viability in the residential care marketplace is uncertain. Additionally, while the absence of burdensome regulation and increased public funding the AL program offers are attractive, whether RCFs will be able to access capital necessary to convert, and whether sufficient reimbursement will be available after conversion, is also questionable.

In addition to interviews with practitioners representing all key sides of this policy issue, and data analysis of statewide AL survey, the primary information for this study was derived from a case study of one RCF considering conversion to AL. A case study was used to identify the key variables influencing conversion feasibility, to assess the facility’s relationship to these variables, and to adapt these finding to peer facilities. From these findings, mismatches in RCF/AL conversion policy design and implementation were identified, and recommendations to RCF management and state policy makers were made.

My research indicates that while a number of RCFs who serve a balanced mix of private-/public-pay clients may be able to convert to AL, findings for RCFs who primarily serve low-income persons proved different. Given their combined inability to obtain conversion capital and insufficient revenue after conversion, not only will RCFs serving the poor be unable to make an appropriate conversion to AL, but most will also lack the ability to meet basic programmatic requirements necessary to qualify as AL providers. Additionally, in the absence of conversion, my findings indicate that the future operations of RCFs serving low-income persons is also highly questionable. RCFs serving the poor must seriously re-evaluate their future operations and state policy makers must reassess and determine where current, as well as future, RCF residents will be housed and care for.

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- My case study, The German Home (particularly Valerie Emerton, Administrator), who welcomed and assisted me with open arms.

My best to you all!
CHAPTER I

INTRODUCTION
Chapter I: Introduction

Massachusetts Resident Care Facilities (licensed Level IVs)\(^1\) have been serving the housing and service needs of older adults for more than one hundred years. Yet within the past decade, many Resident Care Facility (RCF) administrators and Boards of Directors have contended that they are being slowly and painfully phased out of the state long-term care continuum\(^2\). RCFs primarily serving the poor have been particularly affected by what administrators perceive as dangerously inadequate reimbursement and an overall lack of attention by the state. Most recently, RCFs anticipate the development of a competitive housing with services model seriously threatening their continued operations.

In early 1992, Massachusetts policy makers began developing their version of the latest highly-publicized elderly housing with services model; Assisted Living (AL).\(^3\) Developed in other states primarily as a private market model serving middle- to upper-income elders, Massachusetts policy makers maintain they are designing their AL model to include low-income persons. Except for a few subtle differences, Massachusetts RCFs argue they have been providing "assisted living" since their inception; a home-like setting with personal care services that enable older persons to age-in-place. If offered assistance, many RCFs regard themselves as suitable candidates for conversion to AL.

The key challenges Massachusetts RCFs face in conversion are of two types: 1) physical plant changes (i.e. meeting programmatic physical plant requirements necessary to qualify for increased public subsidies, and integrating additional physical plant changes

\(^1\)While a detailed definition follows, RCFs (also know by their previous name "rest homes" or by their licensure status as "Level IVs") are housing settings for elders who need a supervised, supportive environment with services that do not require continuous medically-related care. Along the long-term care continuum, RCFs may be appropriately placed between congregate housing and nursing facilities.

\(^2\)Massachusetts' long-term care continuum represents a range of providers serving the elderly. Moving from the most to least acute level of care, providers include hospitals, nursing homes, Resident Care Facilities, independent housing, and community-based services, among others.

\(^3\)Throughout the US, 50,000-90,000 AL facilities (serving over one million elders) have been developed. Oregon, Washington, Florida, and New York are examples where AL has been fully integrated into their state long-term care continuums.
essential to attaining and maintaining long-term competitiveness), and 2) financial viability in the residential care marketplace.

With the absence of burdensome regulation and promises of increased funding, the proposed AL program has been presented as a welcome alternative to many RCFs. However, without access to capital and sufficient reimbursement after conversion, it is highly questionable whether these anticipated changes are sufficient to enable and to convince RCFs to convert.

CENTRAL POLICY ISSUE:

Is conversion to AL attractive and feasible for RCFs whose central mission is to serve low-income individuals? While the original intent of this study was to test the financial feasibility of conversion (whether or not projected cash flows would support expenses after conversion), as I progressed in my research, other more imperative systemic issues within both the RCF and the emerging AL industry arose. As a result, I shifted from a centrally "quantitative" focus to investigating, among others issues: why RCFs would want to convert, what would be contained within their conversion plans, how they would arrive at their conversion decisions, whether conversion would be appropriate at all, and what other programmatic alternatives would be envisioned in the absence of conversion.

Policy questions this thesis addresses relate to: 1) will AL, with its new concept of flexibility in program design, virtually transferring operational responsibilities from the state to the provider, allow for a more attractive and appropriate alternative than that which RCFs offer? Many RCFs envision the proposed AL model as "old wine, new bottle" and question whether AL will be all it promises, 2) Will conversion to AL result in long-term improved operations and financial security for RCFs?, and lastly 3) Since many
Chapter I: Introduction

RCFs are skeptical about continued operations in the absence of conversion, who will house and care for current, as well as future, residents if RCFs close?

HYPOTHESIS:

Until a clearer definition of "Assisted Living" is formulated and legislation is passed, conversion will be unattractive or unfeasible (or both) for the majority of RCFs that serve the poor. Absent such clarity, participation by all key players necessary for conversion will be skeptical. While the fear of being dropping out of the long-term care continuum is very real for RCFs, the proposed policy may not offer many RCFs the ability, or sufficient motivation, to embark on such an uncertain venture. Likewise, developers', capital markets', and even state and federal funding agencies' willingness to participate in what is still considered an undefined, risk laden, product market (particularly those involving indefinite public subsidies) is also questionable.

RELEVANCE OF STUDY:

Whether it is attractive and feasible for RCFs to make an adequate and appropriate conversion to AL has been, is, and will inevitably be on the minds of approximately 160 Massachusetts RCF administrators and boards. Additionally, whether its members, representing nearly half of the state's RCF stock (total stock = 5,500 beds -- 50-60% entirely publicly supported), will be able to convert is a top policy issue for the Association of Massachusetts Homes for the Aging (AMHA). In essence, RCFs are faced with three choices, to: 1) continue operating as is, 2) convert to AL, or 3) face closure. Numerous risks and rewards, advantages and disadvantages, are inherent in each

4 In 1990, Massachusetts maintained 184 state-licensed RCFs. Based on a rough estimate of how many RCFs are no longer in operation, the current number of RCFs was estimated.
5 Interview with Diane Flanders, Director of Long-Term Care, Dept. of Public Welfare, April 27, 1993.
6 The Association of Massachusetts Homes for the Aging is a statewide network representing over 140 not-for-profit providers of housing, health care, and support services for older people. AMHA is affiliated with the national organization; the American Association of Homes for the Aging.
choice. If RCFs maintain the status quo, ignoring marketplace trends and policy changes, many may place themselves at risk of insolvency within a decade. Yet the uncertainty of moving ahead with conversion (if feasible) while policy is in a formative stage is also risky. The option of closing, which many have taken (Rate Setting Commission statistics indicate 20% of all RCFs have closed since 1982), means facilities must confront the task of finding an appropriate home for their residents and resigning their missions.

Two parties primarily concerned with the feasibility of conversion are considered the primary "audiences" for this study: 1) RCF management (its Boards, administrators, owners, and operators) and 2) state policy makers developing the AL program model. Other RCF advocates (i.e. AMHA) and state officials responsible for the operations of RCFs should also find this study useful. By outlining mismatches between the policy design and implementation, and offering recommendations to address these issues, RCFs should be in a more informed position to consider future operations, and policy makers more informed to develop AL legislation.

METHODOLOGY:

Four components comprised my research methodology: a literature review, data analysis from an "Assisted Living" survey, interviews, and a case study.

1) The main areas my literature review included were a review of historic and current national and state long-term care and housing policies, the development of AL in other states, and the development of the AL model in Massachusetts (see Bibliography).

2) As an intern at the Association of Massachusetts Home for the Aging (AMHA) since May 1992, I assisted in writing, conducting, analyzing data, and producing reports from a statewide "Assisted Living" survey. Survey data helped piece together trends in the industry and provided an opportunity to offer a snapshot of the current state of the
Chapter I: Introduction

residential care marketplace. Lastly, with advice from practitioners, this data assisted in the selection of my case study.

3) Interviewing a variety of practitioners was a key component of my research. Interview participants represented all key sides of the issues my study investigated: RCF administrators, feasibility consultants, professional and academic researchers, past and current state policy makers, among others (See Resources).

4) As the body of my thesis, I choose a case study to gain a "hands-on" understanding of past and current operations of RCFs and to exercise the affect of conversion policy upon. By adapting traditional case study methodology, I integrated the quantitative components of a feasibility study (primarily simplified financial forecasts) to conduct a feasibility study of one RCF converting to AL. The central purposes of the case study were to identify the key variables influencing conversion feasibility, assess the facility's relationship to these variables (its strengths and weaknesses), adapt these findings to peer facilities, identify the mismatches in RCF/AL conversion policy design and implementation, and make recommendations to RCF management and state policy makers based upon these findings.

ORGANIZATION OF STUDY:

This study is made up of nine chapters. Chapter II frames the context of the study by discussing the affects of national and state long-term care trends on the development of housing with services models. Following this general review, Chapter III describes the AL model as developed and implemented in other states, and follows with a description of the Massachusetts AL program model. While most of Massachusetts' AL legislation has been drawn up, it is important to emphasize from the outset that no bill has passed. Chapter IV offers a brief history of the evolution of the US residential care industry, followed by a discussion of the history and current state of Massachusetts RCF providers.
Chapter I: Introduction

While little empirical research has been conducted on the subject, Chapter V discusses the key differences between residential care and assisted living. Chapter VI moves on to focus on both required, fundamental, and desirable physical plant changes necessary when considering conversion.

Representing the body of this study, Chapter VII is the feasibility study of conversion. After briefly reviewing traditional feasibility analysis, an overview of the case is presented, and the feasibility study is conducted. In addition to discussing the key variables affecting the abilities of RCFs to convert, Chapter VIII outlines key mismatches between the design and implementation of conversion policy. Lastly, Chapter IX summarizes conclusions about the feasibility of conversion and offers recommendations to both RCFs and state policy makers.

CONCLUSIONS:

Findings from this research indicate that the majority of Massachusetts RCFs that primarily serve low-income individuals will not only be unable to make an appropriate conversion to AL, but also lack the ability to meet basic programmatic requirements necessary to qualify as AL providers. Additionally, my findings indicate that contrary to the general consensus, a small number of moderate- and low-income individuals will be served in Massachusetts AL facilities. Lastly, in the absence of conversion, whether or not RCFs that serve the poor will be able to continue operations in their present states for much longer is also highly questionable.
CHAPTER II

BACKGROUND/CONTEXT FOR STUDY
Chapter II: Background/Context for Study

Unprecedented changes in long-term care policy will take place within the next decade. On both the national and state level, three primary trends in long-term care planning and policies frame the context of this study: 1) demographic changes, 2) consumer demands for new housing with services options, and 3) long-term care cost-containment initiatives.

1. Demographic Changes:

The US is experiencing unprecedented growth in its elderly population that will continue well into the first third of the 21st century. This growth is demonstrated by increases in: 1) cohort size, 2) human longevity, and 3) the proportion of the elderly to remaining population subgroups. Between 1980 and 2030, the elderly population (those 65+ years) is expected to increase 40% comprising 22% of the total US population.

National figures of the number elderly requiring long-term care in 1988 was seven million, a projected nine million in 2000, and eighteen million in 2040.\(^1\) Within Massachusetts, in 1988, the elderly represented 14% of its total population and is projected to comprise 19% in 2030. Also within Massachusetts in 1988, the oldest old (those 85+ years) comprised 11.3% of the elderly population which is projected to increase to 37% in 2050.\(^2\)

Given age as an accurate predictor of impairment, the growth of the oldest old group is of particular concern to health and housing policy makers. Since 1940, life expectancy has increased nine years with only two of these years relatively healthy and free from disabling chronic illnesses. Despite advances in medical technologies, these remaining years of elders' lives are often accompanied by complex problems of acute and chronic illness. Currently, 210 out of every 1000 of the oldest old require assistance with activities of daily living (ADLs)\(^3\). However, among all elderly, only 35% require care that

\(^1\)The Center for Vulnerable Populations, p. 1.
\(^3\)ADLs include bathing, dressing, toileting, transferring, continence, and eating.
must be delivered in nursing facilities and may be more suitably and economically served in less acute settings.  

The proportion of elderly to younger population subgroups is also important because of threatened decreases in informal caregiving often provided by elders' children and friends at no cost. While nearly 75% of the care non-institutionalized elders receive is still informal, changes in familial values, decreases in intergenerational living arrangements, increases in geographic separations, and the influx of women into the workplace have made informal care provision a challenge for elders to rely upon. As informal caregiving continues to decrease (as it likely will), a historic long-term care resource dwindles, and demands for alternative housing with services options increases.

2. A Demand for Alternatives:

The demographic changes mentioned above have considerably increased the demand for elderly housing with services. After decades in which the inevitability of institutionalization was rarely questioned (due to the absence of desirable alternatives), long-held elder cultural and social preferences to remain at home or to age in home-like settings are finally being heard by policy makers, housing sponsors and developers, and supportive service providers alike. In December 1992, The Wall Street Journal ran an article on how nursing homes are perceived as proverbial poorhouses and how people will do almost anything to avoid them. A 1991 survey conducted by the Alliance for Aging Research indicated elders' single greatest fear as "being sent to a [nursing] home."

Providing momentum behind increased demands, favorable economic changes have fostered the growth of the new, more affluent group of elderly that have forced sponsors to upgrade housing with services models to compete for more sophisticated consumer

4K. B. Wilson
5 Leutz, Capitman, MacAdam, and Abrahams, p. 24.
attention. In addition to Assisted Living, an earlier example of response to these demands was the emergence of Continuing Care Retirement Communities (CCRCs). In essence, the model of the past few decades in which a person was moved from one location to another as deterioration occurred is out. The current trend in elderly housing is to offer a homelike setting with flexible supportive services that allow persons to "age-in-place;" if possible, until death.

3. Long-Term Care Cost-Containment Initiatives:

The 1980s era of New Federalism, with the virtual transference of policy making responsibilities from the federal to state level, and the absence of coherent federal policy initiatives combining housing with services, has left states to make amends with limited funding and leadership. Nationwide health care crises precipitated a series of cost-containment strategies in the 1980s (i.e. Medicare's Prospective Payment System [PPS] and the implementation of the Health Care Financing Administration's [HCFA] Diagnostic Related Groups [DRGs]) that reduced the amount, and many would argue the quality, of services provided to low-income elders. Since the elderly represent 29% of all health care costs, increases in long-term care costs have only exacerbated the national health care crisis. For example, in 1990, while the elderly comprised 5% of all Medicaid recipients, they consumed 23% of total expenditures. In absence of change, the US will struggle to simply cover Medicaid expenditures predicted to rise nearly 120% between 1990 and

---

7 Improved economic conditions of older people have been fostered by the development of the Social Security Act, public and private pension funds, aggregate increases in asset value (particularly homeownership), and the development of health insurance (i.e. Medicare).

8 CCRCs offer a continuum of housing settings (from independent housing on one end to Skilled Nursing on the other) within the same relative location and all of which are owned and managed by the same entity. Costs to live in a CCRC in Massachusetts range from approximately $1,500 - $2,000/month.

9 Under Medicare's PPS and HCFA's DRGs, hospitals implemented a vigorous campaign to reduce the length of stay for Medicare patients. Results have included earlier patient discharges and increased demands for services in all settings.

10 Medicaid is the combined federal and state program providing medical assistance to low-income persons.
Chapter II: Background/Context for Study

1996.\textsuperscript{11} It is therefore logical that policy makers have targeted "budget-busting" long-term care programs for cost reductions.

In addition to a host of other budgetary problems, the chart below demonstrates why Massachusetts policy makers are so concerned about Medicaid spending and cost-containment:

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Rate of Medicaid Increased Spending Over the Previous Year</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Massachusetts</td>
<td>12.8%</td>
<td>12.5%</td>
<td>30.1%</td>
<td>44.0%</td>
</tr>
<tr>
<td>National Average</td>
<td>8.6</td>
<td>12.2</td>
<td>18.6</td>
<td>26.9</td>
</tr>
</tbody>
</table>

Source: Congressional Research Service

Currently, roughly a third of all Massachusetts Medicaid expenditures are spent on nursing homes. Charles Baker, Secretary of Health and Human Services was recently quoted in The Boston Globe: "...unless we can bring the program [Medicaid] under control, it is going to eat the rest of state government alive.\textsuperscript{12}"

Within its cost-containment maneuvers, in 1991, the state tightened its clinical level of care criteria mandating all nursing home residents have a combination of at least three care needs including one nursing need (at least three times/week) and two activities of daily living (ADLs) needs. In July 1992, the state attempted legislation to further tighten eligibility which was reversed despite a gubernatorial veto.

To compensate for increases in nursing home admission criteria, two community-based programs have been developed for persons at risk of institutionalization; the Department of Public Welfare's "Group Adult Foster Care Program" and the Executive Office of Elder Affairs' "Managed Care in Housing" (see Chapter III). Both programs

\textsuperscript{11}The Center for Vulnerable Populations, p 1.
\textsuperscript{12}The Boston Globe, "Tackling the Medicaid Budget Buster," March 21, 1993, p. 94.
provide subsidies for in-home (often in group elderly housing settings such as public housing) services with expectation of preventing or postponing institutional placement.

Trends toward restricting nursing home placement and searching-out ways to provide affordable services to persons in the community has resulted in a void for intermediate (low acuity) long-term care users. State policy makers attest the Assisted Living program will help fill this void.
CHAPTER III

WHAT IS ASSISTED LIVING?
Chapter III: What is Assisted Living?

While "assisted living" is a new term, it represents the old concept that some people will need a more sheltered environment with services as they age. Assisted Living (AL) maintains that instead of being placed in a standardized setting, older people should be offered a choice of preferred settings and services they deem most appropriate. While AL describes a philosophy of care and an idea about the character and appearance of the environment, there is no universally agreed upon definition. Some believe a definition that differentiates AL from other types of care rightly sets AL apart as a higher standard of residential long-term care provision. They maintain that among the myriad of programs offering a range of setting, services, and costs, AL's differentiation will also eliminate consumer confusion. On the other hand, others argue a narrow definition is restrictive and recommend a broad definition encompassing a full range of options to foster innovation and competition.

Despite differences in interpretations, considerable common ground exists on which to define and describe AL. This discussion of AL's "common ground" is divided into two parts describing first, a national perspective of the definition of AL, and second, the development of the AL model in Massachusetts.

I. A NATIONAL LOOK:

a. Definition:

Victor Regnier's (nationally renown AL researcher and Dean of Architecture at the University of Southern California Center for Gerontology) definition of AL is as universally accepted as any:

"[AL]...is a housing alternative based on the concept of outfitting a residential environment with professionally delivered personal care services, in a way that avoids institutionalization and keeps older frail individuals independent for as long as possible."\(^1\)

\(^1\)Regnier, Hamilton, and Yatabe, p. 1.
Chapter III: What is Assisted Living?

My version of Keren Brown Wilson's\(^2\) four concepts that underlie AL are as follows:

1. **Create a Place of One's Own**
   Provide residents with a single occupied unit with private baths, kitchens, and lockable entry doors. This assures individuality, privacy, and respect.

2. **Serve the Unique Individual**
   Serve a range of competencies with flexible, individualized services.
   Monitor residents needs on a monthly basis and adjust service levels (as needed) with the input of the staff, family, and friends.

3. **Share Responsibility Among Caretaker, Family and Residents**
   Share responsibility in decision making with residents and their families so active participation in appropriate care plans is fostered. This contrasts with traditional care plans defined by the state through exhaustive regulation that alienates families and erodes these important relationships.

4. **Allow Resident Choice and Control**
   Empower residents to exercise a full range of choices focusing on wellness (as opposed to impairment) to allow each to control his/her destiny. Respond creatively to issues of choice and control that reinforces self-esteem, self-respect, and ongoing independence. In essence, envision older people not as helpless, but as capable consumers.

**b. Who lives in Assisted Living?**

AL is targeted to elders at imminent risk of institutionalization\(^3\) who do not require continuous medically-related care. Many elders enter AL facilities after experiencing a decline in physical and mental competency depriving them of their abilities to organize the necessary network of services to live independently. Approximately a third of all AL residents have entered after hospitalization, 10% previously lived in a nursing home or a RCF, and the remainder had been living with their families or alone. The average duration of stay in an AL facility has been two-three years.\(^4\)

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\(^2\)Keren Brown Wilson is considered by many as the "founder" and leader researcher of AL who has developed over 300 successful AL units in Oregon.

\(^3\)Institutionalization is any environment offering skilled nursing care (medically-related services) yet ordinarily does not refer to acute hospital care. For the purposes of this paper, institutionalization can be considered placement in a nursing home.

\(^4\)ALFAA, p. 9.
A typical AL resident is described as a frail, female (75%) in her mid-80s. Most maintain a host of IADL\(^5\) impairments, an average of 2.5 ADL\(^6\) impairments, and 30-40% experience problems with incontinence. Many are cognitively alert yet physically frail. Others are mentally frail (within early stages of dementia) and are physically able. Given the ranges of impairment and disability, services in AL must be flexible and staff trained to care for a diversity of needs.

c. Physical Design of Assisted Living Facilities

The physical as well as environmental design of AL facilities are as important as the services provided within them. Three key aspects influencing the form of AL include:

1. **Size and Scale**
   Most AL facilities are in the range of 20-30 units. Beyond 80 units, a facility takes on the appearance of an apartment building or hotel. One- to two-story buildings that maintain a residential scale are most preferable.

2. **Appearance**
   AL facilities reflect the precedent with which their architectural styles are borrowed. Desirable precedents include the large mansion house and the compact European-style bed and breakfast hotel. In all cases, AL facilities truly behold a residential look and "feel."

3. **Autonomy**
   While AL can be part of a continuum of care, when connected to more acute settings, AL often takes on an undesirable institutional feel. Most successful AL facilities are freestanding homelike residences that are viewed as service-intensive settings.

As will be discussed later, the physical design challenge in AL is to achieve two competing goals: 1) attaining and maintaining a viable facility with a compelling residential character

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\(^{5}\)IADLs (Instrumental Activities of Daily Living) includes laundry, cleaning, cooking, shopping, money and medication management, transportation, among others.

\(^{6}\)ADLs (Activities of Daily Living) include bathing, dressing, toileting, transferring, continence, and eating.

\(^{7}\)The Center for Vulnerable Populations, p. 16.
Chapter III: What is Assisted Living?

while, 2) satisfying the economies of scale to cost-effectively deliver a range of personal care services.

d. Services in Assisted Living

Great diversity exists in the range of services available in AL facilities. Low intensity services include housekeeping, structured activities, meals, laundry, and transportation. In the middle range, services focus on personal care such as assistance with bathing, dressing, and medication management (as well as other ADLs). A few models provide higher levels of care incorporating nursing care (i.e. health assessment and monitoring of clinical symptoms). Many services in AL facilities are provided through contract with community-based providers. At minimum, service capacity includes:

- **24-hour Emergency Response System** to meet unscheduled, unpredictable needs.
- **Service Coordination** capability to arrange access to services not provided directly by staff.
- **Service Planning** capability to create individualized service plans.
- **Capacity to Address Common Dementia-Related Problems** (i.e. memory loss, depression, and sleep disorders)

e. What does Assisted Living Cost and how is it Financed?

AL costs are a function of the service package, amenities, and payment sources utilized and therefore can vary greatly from one facility to another. Market rates for the total package (shelter, food, and services) range from $1500-$3000+/month (the average is roughly $2,500/month). Thus far, AL has proven itself to be less expensive than nursing home costs. Payments for both public- and private-pay clients have thus far been
Chapter III: What is Assisted Living?

80% of nursing facility rates. A Coopers & Lybrand study found expenses in AL facilities run about 50-60% revenue as opposed to nursing facilities running at 80%.  

AL can be financed publicly through a variety of mechanisms: from federal programs (Section 202 Supportive Housing for the Elderly, Section 232 Mortgage Insurance, Congregate Housing Services Program, and Farmers' Home Administration) to federal funds administered by states such as Low-Income Housing Tax Credits, tax-exempt bonds, and Community Development Block Grant funds. Most of these programs have just begun exploring AL and at this time would exclude (through eligibility requirements) most not-for-profit RCFs looking to convert to AL. Providers primarily serving low-income persons look to Supplemental Security Income (SSI) or Medicaid for financial assistance.  

II. ASSISTED LIVING IN MASSACHUSETTS

While well-developed in a number of states, AL has emerged in Massachusetts only recently. However, the fact that congregate housing (from which many of AL roots are derived) has been part of the state's long-term care continuum since 1978 (83 current projects), indicates that housing with supportive services is not a new concept to the state. Additionally, in comparison to most states, AL's development may have been delayed because Massachusetts has developed and funded a relatively strong community-based system of home care services.

While AL has different meanings throughout the state, my explanation of the Massachusetts' AL model will rely primarily on drafts of AL legislation as its source.

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9 SSI is a subsidy for low-income individuals, financed by the federal government, channelled through the states to providers, for room and board in RCFs. Medicaid is public assistance program for needy individuals in a health care setting. Since they are not defined by the state as medical facilities, Massachusetts RCFs are not eligible for Medicaid.
Chapter III: What is Assisted Living?

a. Definition:

In a November 1992 publication entitled "Assisted Living Program Model" (four pages long), the Department of Public Health, the Department of Public Welfare (DPW), the Rate Setting Commission, and the Executive Office of Elder Affairs (EOEA) released their consensus development of the state's AL model. While two state Representatives have since filed another bill, the November publication offers the first clear description of AL's direction. The publication (see summary in Appendix A) describes that AL:

"...is intended to help residents remain as independent as possible in order to avoid premature institutional placement. Assisted Living entities should adopt policies that enable residents to 'age-in-place'"

AL is targeted to the elderly in need of a protective environment with supportive services.

b. Setting:

There is no prototypical setting of AL. The 1992 publication describes:

"a model may include, but is not limited to, such sites as elderly housing units with supportive services, other group living arrangements... or individual homes. This option may also be available to any nursing facility or rest home [RCF] wishing to convert to assisted living [emphasis added]."

At a Fall 1992 presentation to a group of RCF and nursing home administrators, Diane Flanders (Director of Long-Term Care, Dept. of Public Welfare [DPW]) spoke about AL. Diane emphasized that AL was in a developmental stage and that policy makers are

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10The November 1992 publication was the draft of H 6236: "An Act Establishing Assisted Living Housing" filed near the close of the 1992 legislative session. While the bill died, it was re-filed in May 1993 with a Special Message from Governor. Additionally, in February 1993, H 3030: "An Act Relative to Community Based Long Term Care," was filed by Representatives Buell and Kollios. The key difference in the Buell/Kollios bill is that AL facilities are broken down into three types depending on the number of persons cared for in a setting. At the time of printing (5/20/93), the redrafted Buell and Kollios bill is working its way to the legislature (has received unanimous approval by the Joint Committee on Human Services and Elder Affairs).
"inventing as they go along." The state continues to appear opened-minded about potential AL settings.

c. Physical Plant:

All entities must meet local fire, safety, building codes, and applicable American with Disabilities (ADA) and Fair Housing requirements. (See Chapter VI for a detailed discussion of physical plant changes.)

d. Services:

An entity must provide direct assistance with any ADLs indicated in its registration. Services may be provided by trained staff or by contract with community-based service agencies (i.e. Home Care). While all must provide assistance with bathing, dressing, and ambulating, entities are strongly encouraged to provide assistance with feeding, transferring, and toileting. Medications must be self-administered (although prompting and reminding are permitted). Actual medication administration may only be performed by licensed personnel or unlicensed personnel according to procedures specified by the DPW.

Assistance with IADLs are also important components of service provision. Household-type services (cleaning, laundry, shopping, and transportation) are strongly encouraged. Additionally, an entity should ensure adequate daily nutrition to all residents (many facilities will choose to provide all meals). Lastly, an emergency response system must be provided to residents to assure immediate access to a responsible person on the premises 24-hours/day.

Plans have been developed so that two publicly-assisted service programs designed for low-income persons mainly in public housing will be available to AL residents, the:
Chapter III: What is Assisted Living?

1) Dept. of Public Welfare's (DPW) Group Adult Foster Care Program, and 2) Executive Office of Elder Affairs' (EOEA) Managed Care in Housing (see Appendix B).

The Group Adult Foster Care Program (GAFCP) was designed to "provide room, board, and personal care services in a residential setting to elderly individuals at imminent risk of institutional placement." Eligibility requirements specify that no more than three individuals residing in one "home" (unit) can participate (not subject to institutional licensing requirements). Care plans are to be developed by Registered Nurses and regulations require 24-hour emergency response system availability for all participants.

Upon de-licensing its beds, participating RCFs that have converted to AL will receive Medicaid funds (GAFCP) for personal care and administrative services.

Managed Care in Housing (MCH) was developed by the EOEA (in close conjunction with the DPW) to provide supportive services to elderly individuals who remain in the community because of changes in Medicaid regulations governing nursing home eligibility. Like the DPW, the EOEA is adapting its program design for elders in AL entities. For all intents and purposes, MCH mimics the GAFCP with the main exceptions of serving those with fewer financial limitations, targeting persons in public housing, and running through local Home Care agencies.

e. Terms of Participation:

A written contract outlining the responsibilities of the resident, facility, frequency of service delivery, and costs of all standard and optional services must be complete upon resident admittance. After assessment by a licensed nurse, a care plan (updated periodically) addressing the unique physical and psycho-social needs, abilities, and personal preferences of each resident is to be drawn up. An agreement defining

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11 The DPW has amended this rule to include AL facilities.
Chapter III: What is Assisted Living?

responsibilities for finding alternative arrangements, in the event it becomes necessary, is also required.

Since AL is proposed as an unlicensed and virtually unregulated model (unlike most RCFs licensed by the Dept. of Public Health), a registry within the Executive Office of Communities and Development (EOCD) has been proposed to keep track of AL entities. To register, entities must: 1) define the services they will offer, 2) outline plans for meeting resident needs, and 3) demonstrate the capacity to meet baseline state AL requirements. Registration will be renewed on an annual basis.

f. Oversight/Consumer Protection:

The EOEA's Ombudsman program will provide resident advocacy and consumer protection. Conflict resolution and mediation on the local level will be the main roles of the Ombudsman. For consumer protection requiring further action, matters will be referred to appropriate oversight agencies.

Currently, a great deal of controversy surrounds the issue of oversight (particularly the lack of third party involvement) and suggestions for the integration of case management services have been strongly voiced by advocates.

(Note: A discussion of financing mechanisms for Massachusetts RCFs looking to convert to AL is discussed in Chapter VII.)
CHAPTER IV

PROFILE OF THE INDUSTRY:
WHAT IS A RESIDENT CARE FACILITY?
The history of Resident Care Facilities (RCFs) makes clear why conversion to Assisted Living (AL) represents significant change. After discussing the history of residential care from a national perspective, this chapter examines the history of Massachusetts RCFs, offers a short profile of Massachusetts RCF providers, and lastly focuses on why RCFs who serve a high percentage of public-pay individuals are in such tenuous financial and operational positions.

**A Brief History of US Residential Care Facilities**

Like other forms of care provision for dependent populations, residential care for the elderly developed in an incremental manner in response to changing social forces rather than in a deliberate and comprehensive fashion. Patterns of growth within the residential care industry, having developed much in response to the growth of the nursing home industry, in many ways mimics the evolution of nursing home care.

The history of residential care (RC) facilities and modern nursing homes can be traced through three modes of care: 1) the "poor farm" (the primary mode of care for indigent elders throughout the 19th century), 2) private homes for the aged (which emerged around 1900 for healthier elders with limited incomes or no families), and 3) the proprietary boarding home (developed around 1900 for elders able to pay for their care). Today, private homes for the aged and proprietary boarding homes are commonly referred to as "rest homes" and "board and care" facilities. In Massachusetts, these homes are formally referred to as "Resident Care Facilities." As residents aged, providers found it necessary to add nursing staff and thus, many RC facilities gradually evolved into nursing homes. While some local requirements developed, these facilities were unregulated and basically run through "private" agreements between residents and providers.

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1Due to the efforts of reformers to close these often substandard institutions, "poor farms" (also known as almshouses) disappeared in the 1930s and 1940s.
Chapter IV: A Profile of the Industry: What is a Resident Care Facility?

The growth of the nursing home industry followed the passage of the Social Security Act of 1935. Title I of the Act created the first federal program to provide financial support to elders; Old Age Assistance (OAA).1 OAA was distributed in the form of grants-in-aid to states, eligible to persons in their homes, and forbade payments to "inmates of a public institutions" (to prevent the support of poorhouse residents). By greatly expanding elders' ability to purchase nursing home care, OAA fostered the transformation of many rest/boarding homes into nursing homes.

Despite the fact that from 1940 to 1960, the proportion of elders residing in "group quarters" (i.e. rest/boarding homes) declined from 41% to 12%, and that in nursing homes grew from 24% to 72%, a small cottage industry of private homes continued operation.2 Having firmly established themselves during the Depression and World War II, often run by unemployed nurses and their families as a way to finance their homes, these large homes typically set aside a few rooms for the care of the poor elders. Rest/boarding homes filled a relatively small but important affordable housing and care need for those unable to afford more expensive residential, or nursing home, care.

The 1950 amendments to the Social Security Act fueled health care provision in nursing homes by lifting the prohibition of payments to persons residing in medical facilities. A licensing system for nursing homes was established, but with few requirements and provisions for enforcement, its legislative intent of insuring quality care to residents failed.3 However, with the advent of Medicaid in 1965, and in recognition that many nursing home residents could be cared for in a less care-intensive settings, in 1967 Congress established the Intermediate Care Facility (ICF) (Medicaid funding in

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1In 1972, OAA was transformed into the Supplemental Security Income (SSI) program. SSI provides monthly payments to the aged and disabled. To qualify for SSI, a person must have an income below approximately $730/month and no more than $2000 in assets. While financed and administered by the federal government, many states (including Massachusetts) supplement these payments.
2Baggett, p. 61.
3Baggett, p. 65.
1972) that allowed more elders with financial limitations access to less acute institutional care.

Throughout the 1960s and 1970s, during a period of increasing levels of public expenditures for nursing home care, reports of abuse and disasters surfaced in nursing homes. Regulation within nursing homes flourished and quickly infiltrated the RC industry (comprised of rest/boarding, and comparable homes) experiencing similar, yet more severe, problems including fires, exploitation and abuse of residents, and unsanitary, unsafe physical plants conditions. The 1976 Keyes Amendment to the Social Security Act was the first of a series of federal initiatives to increase oversight of the RC industry. Great concern that public dollars were subsidizing substandard institutions where Supplemental Security Income (SSI) recipients resided fueled RC regulation.

However, as in the regulation of nursing homes, the intent of this legislation fell short because of lack of state enforcement. In 1981, the Rinaldo amendment to the OAA made mandatory the inclusion of board and care/rest homes in state ombudsman programs. In 1989, the National Board and Care Reform Act created a commission to make recommendations to Congress regarding minimum national standards for RC facilities including resident rights, adequate staffing, physical structure, fire safety, sanitation, proper diet, access to needed health care, and resident activities.

Despite all initiatives to regulate and "professionalize" the RC industry, the operations of the rest/boarding homes (often regarded as "mom and pop" homes) today are quite similar to that of a half-century ago. RC facilities continue to offer alternatives lower-income elders unable to remain at home and ineligible for nursing home placement. Many RCFs are owner-operators and run by administrators and boards generally unskilled in terms of adequate business skills to run these facilities well. While little research has been conducted on the RC industry, serious financial and operational management

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5 Acting much like "consumer watch-dogs," ombudsman programs are designed to investigate and resolve consumer (i.e. residents, family, friends) complaints within facilities.
problems involving inadequate training and experience of personnel (due to weak regulatory personnel requirements) have been reported. Mismanagement of residents' money is the most frequently reported abuse. Additionally, numerous reports of poor resident care and substandard physical plants continue to surface. Today, marketing efforts and interest in RC industry by developers is virtually non-existent. In Massachusetts, no new RCFs may be built (per the Dept. of Public Health). In many respects, the labels "rest home" and "board and care" continue to carry the stigma of a down-sized nursing home run by unscrupulous owners, a place where "poor people go," and where quality of care is continually questioned.

MASSACHUSETTS RESIDENT CARE FACILITIES

From their inception, Resident Care Facilities (regarded as "rest homes" until 1989) have played an ambiguous role in the state's long-term care continuum. While never intended as medical facilities, RCFs are now regulated, reimbursed, and operated with strong influence from the traditional medical-model view of institutional long-term care. Additionally, while RCFs were developed as community resources and alternatives to nursing home placement, many RCFs are isolated from the community and are poorly integrated into the network of community-based health and social service providers.

From its beginnings, given the diversity among facilities, Massachusetts' RCF program has been unfocused in sharply defining its target population and addressing resident needs. This lack of precision was compounded by policies de-institutionalizing the mentally-ill during the 1970s. For the many RCFs that "adopted" mentally-ill persons, the needs of the de-institutionalized unfortunately often outstripped the follow through

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7 Kalymun, p. 99.
8 All licensed RCFs must comply with standard set by the Dept. of Public Health's: "Rules and Regulations for the Licensing of Long Term Care Facilities."
Chapter IV: A Profile of the Industry: What is a Resident Care Facility?

and commitment of the state to provide reimbursement and support. While a separate licensed level of care for facilities with a high percentage (50% or greater) of persons with mental illnesses was created (Community Support Residences), many RCFs continue to care for elders (as well as younger people) with mentally-ill diagnoses who had previously been institutionalized.

Susan McDonough, past Long-Term Care Ombudsman within the Executive Office of Elder Affairs (EOEA), confirmed RCF management suspicions that the Commonwealth: "ignored Level IVs [RCFs] for years." Robert Mollica, Assistant Secretary at the EOEA from 1983-1991, agreed that RCFs were "neglected because of far more pressing issues.... Given the abundance of nursing home beds during the early 1980s, state officials questioned whether RCFs were necessary to the long-term care continuum. Until the case-mix system was implemented (1988-1991), nursing homes worked to attract RCF residents because they were easier (cheaper) to care for than their typical residents. However, once the case-mix system came on-line and facilities began being reimbursed according to resident acuity, nursing homes have focused on more acute levels of care. As a result, RCF residents, ineligible for nursing home placement, have been left with few alternatives.

In retrospect, Susan McDonough explained that there was (and likely continues to be) a "perception problem" among state officials regarding RCFs. A "good guys, bad guys" (expect for a few nice homes, RCFs generally provide poor care) attitude developed that has given RCFs a bad name. Diane Flanders, Dir. of Long-Term Care at the DPW, confirmed that "there are some very poorly run facilities out there." After witnessing "horrific" cases of resident abuse and substandard physical plants, many state officials

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9 Interview with Susan McDonough, April 1, 1993.
10 Interview with Robert Mollica, Professional Staff, National Academy for State Health Policy, April 12, 1993.
11 Case-mix systems were designed to match the level of services needed by a patient to the reimbursement amount the provider receives for that person. In part, the systems were designed to inhibit providers from selectively treating healthier persons (i.e. rest homes residents) to minimize costs and maximize revenues.
embarked on a "crusade" to improve the quality of care and operational sophistication in RCFs. And while some of the well-run RCFs "occupy a very important role" between nursing home care and receiving services at home, Susan McDonough explained that the state has never looked to RCFs as "a logical response to the needs of those [RCF residents] within the gap."

Since RCFs informally worked themselves into the long-term care continuum (by filling gaps in the continuum), many RCFs providers argue they have never been considered to occupy an important role in the eyes of state policy makers. Many RCF administrators express that judging from the state's treatment of them, providers have been doing an essentially unrecognized, thankless job. One interviewee responded: "The state simply doesn't know what to do with Level IVs [RCFs]." To date, RCF licensure regulations (developed by the Dept. of Public Health) do not specify a specific role for RCFs in the continuum.

A Brief Profile of Massachusetts' RCF Providers:

In addition to the characteristics noted above, data from an "Assisted Living" survey conducted by the Association of Massachusetts Homes for the Aging (AMHA) offers a closer, yet not conclusive, snapshot the Massachusetts RCF population.

Conducted during the Summer of 1992, AMHA sent 393 surveys to a range of elderly housing and care providers with the central purpose of tracking the "state" facilities in Massachusetts. Of the 251 total responses received (response rate = 63.9%), 119 respondents (47.4%) included in this thesis analysis categorized themselves at least one of the following, as: 1) an Assisted Living Facility, 2) a Residential Care Facility 3) a Freestanding Level IV Facility, 4) Board and Care. Significant findings from the

12Interview with Diane Flanders, April 27, 1993.
13Note that each facility was asked "how it categorizes itself" which may, or may not, indicated its official licensure status.
Chapter IV: A Profile of the Industry: What is a Resident Care Facility?

Analysis of these 119 respondents (approximately half for-profit [FP] ownership, half not-for-profit [NP]) are summarized below:

- **Year Facility was Founded**: Within NP respondents, over 64% were founded between 1850-1949. In contrast, 84% for FP respondents were founded between 1950-1992. While, in general, the NP stock is older than the FP, one should recognize that many NP facilities are bought-out and operated by FP organizations.

- **Number of Years Operating in Present State**: Nearly 70% of NP respondents have been operating for 25-150 years in their present states (as opposed to 60% of FPs for 16-49 years, almost a quarter for only 1-5 years). It is generally recognized that many RCFs have not made significant changes to their physical plants in over twenty years.

- **Occupancy Statistics**: Statistics were collected for 1990, 1991, first quarter 1992, and May 1992. Except for May 1992, FP statistics were roughly 10% higher than NPs. Except for May 1992 with rate of 84.7%, mean NP statistics were in the low-mid 70s. FP mean rates were in the mid 80s, and 90.4% in May 1992. In general, these statistics demonstrate that RCFs have experienced occupancy problems.

- **Public Assistance**: On average, nearly two-thirds of respondents indicated their residents (or facility) is publicly subsidized in some way. While nearly 15% more FPs indicated "public assistance" (77%), this does not mean that these facilities maintain a higher percentage of publicly subsidized residents.

- **Type of Public Assistance**: The majority (over 80%) of all respondents indicated their residents (or facility) is receiving Supplemental Security Income (SSI) and/or Emergency Aid to the Elderly and Dependent Children (EAEDC).

- **Accommodations**: Including one-bedroom and studio apartments, between 32% (FP) and 42% (NP) of the respondent stock is comprised of single-room occupancy rooms with private bathrooms. These statistics indicate that a significant amount of renovation would need to take place within RCFs to accommodate only single-room occupancy.

Almost 8% of the total stock offers private rooms with two persons sharing a bathroom, and 28% with private rooms with more than two persons sharing a bathroom. Lastly, roughly 7% of the total stock is comprised of more than one person sharing a room with more than two persons sharing a bathroom.
Chapter IV: A Profile of the Industry: What is a Resident Care Facility?

- **Monthly and Per Diem Rates:** Both mean and median rates (high and low) were calculated for all respondents offering their rates.

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The above rates exhibit why, in comparison to RCF rates, most AL rates (which average around $2,500/month) are not affordable to RCF residents.

- **Meal Provision:** Nearly all respondents indicated that three meals per day (including snack) are provided and the costs of meals are included in the monthly/daily rate to reside in the facility.

- **Policy on Locking Doors and Medications:** Over two-thirds of all respondents indicated allowing residents to lock their doors. Just over 70% indicated allowing locking of medications.

- **Service Provision:** As mentioned earlier, most of the services provided within RCFs are dictated by regulations. AMHA asked respondents about thirty-nine different services categories and whether or not they services are provided within the costs of their daily rate or at extra charge.

More than 75% of respondents indicated the following services are provided within the daily rate: 24-hour staffing; emergency response system; monitoring or supervision of self-administered medications; administration of medications per physician's order; assistance with ADLs on a constant/as needed basis (bathing, dressing, and toileting); assistance with ADLs on an occasional/as designated basis (bathing and dressing); housekeeping, laundry, transpiration, and shopping services; and organized leisure time.
Chapter IV: A Profile of the Industry: What is a Resident Care Facility?

More than 75% of respondents indicated the following services are available at extra charge: administration of medications per physician's order, assistance with ADLs on a constant/as needed basis (bathing, dressing, and toileting), and assistance with ADLs on an occasional/as designated basis (bathing, dressing, toileting, eating, and ambulating).

The resounding majority of respondents indicated that services are provided by staff as opposed to by contract.

(Please Note: The above statistics are for discussion purposes only. Do not quote without permission of the author.)

Why are Massachusetts RCFs in Such a Predicament?

Several trends indicated why most Massachusetts RCFs have arrived at the consensus that imminent changes (either by policy makers or themselves) are in order. First, since the late 1970s, low reimbursement rates to RCFs (including rate "freeze"), which were confirmed by many state officials, have resulted in depressed revenues within RCFs. From 1985 to 1990, reimbursement rates lagged 32% behind costs. A large part of the reimbursement problem is the prospective nature of the system. For example, 1992 RCF reimbursement rates are based on 1990 costs multiplied by a "cost-adjustment factor (CAF)." Unfortunately, CAFs have not kept up with inflation and facilities have been forced to bare the burden. Additionally, this is a inescapable "Catch-22" system for RCFs; the more they work to accumulate capital to reinvest in their facilities, the less they are reimbursed, which eliminates then their savings. In essence, it is nearly impossible to save any money based solely on public-pay revenues.

Lastly, since the Dept. of Public Health maintains no historical data on resident health status, little information exists to base a rate adjustment, particularly to changes in resident needs. One RCF administrator remarked: "Current Medicaid [SSI] funding is

14 Letter from Merlin Southwick, Executive Director of the Association of Massachusetts Homes for the Aging to Charles Baker, Undersecretary of Health Services, June 20, 1991.
totally unjust and has no correlation to the quality of care given. Other problems within the reimbursement system that have undermined the operations of RCFs (which nursing homes have been unaffected by) include:

1) No allowable equity supplement "equal to the annual building depreciation;"
2) No allowable basis for fixed assets purchased after January 1, 1983;
3) No incentive payment for high publicly-subsidized censuses and no increase in reimbursement when resident acuity level rise;
4) After full depreciation, no allowance in lieu of depreciation "equal to the building depreciation previously allowed in the last full year of the facility's useful life;"
5) Administration and Policy Planning allowance is proportionally low;
6) Inability to reduce allowable interest expense by interest income, and;
7) Wage increases have not been granted.

Second, low reimbursement rates have been exacerbated by increases in resident acuity. Due to the tightening of nursing home eligibility requirements, today's RCFs are caring for increasingly infirm elders aging-in-place. Administrators agree that the majority of their residents could have easily been placed in a Level III facility (the next, more acute level of institutional care) ten years ago. One administrator aptly described the current situation:

"In the past year we have had to add to our nursing staff in order to provide adequate care for residents awaiting transfer approval for nursing homes, and to care for being returned to us from hospitalization but unable to resume their previous level of activity. This has become a markedly stressful experience for staff, other residents, and the specific resident who is too weak to cope, but embarrassed and apologetic."\(^{17}\)

Unfortunately, increases in facilities' responsiveness to resident service needs have not been followed by comparable increases in reimbursement.

\(^{15}\)1992 AMHA Assisted Living Survey
\(^{16}\)Letter from Paul Hollings (former Director of Public Policy, AMHA) to Matt Fishman (former Assistant Secretary for Health and Welfare, Executive Office of Human Services), July 20, 1990.
\(^{17}\)1992 AMHA Assisted Living Survey
Chapter IV: A Profile of the Industry: What is a Resident Care Facility?

Many RCFs, particularly facilities serving a high percentage publicly-subsidized persons, have found themselves in tenuous financial positions after operating "hand-to-mouth" with considerable deficits for many years. Coping with financial problems has translated into RCFs dangerously withdrawing from their financial reserves or borrowing. Financial conditions have gotten so bad that many RCF administrators feel they are being slowly squeezed out the system, are considering shifting in missions to leave the government reimbursement system altogether, and are only accepting private-pay residents.¹⁸ One interviewee (a CPA), when posed with the question: "Are times all that bad for RCFs?" responded with a resounding: "Yes."

Third, as mentioned earlier, many RCFs experience management problems and lack the professional expertise (particularly weaknesses in business principals) to run their facilities well. Many RCF administrators have little interest in finances (most finances are kept on a cash-bases and some are still done manually) and entered the business to care for the elderly in a deliberate, altruistic "hands-on" fashion. Since RCFs are not reimbursed for bookkeeping activities, financial realities have often been ignored. James Mecone, CPA, who in conjunction with Association of Massachusetts Homes for the Aging (AMHA) voluntarily conducts a yearly workshop on RCF financial survival mentioned hearing "the same questions [from RCFs administrators], about the same basic problems, year after year." Unlike proprietary RCFs who operate more like "businesses," he attests that many non-profit RCFs administrators and boards do not fully understand their regulations, experience difficulty in balancing their budgets, and often do not receive the technical assistance required to run their facilities properly.¹⁹ However, the very nature of RCF reimbursement requires specialized business skills that are counter-intuitive to general business principles (i.e. a facility will not "get ahead" by cutting costs and saving).

¹⁸Continuum, Vol. 3, No. 4.
¹⁹Interview with Jim Mecone, Partner, Mullen and Company, March 18, 1992.
Another factor affecting RCF management is that its leadership (administrators and boards) is aging. The majority of today's administrators are middle-aged, and their board members, either approaching or in their retirement years. A consensus among interviewees confirmed that RCF management, particularly their boards, rarely consider long-, or even, short-range planning and are in great need of revitalization. Given that 70% of not-for-profit RCFs have been operating for over forty years (half with no significant changes in 50-150 years), great inertia hampers change. Not surprisingly, few, if any, young people are interested in participating in such a risky industry.

Fourth, this is a "policy gap" period for RCFs. Given their tendency to react as opposed to act, many RCFs are simply "waiting out" policy changes within the advent of Assisted Living before making any moves. Many RCFs fear policy changes will be "the straw that broke the camel's back" and anticipate being excluded from the state's AL definition. This policy gap period has contributed to RCF administrators continued pessimism about their futures. In 1989, 74% of all RCFs responding to an AMHA survey expressed confidence they would be operating as a RCF in 1994. This may explain the significant number of RCFs closures (nearly one per month), as well as others anticipating closure. Administrators are duly skeptical about making changes (which may only further jeopardized operations) until policy changes are ironed out.

Worse yet, many RCFs operate with little association with other peer institutions and are oblivious to policy changes. Others are simply ignoring changes. Having endured hardship for many years, and having given up on state support and assistance, many RCFs unfortunately maintain the attitude: "we've gotten through many crises before, we'll get through this one."

201992 AMHA Assisted Living Survey
21Interview with Diane Flanders, April 27, 1993.
CHAPTER V

KEY DIFFERENCES BETWEEN RESIDENTIAL CARE AND ASSISTED LIVING
Chapter V: Key Differences between Residential Care and Assisted Living

Much of the confusion differentiating residential care (in Massachusetts, RCFs) from assisted living (AL) stems from the absence of a universal, commonly-accepted or mandated definition of AL. Many would agree that one of the long-term care industry's most pressing needs is to dismantle the "semantic tangle" of long-term care living arrangements and to formulate a clear distinction between residential care (RC) provision and contemporary assisted living environments.\(^1\) Understanding the differences between RC and AL is particularly important so that RCFs can appropriately design their conversion plans, and state officials can properly design RCF/AL policy.

Distinguishing AL facilities from RCFs is confusing since the statutory and regulatory definition of Massachusetts RCFs (defined by the Dept. of Public Health) is quite similar to previously discussed definitions of AL:

"Resident Care Facilities (Level IV) shall mean a facility or units that provides or arranges to provide in addition to the minimum basic care and services and required in these rules and regulations, a supervised supportive and protective living environment and support services incident to old age for residents that have difficulty in caring for themselves and who do not require Level II and III nursing care or other medically related services on a routine basis. This facility's services and programs seek to foster personal well-being, independence, an optimal level of psycho-social function, and integration into community living."

Massachusetts RCF advocates believe RCFs provide comparable housing environments and service provision as AL facilities and argue that all but poorly run facilities (usually defined as near-insolvent) should be included under the states' umbrella AL definition. Opponents of this ideology (particularly AL developers and managers) argue that the inclusion of RCFs into the AL definition would discredit "true" AL facilities and limit AL from developing as a new, distinct model. Many interviewees remarked that if nearly all housing with support service providers were permitted to call themselves

\(^1\)Kalymun (1992), p. 35.
"AL," Massachusetts' AL program would be highly regulated, and "AL" would amount to no more than a label.

Advocates of RCFs inclusion to the AL definition believe AL facilities are nothing more than RCFs with wealthier residents, greater revenues, and therefore enjoy the luxury of amenities unavailable in most RCFs. A fear has been expressed that if RCFs are excluded from the AL definition, a two-tiered model of housing with services will form. On the bottom, poorly reimbursed and neglected RCFs will likely continue operation with increasingly limited means (likely sacrificing quality of life for residents), and will eventually be forced to close. On the top of the tier, a new attractive model (AL) will not only serve elders with fewer financial limitations, but will also compete with RCFs looking to attracting private-pay residents. Either way, for most RCFs who choose not to convert, a grim future lies ahead.

What is the Difference between Residential Care and Assisted Living?

While strong evidence suggests that residential care (RC) and AL are similar in concept (both attending to the needs of frail elders in a community-based residential settings), the tendency of many practitioners to interchange "AL" and "RC" masks significant differences between the two in practice.

Since AL is new to Massachusetts, figuring out its key differences from RC requires detailed investigation. Additionally, since AL legislation is in its formative stage, identifying its specific characteristics is chasing a moving target. Despite this, states with mature AL programs that have been fully integrated into their long-term care continuums, as Massachusetts' precedents, are comparative sources to draw upon.

While the many secondary differences exist, I have identified five main areas to distinguish RC from AL: 1) historical precedents, 2) target population, 3) role of the state (regulation), 4) physical design, and 5) service provision.
Chapter V: Key Differences between Residential Care and Assisted Living

1. Historical Precedents

There is no concrete evidence of a definite prototype for the design of contemporary AL facilities. Nonetheless, AL's roots may be unearthed in residential models from northern European housing and systems of long-term care (particularly those in the Netherlands), and within the variety of US Continuing Care Retirement Communities (CCRCs) and US Residential Care Facilities. Europeans models, including the large mansion house and the compact bed and breakfast hotel, offer elderly housing options comparatively smaller than their US counter-parts that have been designed, styled, and constructed as residential rather than institutional environments. Notions borrowed from CCRCs and RCFs demonstrate working to allow persons to remain within the community, and out of skilled nursing care, for as long as possible.

In contrast, the evolution of RCFs (as described in Chapter IV) has been dominated by small "mom and pop" operations as well as large and small charitable non-profit organizations. RC founders highly contrast the corporate world of development (i.e. the Marriot Company) that have adapted historical precedents in their program designs and have avidly searched-out locations to "grow" their retirement housing empires. In fact, interviewees remarked their beliefs that Massachusetts AL policy is being driven by "big money" which is very different than the impetus that has driven the RC industry.

2. Target Population

As opposed to RCFs that offer low-cost housing with supportive services for primarily the poor (although approximately a third of all RCFs accept only middle-class private-pay clients), most AL facilities serve upper-middle class elderly and are therefore usually affordable only to the financially well-endowed. As mentioned above, AL

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developed by entrepreneurs and the corporate world specializing in elderly housing in response to private-pay market demands. This contrasts RCFs administrators who are typically middle-aged women whose aspirations are commonly altruistic as compared to AL developers whose primary motivations are economic gain. By serving upper-income populations, AL revenues permit many amenities (physical and environmental design as well as services) well-beyond beyond the reach of most not-for-profits RCFs without significant endowments. On the contrary, RCFs public-pay "markets" (subsidized by federal and/or state government) respond to state policy making activities (i.e. political priorities, fiscal constraints, to name a few) as their propelling force as to whom to serve and how to run their operations.

3. Role of the State (Regulation)

In comparison to the numerous regulations attached to RCF operations, states' involvement in AL has thus far been minimal. In many respects, AL may be accurately described as a privatized model of elderly housing with services. While all states with formal AL programs require facility licensure, AL is clearly a "hands-off" model in terms of federal and state involvement that is intended to control costs and foster private-market competition. After years of arguing that regulation has excessively driven up costs (RCFs most conform to a significant amount of regulation and to preset reimbursement ceilings unlike other residential care alternatives [congregate housing]), AL facilities in other states have managed "to get out from under the wing of bureaucracy." AL developers and providers claim that reduced regulation has allowed them to streamline developmental and operational requirements, and costs, considerably.

4In an effort to define "Assisted Living," and after reviewing of numerous Assisted Living (AL) entities, researcher Mary Kalymun concludes that one of the most distinguishing factors about AL is that it "... is currently affordable only to those representing the upper middle class," p. 130.
Chapter V: Key Differences between Residential Care and Assisted Living

4. Physical Design

In addition to considerably more common space, the key physical design difference between RCFs and AL facilities is that the former typically offers residents shared bedrooms in a private home-type residence and the latter most often provides single-occupied self-contained units within a variety of floor plans.

As opposed to RCFs burdened by a host of regulatory physical plant requirements, AL policy in other states has been designed to allow providers to design facilities as they choose (primarily as an extension of residents' homes). For example, many AL facilities have small dining areas to limit the number of people at one seating to sustain a more personal atmosphere. Other fundamental requirements AL incorporates include private kitchens (often kitchenettes), private bathrooms, lockable doors, and self-regulated thermostats that reinforce the philosophy that each resident's room is private and in her/his control (see Chapter VI).

5. Service Types

To maintain a residential atmosphere, most AL facilities rely heavily on contracts with community-based providers for resident service needs as opposed to service provision primarily by staff in RCFs. (The amount of in-house staff provision is a function of the predominant level of resident acuity the facility serves.) Provision by contract allows residents to purchase the amount of services they choose as well as offering a longer menu of servicing options. Additionally, provision through contracts allows services to be integrated when needed, rather than within a routinely described format characterized by RCFs.

Other distinctions in servicing demonstrate that while AL touts the concept of aging-in-place, AL facilities often identify cut-off points that require the need for resident relocation (determined by physical and psychological functioning). In comparison, RCFs
have adapted services to declines in functional status. The average length of stay for residents in RCFs ranges from 3 to 5 years as opposed to 2.7 years within AL facilities.

Lastly, another important consideration which has not been discussed in the literature are staffing differences between RC and AL facilities. In her long-term care publication, Continuum, Anne Harrington discusses the experiences of a nursing home sponsor who developed an AL facility. While there are considerable differences between nursing home care and residential care, this sponsor faced many issues that RCFs must consider in conversion. For example, staff had to rethink what AL was on a day-to-day basis and shift from notions of caring for a resident/patient, to assisting persons to care for themselves. Likewise, the role of the nurse was de-emphasized while the role of the aide was enhanced. This facility aptly exhibited that success with AL comes not from only the building, but from "a set of cultural values, beliefs, and expectations ⁵" that are oftentimes contrast current operations.

⁵Continuum, April 1993.
CHAPTER VI

ADDRESSING PHYSICAL PLANT CHANGES
Chapter VI: Addressing Physical Plant Changes

In addition to differences in managerial philosophies, and service provision, required and desirable physical plant changes are key issues to be considered in the conversion of Resident Care Facilities (RCFs) to Assisted Living (AL) facilities. While many inherent changes must be investigated, physical plant changes can vary greatly depending upon location, financing package(s) anticipated, among others.

An overview of physical plant changes is divided into three sections: 1) a review of fundamental physical plant changes, 2) a brief outline of required federal/state/local requirements, and 3) a discussion of integrating qualitative physical and environmental design changes into conversion plans. While fundamental plant, as well as qualitative physical and environmental, changes are universal to AL facilities throughout the US, this chapter focuses on regulatory requirements specific to Massachusetts facilities.

I. FUNDAMENTAL PHYSICAL PLANT CHANGES

While Chapter III reviewed the general physical plant characteristics of AL facilities, this discussion is developed so RCFs considering conversion will more clearly understand changes necessary to attain and maintain a marketable conversion product. Three fundamental changes RCFs must consider are:

a. Reduction in Room Occupancy

Since privacy, independence, and dignity are fundamental aspects of AL, AL facilities almost always provide single-occupied rooms with an average of 350 sqft. per room (a very generous size compared with most RCF rooms). However, RCF physical plant constraints (the general layout of the facility) will likely present major impediments when considering conversion from primarily double- to single-room occupancy. The fact that 40% of all not-for-profit RCF rooms are double-occupancy with two people sharing a
bathroom (only approximately 25% are single-occupancy with private bathroom)\(^1\)
translates into the need for major plant changes that are likely impractical in terms of
rehabilitation costs. One interviewee remarked that given their physical plant constraints,
many RCFs may as well consider "tearing the place down and starting over."

Physical plant constraints aside, significant economies of scale problems (due to
reduced occupancy) may also arise when RCFs consider changing accommodations to one
person per room. Given its management- and service-intensive nature, AL facilities
require a minimum of 20-30 units per development to achieve financial viability.\(^2\)
Therefore, with a median of 27 rooms per facility (mean = 34.4),\(^3\) in the absence of adding
a considerable number of new rooms to the facility (entailing new construction), conver-
sion to single-room occupancy will likely be difficult. Given present financial constraints,
the ability of most RCFs to consider both conversion and new construction to achieve
these economies of scale is poor.

b. Addition of Bathrooms

Private bathrooms are the second key physical design component of AL facilities.
Just as older persons dislike sharing rooms, they equally demand the privacy of their own
bathrooms. Additionally, since over half of all AL residents experience embarrassing
incontinence problems, private bathrooms are not simply amenities.

All new bathrooms must be handicap accessible (per the American with Disabilities
Act) and showers, as opposed to bathtubs, are encouraged because of resident frailty.
Oftentimes the toilet and shower are located in different, yet adjacent, spaces so the sink
may be used for tasks other than personal hygiene (i.e. dish washing).

\(^1\)1992 AMHA Assisted Living Survey
\(^2\)Regnier, Hamilton, and Yatabe, p. 21.
\(^3\)1992 AMHA Assisted Living Survey (includes both not-for-profit and for-profit respondent facilities).
In addition to the recommendation of private bathrooms, RCFs considering conversion to AL that anticipate enrollment in the Department of Public Welfare's Group Adult Foster Care Program (GAFCP) may need to consider the costs of adding bathrooms. A 3/1 ratio of residents/bathroom is required for GAFCP participant facilities.

c. Addition of Kitchens/Kitchenettes

While not as high of a priority as private rooms with private bathrooms, small kitchens (oftentimes kitchenettes) foster resident independence and satisfaction. Despite this, considerable controversy surrounds the issue of kitchens in elderly housing units. Insuring resident safety (i.e. avoiding problems such as a person forgetting to turn off the stove) and determining whether or not kitchen-type facilities are actually used when all meals are prepared for residents, question the importance of their incorporation into units. In fact, after asking RCF residents what is important to them in terms of food preparation, the consensus was "to be able to make a cup of tea" without having to leave their rooms.4

Many AL facilities satisfy residents by offering a mini-kitchenette in each unit which typically consists of a small countertop (3'-4' long) where a microwave and a small refrigerator is be placed, with cabinets underneath for food storage.

II. FEDERAL/STATE/LOCAL REQUIREMENTS

Four regulatory considerations must be examined when considering conversion from RC to AL: 1) building codes, 2) life safety codes, 3) zoning and town licensure requirements, and 4) Architectural Access Board (AAB) requirements for renovations.5

4 Interview with Susan McDonough, April 1, 1993.
5 Facilities considering new construction, in addition to conversion, must examine other requirements such as the Fair Housing Act.
Chapter VI: Addressing Physical Plant Changes

While both federal and state requirements are universal for all Massachusetts RCFs converting to AL, local requirements/codes differ depending on the location of the facility.

Before discussing these five elements, one must recognize how the immaturity of the AL model confuses the interpretation, and compounds the everyday bureaucratic intricacies, of conversion requirements. For example, most building officials have not even heard of AL and exercise caution when presented with new housing model (particularly one that does not legally exist in Massachusetts). One RCF that converted to AL in 1988 spent over two years gaining community approval and meeting all requirement necessary for conversion.

a. Building Codes

Massachusetts building codes currently do not cover AL and therefore any facility considering conversion must consult their local building inspector and fire marshal. When speaking with state and town officials, facilities should seriously investigate loosing existing grandfather clauses upon conversion.

b. Life Safety Codes

The majority of life safety codes as covered within the requirements of the National Fire Prevention Association.

c. Local Zoning Requirements

Confusion in "categorizing" AL facilities within the existing scheme of regulatory ordinances exists. A lack of consistency from one area to another further complicates zoning designation (i.e. is AL a residential or a medical model?, a nursing home or a rest home?). Special use permits (i.e. permits for non-conforming use) and variances may be required.
d. Architectural Access Board (AAB) Requirements for Renovation

The AAB, a state requirement, has different requirements depending upon the cost and scope of the proposed renovation/conversion project. AAB standards fall into three categories:

If the proposed renovation constitutes less than 25% of the assessed value of the property and costs less than $50,000, only the section being renovated must comply with AAB Regulations for Accessibility.

If the proposed renovation constitutes less than 25% of the assessed value of the property and costs more than $50,000, the area renovated must comply and the facility will also be required to create an accessible entrance and toilet facilities.

If the scope of the renovations constitute more than 25% of the assessed value, the entire building must comply with the AAB requirements.

Generally, AAB regulations require: 1) an accessible entrance way, 2) handicap accessible bathrooms, 3) an accessible entrance pathway to the residents rooms, and 4) elevators in multi-story buildings.

Lastly, since regulation for AL facilities is now being developed, RCFs looking to convert to AL should conservatively anticipate additional regulatory requirements besides those summarized above.

III. QUALITATIVE PHYSICAL AND ENVIRONMENTAL DESIGN CHANGES

Winston Churchill once said: "We shape our dwellings and afterwards our dwelling shape us." As competence dwindles, the physical and environmental design of housing plays an increasingly significant role on the quality of older persons' lives. For example, older people spend more time in their housing, experience more difficulty in taking care of it, and have often developed stronger attachments to their environments than younger people. While understanding the relationship between physical and environmental design
and the quality of an older person's life is subject within itself, it is important for RCFs anticipating conversion to consider additional key qualitative issues to integrate within their conversion plans.

Victor Regnier and Jon Pynoos (researchers within the Andrus Center for Gerontology at the University of Southern California) have written extensively on the relationship between the design of elderly housing environments and the quality of older persons' lives. The following summarizes the "environmental-behavior" principles culled from their work that they believe should guide the design, as well as the management, of AL housing:

a. Privacy

AL facilities should provide opportunities for places of seclusion from company or observation where one can be free from unauthorized intrusion. The need for single-occupied rooms is key since the ultimate loss of privacy occurs when a person must share a room with one or more unrelated individuals. Methods to enhance privacy that AL embrace are evidenced in: lockable doors, mobile dividers for shared rooms, and policies requiring staff to knock on unit doors before entry.

b. Social Interaction

AL facilities typically offer a generous amount of shared common space to provide the opportunity for social exchange. Social interaction is important to facilitate problem-solving and emotional development. Additionally, by reducing isolation, increases in life satisfaction may be achieved. Social interaction is enhanced by offering both formal large communal spaces, as well as small areas supporting intermittent and informal contact.
c. Control/Choice/Autonomy

Controlling as many aspects of one's social and physical environment is fundamental for positive adjustment in senior housing. The absence of control, choice and autonomy makes residents feel alienated in "task dependent settings" that are highly restrictive and regimented which ultimately promote dependency. Methods to enhance independence included: ability to control heating in one's room, ability to personalize one's room (furnishing and decorating), and the design of flexible daily "schedules" for residents.

d. Orientation/Wayfinding

Many older persons in AL facilities experience general confusion as well as mild forms of dementia. Fostering a sense of orientation throughout the facility reduces confusion, facilitates "way finding," and allows a person to develop a "cognitive map" of the facility to prevent disorientation.

e. Safety/Security

While AL promotes shared risk between resident and provider, the layout of the facility should ensure an appropriate balance between resident independence and preventing undue harm or injury. Safety/security should also be considered in terms of compensating for sensory (visual, auditory, and olfactory) losses of older people.

f. Accessibility and Functioning

In addition to regulatory requirements mandating accessibility, given the frailty level of older residents, AL facilities should consider manipulation and accessibility throughout the facility as basic requirements for functionality. For example, while many RCFs converting to AL will minimally need to consider ADA compliance, ADA
requirements should be used as a rule of thumb in designing elderly housing since many older people experience problems with impairments and disability.

g. Stimulation and Challenge

While safety/security are genuine concerns, AL residences should provide stimulating environments that are both safe and challenging. Stimulating environments balance the need for wayfinding and challenge by integrating an appropriate variety and complexity of richness in color, texture, and patterns in their designs.

h. Familiarity and Aesthetics/Appearance

As has been reiterated, AL embraces residential models that evoke historical reference and familiarity with past living arrangements. Methods to enhance familiarity and aesthetics are to design the housing as consistent as possible with residential environments by reinforcing "homelike" iconography, an appropriate scale to the housing, and comparable furnishings. Additionally, attention should be given to establishing an interior/exterior connections with nature (i.e. sunrooms, courtyards, landscaping).

i. Adaptability

For a setting to meet the dynamic capabilities of frail older persons, its must either include supportive features (i.e. ramps, grab bars, handrails) or have the ability to be retrofitted (particularly for handicap accessibility).

In summary, Massachusetts RCFs converting to AL must attempt to answer the complex question: How can the design of our converted facility conserve resident energy, reduce frustration, and encourage social contact to help keep residents mentally active, physically fit, and socially filled for as long as possible?
CHAPTER VII

FEASIBILITY STUDY OF CONVERSION
Chapter VII: Feasibility Study of Conversion

This chapter presents a case study method which investigates the feasibility of converting Resident Care Facilities (RCFs) into Assisted Living (AL) facilities. Findings and conclusions from the case are then applied to the set of Massachusetts RCFs to suggest the barriers to, and the opportunities for, conversion (see Chapter VIII).

This chapter is divided into three principle sections: 1) a review of traditional feasibility analysis as well as how its methodologies were adapted for RCFs considering conversion to AL, and 2) an overview of the case study, and 3) the case feasibility study.

I. A BRIEF DESCRIPTION OF FEASIBILITY ANALYSIS

A feasibility study is important as an independent evaluation of a proposed project by both confirming the need for the project and determining its financial feasibility based on the need. Additionally, by assessing the financial risk of the project, a feasibility study is an intrinsic part of the documentation necessary for project financing.

Two main components comprise feasibility analysis: 1) a market study forecasting and defining the nature of the demand for the proposed project, and 2) a financial feasibility study forecasting whether or not sufficient cash flow will be available to support the additional cost (often the debt) of the proposed project.¹

A. MARKET STUDY

Traditional market analysis strives to accomplish three objectives, to: 1) develop a conceptual model of the proposed program (clearly defining the "commodity"), 2) quantify the number of potential clients (residents) needing its services and are income-qualified to participate in the program (possess the "ability to pay"), and 3) determine consumer

¹Methodologies utilized in feasibility analysis for retirement housing projects are derived from a combination of traditional health care and real estate industries. Since freestanding facilities providing personal care (i.e. AL) are still in their infancy, feasibility studies specifically for this market are in their formative stages.
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willingness to pay for the benefits the program offers (the "desire" combined with the "ability to pay").

1. Developing a Conceptual Model

Developing a conceptual model of a project begins by identifying the targeted market to be served and investigating the needs and desires of this market. A clear understanding of both the wants and needs of current and future residents is necessary. Another imperative is to predict the costs of the program to be incurred by potential residents. To answer "How many people in need have the ability to pay for this project?" a sponsor (RCF management) must first develop a reasonable projection of the cost to utilize in the project. Cost projections should then assist the sponsor in focusing program costs in order to target the appropriate market.

2. Documenting Need and Estimating Demand

The number of potential residents in the local market who may need the program's services and can afford its costs is often documented utilizing secondary market research methods. Databases utilizing annual elderly household income data within a defined area are used to determine the number of income-qualified elderly in the market. This analysis also estimates the number of persons who may wish to occupy the project.

3. Investigating the Market's Willingness to Purchase the Product

After the conceptual model is clear and assuming secondary research supports the need for the project, the final step is to conduct primary research with potential residents, other purchase decision makers (elders' children), and marketing intermediaries (i.e. local elder care service providers). Primary research often includes interviews with key people in the local elder services network, telephone calls, focus groups, as well as mail surveys.

2The Bristol Group, p. 1.
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to potential residents. This primary research confirms (or refutes) the actual demand for the proposed project by measuring the market's willingness to purchase the product.

B. FINANCIAL FEASIBILITY STUDY

In addition to the guidance and recommendations of the market study, conclusions from forecasting the financial future of the proposed project (proforma analysis) are used to ultimately decide whether or not to proceed with a project. The key question a financial feasibility study attempts to answer is: Given the anticipated costs charged for service, will there be sufficient cash available to finance operating needs and debt service for the project? In the case of proprietary sponsors, the financial forecast indicates whether or not adequate return on investment will be achieved. In answering this question, the study tests the management's project analysis, the reasonableness in its projected utilization and financial assumptions, the sensitivity of variables (line items), and makes recommendations for changes when necessary.

Funding Sources

Understanding the financial forces that detrimentally affect long-term care sponsors/providers' access to capital is important to potential "converters." First, significant negative publicity about high failure rates of Continuing Care Retirement Communities (CCRCs) during the 1970s and 1980s continues to affect the entire senior housing market. Additional senior housing market financial failures include: over-building; overestimating the values of property, location or need; over-borrowing; depleting financial reserves; poor marketing; and financial and operational mismanagement. For many years, senior housing developers appeared to have been driven by what the market indicated older persons wanted as opposed to what they needed. In response, the results of these market "mismatches" have made most lenders/underwriters cautious when considering capital financing to long-term care sponsors/providers.
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Second, trouble throughout the real estate industry and banking problems nationwide have precipitated the tightening of lending criteria among all financial agencies. It is considerably more difficult to obtain a loan/mortgage today than ten years ago during the real estate boom and before Savings and Loan scandals.

Third, assisted living is an immature industry and the lack of a time-proven model makes lenders/underwriters cautious. A general lack of understanding of the assisted living product is a considerable impediment to accessing debt and equity markets. Until Massachusetts' AL legislation is "ironed out" (clearing up ambiguities in legal definitions and regulatory requirements), involvement by lenders will be skeptical.

Despite apprehension among financial markets, four primary potential funding sources to finance AL development/conversion may be available: 1) Massachusetts Housing Finance Agency, 2) Massachusetts Industrial Finance Agency, 3) the Department of Housing and Urban Developments (HUD), and 4) traditional local commercial lenders. (Note: The below descriptions are a summary of each source. Since lenders/underwriters evaluate proposals on case-by-case bases, a potential sponsor/provider should not immediately rule out any source. Additionally future lending criteria may be relaxed depending upon market demands.)

Massachusetts Housing Finance Agency

Massachusetts Housing Finance Agency (MHFA) is a state bank with a reputable history of financing elderly housing with services. In conjunction with the Executive Office of Communities and Development (EOCD), at the close of 1992, MHFA announced it first publicly-assisted program to provide debt financing to housing with supportive services for elderly providers; Elder Choice (see Appendix B). Although many applications have been filed, one project in Newton (sponsored by A/D/S Senior Housing and National Development Corporation) has secured Elder Choice financing.
While MHFA has expressed interest in financing marketable RCF to AL conversion projects, Elder Choice currently requires that AL units contain private kitchens and bathrooms. Other program requirements suggest that MHFA has designed Elder Choice to finance highly marketable new, mixed-income models (requiring minimum 20% set-aside of units for low-income persons) so that upper-income revenues cross subsidize low-income revenues.

**Massachusetts Industrial Finance Agency**

Massachusetts Industrial Finance Agency (MIFA) is an independent public agency created to issue bonds, insure loans, and make direct loans to attract private investment in the state. MIFA issues tax-exempt and taxable financing to not-for-profit and proprietary long-term care providers seeking capital for real estate acquisition, new construction, renovations, equipment purchases, and debt refinancing. By maintaining strong relationships with underwriters, feasibility consultants, and lawyers, MIFA has made available capital previously inaccessible to long-term care sponsors.

Yet given the costs associated with a bond issue, MIFA recommends a project size of at least $2 million. This eligibility requirement likely rules out RCFs looking to convert to AL. While long-term care facilities have pooled individual capital needs to obtain MIFA funding, at this time, applicability to RCF conversion is inconclusive at best.

**HUD's Section 232 Mortgage Insurance**

Originally designed for nursing homes and intermediate care facilities, in 1985 this long-term mortgage loan program\(^3\) was expanded to cover rest home-like facilities (including RCFs and now, AL). Insured mortgages can cover new construction or substantial rehabilitation for not-for-profit and proprietary mortgagors.

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\(^3\)Insured mortgages have a premium rate of 0.5%, a maximum 40-year term, and a 90% loan-to-value ratio.
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Programmatic requirements of Section 232 make RCFs who remain RCFs good candidates for 232 funding. However, program guidelines mandate that AL facilities be licensed and regulated by the state (or subject to municipal or other jurisdictional requirements) and provide single room occupancy with kitchens and bathrooms.4

Local Commercial Lenders

Commercial lenders are required to serve their communities by writing a given number of loans to entities serving low-income populations within their lending area. Despite this, lenders do attach near-prime lending to criteria (assessing regulation of the sponsor, financial depth, management experience, type of development, ability to support debt, among others) that may, or may not, shed a favorable light of the evaluation of a RCF's proforma. However, if a facility has the ability to use its savings or investments (potentially its property and plant) as collateral, a commercial lender may consider financing the conversion.

II. OVERVIEW CASE STUDY

Before discussing the characteristics of the case study, understanding why the German Home was chosen, and its key differences from others RCF providers, is necessary.

Along the continuum of Massachusetts RCFs (from facilities with relatively optimistic futures to those on the brink of closure [see Chapter IX]), the German Home maintains a higher percentage of public-pay residents (87%) than the most making the facility highly dependent on the public reimbursement system. If one were to conceptualize a range of RCFs scaled from one to ten in terms of obstacles confronting

4The Housing and Community Development Act of 1992 (HR 5334) added "assisted living facilities for the frail elderly" to the list of projects HUD can fund in its 232 program.
conversion (one representing the best, ten the worst, position) the Home may be appropriately categorized between an eight or a nine. While the majority of facilities serve mix of resident incomes, roughly a third of all Massachusetts RCFs serve primarily moderate-income, private-pay persons. Additionally, while participating in somewhat of a "protected" market (the only RCF in the area for the poor), even if the Home wanted to serve a more balanced public/private-payer mix (contrary to its mission), given its location, it would experience great difficulty in competing with other facilities for private-pay residents.

Despite these key differences, the Home is highly sensitive to public policy and therefore qualified as a good candidate to test the feasibility of conversion. While many RCFs are keenly interested in converting to AL, the Home maintains a vital stake in its ability to convert. In many respects, conversion to AL is one of the few possible alternatives for the Home to continue its present operations over a long-term horizon.

1. Facility:

The German Old Folks Home, Inc. ("The German Home")
30-bed Not-for-Profit Massachusetts Resident Care Facility (Licensed Level IV)

2. Location:

374 Howard Street
Lawrence, Massachusetts

One of Massachusetts' oldest cities (current population = 70,200), Lawrence is located approximately thirty miles north of Boston. Once a historic mill town, Lawrence is now well-known for its high crime rates, drug gangs, and preponderance of disinvestment throughout the city. A 1991 The Boston Globe article described the increasing number of vacant and vandalized buildings (250 abandoned buildings) throughout the city. Many residents believe Lawrence is "so old, so mired in chronic
destitution" that little hope is left. In 1992, Lawrence was victimized by seventy arsons which has been interpreted as an indication of the disorder and disenfranchisement among the latest wave of immigrants to the city (Hispanics represent over 41% of the city's population). Today, the average value of a house in Lawrence is $127,700.5

The German Home is fortunate to be located in a "better area" of the city (on "The Hill"). Despite this somewhat favorable location, within the past twenty years, the suburban neighborhood surrounding the Home has transformed from homogeneous middle-income community to an ethnically diverse, predominantly low-income population. Its administrator, Valerie Emerson, aptly described the poverty by explaining: "Instead of sending old furniture to the dump, we leave it out front. By morning its usually gone."

While the Home has been relatively free of vandalism, the shift in the demographic characteristics of the surrounding area has seriously affected the marketability of the facility. Undoubtedly, the location of the Home is its nemesis.

3. Historical Perspective

Since nearly all documents dating up to the late 1940s were written in German (none translated), besides word-of-mouth, very little information about the Home's history is available. Established in 1902 by the German Ruth Society, the Home was founded as "a day nursing for the children of parents obliged to work away from the home during the day." In a 1909, the above quote was amended to include "... also a home for aged persons and to furnish other necessary aid to such persons as may be in need." Whether the Home's mission was later revised to serve poor older German immigrants is uncertain.

While the Home has no mission statement, Valerie explains its mission as: "to stay alive and to care for the needy until the very end [of residents lives]." The only component of the mission she believes has changed over time is an emphasis to allow residents

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to age-in-place for as long as possible. This effort has been made in response to residents' wishes as well as adjusting to changes in nursing home admission criteria that has made transfers from the facility increasingly difficult.

When Valerie assumed the position of administrator in 1982, there was much room improvement in the facility's operation. Its reimbursement rate (publicly subsidized by SSI and Emergency Aid to the Elderly and Dependent Children [in the past, General Relief] programs) was low ($16/day) and residents were not receiving many needed services. Valerie exclaimed: "The place was like a morgue; the employees were like robots and the residents seemed dead!" Additionally, its Board of Directors was weak; all members were over the ages of seventy possessing little leadership or incentive for action. When I asked Valerie why she took on a such white elephant she responded: "I wanted to make a difference in people's lives."

Like most RCF administrators, Valerie does not have a business background and has made clear her distaste for bookkeeping and accounting. Years ago she told her accountant she had no intention of learning all the "financials" of the facility. He told her she may as well quit the business. Perturbed at first, she understood the truth of his wisdom and is now paying more attention to the finances of the Home. In 1990, the Home began computerizing its finances (some RCFs are still operating manually). Valerie explained: "We're in a state of transition from a 'mom and pop' facility to a 'professionalized' one."

Like many other RCFs serving the poor, the German Home has been coping with inadequate reimbursement rates, and increasing service needs among residents, by withdrawing from its financial reserves. In 1992, for the first time in many years, the facility lost money ($12,000 out of a $438,000 budget). Low average occupancy rates (discussed later) precipitated $24,000 in foregone patient revenues. Valerie has convinced her Board that this way of coping cannot continue for much longer.
4. Physical Plant:

The German Home is a massive three-story wood-frame house (approx. 4,730 sqft.) built at the turn of the century. While somewhat "run down," both its interior and exterior display remnants of a German mansion house that has remarkably maintained its residential appearance. Two stories are currently occupied by residents, and the third story (the attic), has the ability to be used for residential purposes. The cellar is used for recreational activities, office space, laundry, and storage.

The Home's maximum occupancy is thirty persons. It maintains eighteen small private rooms (average size = 100 sqft.) and six double occupancy rooms (approx. 210 sqft. with sinks). On the first floor there is a comfortable living room beside a new sunroom, a generous kitchen and dining room, a nursing station/office, and the administrator's office. The facility has five bathrooms (seven toilets, eight sinks, three shower stalls, and two bathtubs). (See floor plans on pp. 71-72.)

5. Management

Like most RCFs, the German Home is managed almost entirely single-handedly by its facility administrator. Like Valerie, most administrators are now middle-aged women who entered the field with an altruistic concern to care for elders. Valerie is ambitious and thrives on the challenge to improve the lives of her residents by improving the Home. As a result, the Home has earned a reputation of servicing its residents well. Valerie is well-known in the field and keeps on top of industry changes through her active membership in the Association of Massachusetts Homes for the Aging (she is Chair of the Residential Care Committee).

The Home's Board of Directors mirrors those of most RCFs. Given the past informal nature of most RCF boards, meetings are slowly "transitioning" from social gathering for the "ladies" of the community, to ones where "business" concerns of the
facilities are addressed. Many of these ladies (and often their husbands) provided many
years of service to the Home and as Valerie says: "they were well-meaning people doing
the best they knew how to do." For example, board members would routinely attend to
the Home (i.e. fill in for dishwashers and maintenance persons) to help keep operating
costs down. Little did they know that within their best intentions, rates were also kept
down actually hurting operation the Home. Other traditions die hard. For example, the
Board continues to insist that private-pay residents pay nearly the same rate as public-pay
residents (the private-pay is $5 more per day). While these equitable intentions are
laudable, they certainly do not help the facility's troubled finances.

Over half of the Home's eighteen board members are approaching or in their
retirement years and have been on the board, as Valerie says: "forever!". While many
older members are invaluable assets to boards, several interviewees joked that most RCF
boards members "are as old as their residents!" As result, great inertia resists change.
However, many boards are working to "professionalize" themselves and becoming more
diverse by adding younger and professional people from the community.

Through her leadership, Valerie's board is now opened-minded to learn about
changes in the residential care industry and it is prepared to seriously consider changes.

6. Staffing:

Following Valerie's leadership, the German Home's staff is a group of individuals
dedicated to the Home's mission. Among my many day-long visits in the Home, a sense
of pride and endurance to "conquer all obstacles" emanated. Valerie makes a conscience
attempt to hire staff from within the surrounding community which presents many
challenges to the facility. She explained that staff learn to accommodate each other:
"Almost everyone here has some problem." Valerie's only ground rule is : "...they [the
staff] treat the residents well." While Valerie's sympathetic nature holds the facility
together (turnover is very low), she admits her tolerance is not always in the best interests
of the facility. While she recognizes that staffing should be cut, she remarked: "How can I let go of people who have been here for longer than I?"

Below is a complete list of the staff at the Home. Adjusting for scale, the staffing at the Home is similar to other RCFs. (Note: FT= full-time position, PT= part-time position):

<table>
<thead>
<tr>
<th>Position</th>
<th>Status</th>
<th>Hours/Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrator</td>
<td>FT</td>
<td></td>
</tr>
<tr>
<td>Consultant Registered Nurse</td>
<td></td>
<td>16 hrs/wk</td>
</tr>
<tr>
<td>Licensed Practical Nurse</td>
<td></td>
<td>32 hrs/wk</td>
</tr>
<tr>
<td>Resident Care Coordinators (4)</td>
<td>PT</td>
<td></td>
</tr>
<tr>
<td>Personal Care Attendants (4)</td>
<td>PT</td>
<td></td>
</tr>
<tr>
<td>Social Worker</td>
<td></td>
<td>18 hrs/wk</td>
</tr>
<tr>
<td>Laundry</td>
<td></td>
<td>30 hrs/wk</td>
</tr>
<tr>
<td>Housekeeper</td>
<td></td>
<td>25 hrs/wk</td>
</tr>
<tr>
<td>Head Cook</td>
<td>FT</td>
<td></td>
</tr>
<tr>
<td>2nd Cook</td>
<td>PT</td>
<td></td>
</tr>
<tr>
<td>Kitchen Aides (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintenance</td>
<td></td>
<td>30 hrs/wk</td>
</tr>
<tr>
<td>Activities Director</td>
<td></td>
<td>30 hrs/wk</td>
</tr>
<tr>
<td>Office personnel</td>
<td></td>
<td>1 FT &amp; 1 PT</td>
</tr>
</tbody>
</table>

7. Residents

As of February 1992, the Home had twenty-four women and six men in residence. Valerie explained a "resident profile" would be impossible given the great diversity of needs among its population. The average age of residents (of those admitted since 1983) is 75.3 years and the average length of stay has been 6.7 years. Additionally, the Home maintains a high percentage of residents with mentally-ill diagnoses (just under 50%) contrasted with the general RCF profile (around 25%). Given its high mentally-ill census demanding more services (particularly the management of medications), the facility utilizes more health specialists and psychologists than most RCFs.

Since the Home does not receive additional reimbursement for mentally-ill persons, I asked Valerie why she accepts so many. Her response: "Where else would they go? No one else will take them." As a result, the facility has earned a reputation (particularly
Chapter VII: Feasibility Study of Conversion

among its largest source of referral, Elder Services of Merrimack Valley) as "the last stop" for persons no other facility will take in.

8. Services

In general, Massachusetts long-term care regulations dictate services to be provided within its licensed RCFs. With the exception of different services provided through contract with outside agencies, adjusting for size, services within the Home are representative of most RCFs. In addition to three meals per day (plus snack) provided seven days per week, the following services are provided/available:

<table>
<thead>
<tr>
<th>Provided by Staff</th>
<th>Provided through Contract</th>
</tr>
</thead>
<tbody>
<tr>
<td>24-Hour Staffing</td>
<td>Supervision of Self-Administered Medications</td>
</tr>
<tr>
<td>Emergency Response System</td>
<td>Transportation (extra charge)</td>
</tr>
<tr>
<td>Monitoring of Self-Administered Medications</td>
<td>Physical Therapy (extra charge)</td>
</tr>
<tr>
<td>Supervision of Self-Administered Medications</td>
<td>Occupational Therapy (extra charge)</td>
</tr>
<tr>
<td>Administration of Medications Per Physician's Order</td>
<td>Hospice Care (extra charge)</td>
</tr>
<tr>
<td>Assistance with ADLs on a Constant/As Needed Basis (bathing, dressing, toileting, eating, and ambulating)</td>
<td></td>
</tr>
<tr>
<td>Assistance with ADLs on an Occasional/Designated Basis (bathing, dressing, toileting, transferring, eating, ambulating)</td>
<td></td>
</tr>
<tr>
<td>Housekeeping Services</td>
<td></td>
</tr>
<tr>
<td>Laundry</td>
<td></td>
</tr>
<tr>
<td>Shopping</td>
<td></td>
</tr>
<tr>
<td>Organized Leisure Time</td>
<td></td>
</tr>
<tr>
<td>Respite Care</td>
<td></td>
</tr>
<tr>
<td>Resident Council</td>
<td></td>
</tr>
<tr>
<td>Family Council</td>
<td></td>
</tr>
</tbody>
</table>

As mentioned previously, despite inadequate reimbursement, the Home continues to pride itself of servicing its residents well.
Chapter VII: Feasibility Study of Conversion

Legend

Sh. = Shower
Cl. = Closet

FIRST FLOOR PLAN

Scale: 0 - 8' - 16' - 24'

The German Home
Chapter VII: Feasibility Study of Conversion

SECOND FLOOR PLAN

The German Home
III. FEASIBILITY STUDY

A. MARKET ANALYSIS

Given the economic status of the residents the German Home serves (the majority are low-income elders dependent upon public subsidies [average annual income = $4,680]), this market study must be modified from the traditional methodology. Since traditional market analysis is based on free-market economic concepts of supply and demand, its methodology does not readily translate to non-market governmental systems. Unlike the proprietary RCF market where elder consumer choice more closely mirrors supply, state policy makers control the supply of not-for-profit RCF beds through regulation and annual appropriations.

Henceforth, given the current and projected demographic characteristics of population of Lawrence, an infinite demand for the Home's services will likely persist. While the Home continues present operations and no monumental economic changes take place in Lawrence, the facility will likely always have poor older people "knocking on its doors," and issues of market saturation can be safely ignored.

Unlike the Home that maintains an average of only four private-pay residents in residence, as mentioned previously, most Massachusetts RCFs have a higher census of private-pay residents. Any RCF considering conversion that receives (or plans to receive) a significant percentage of its revenues from private-pay clients must undertake a "traditional" market study to determine both consumer need and want for the converted facility. Without a comprehensive market study, a facility may ignorantly move ahead with an unneeded project and thereby place the organization at risk of financial failure.

Four main components of market analysis are investigated in this case: a) an outline of the proposed project, b) the definition of the primary market area, c) a brief analysis of demographic and socio-economic projections, and d) an assessment of competition and its utilization patterns.
a. Proposed Conversion Project

Four main components, to be completed in two phases, comprise the German Home's conversion to AL plan. First, serious occupancy problems in 1992, precipitated by inadequate handicap accessibility into and throughout the facility, require the addition of a small elevator (2' x 5') to extend up to the third floor (for potential future residential use) and a handicap-accessible ramp at the entrance. While the Home anticipates paying-off the debt of the first phase before moving onto the second, adding an elevator and ramp are integral elements of its overall conversion plan.

The majority of second phase of the plan will include the addition of five handicap-accessible bathrooms. Five bathrooms must be added for the Home to qualify for the public subsidy service program; the Dept. of Public Welfare's Group Adult Foster Care Program (GAFCP). In addition to other eligibility requirements that the Home likely fulfills, the GAFCP mandates a maximum of 3 residents/bathroom.6 Lastly, the Home is in need of a "face lift" and intends to paint and wallpaper the facility.

As mentioned in Chapters III and IV, many other components (i.e. kitchenettes and private bathrooms) comprise contemporary AL facilities. Besides being out of the financial reach of the Home, physical plant constraints make impossible the addition of kitchenettes and private bathrooms.

Development costs of the conversion project are outlined within the financial feasibility study on pp. 79-80.

b. Definition of Primary Market Area

The circle drawn on the following page indicates the area within the German Home's primary market area. While the circle drawn on the map only encompasses a 2.5

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6There is no one definition of "bathroom" in the GAFCP. Bathrooms are evaluated on a case-by-case basis.
mile radius from the facility, for all intents and purposes, the larger market area extends up to five miles from the facility.

The Primary Market Area Surrounding the German Home
(Length of radius = 2.5 miles)
Chapter VII: Feasibility Study of Conversion

c. Demographic and Socioeconomic Projections

Demographic and socioeconomic projections are used to quantify the number of potential residents with the need and ability to afford the residing in the converted facility. While this data may not be as important to facilities planning to serve elders unable to purchase services "out-of-pocket," whether there will be enough "poor" elders in the Home's market area to keep its occupancy rate high is important.

For the purposes of this exercise, I have relied upon 1990 Bureau of the Census data to roughly projected the demand for the Home's "product." As mentioned earlier, in absence of large demographic changes, a steady increase in the number elderly persons (from oldest to youngest age group) living in Lawrence will continue (those 80-84 years comprised 1.6% of the population, those 75-79 comprised 2.7%, those 70-74 comprised 3.2%, and those 65-60 comprised 3.6%). Based on 1989 income data of those 65+ years living below the poverty level (1,268 persons comprising 15% of those 65+ years) indicate that there will likely be a significant demand for the Home's for housing and services. Therefore, if only 2% of those 65+ years living in Lawrence were to reside at the Home (few other alternatives exist), the Home would likely have few problems keeping the facility fully occupied.

d. Assessment of Competition

Identifying comparable facilities7, including proposed projects, within immediate and adjacent market areas is the primary means to assess the German Home's competition. Despite differences in the clients its competitors serve (primarily individuals with higher incomes), the Home is part of complex market dynamics. For example, if one of its competitors were to close, the prospect of the Home obtaining their current, as well as

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7Comparable facilities include not only other RCFs, but also programs such as freestanding AL residences, congregate housing, CCRCs, adult day care programs, among others.
future, clients may change. Understanding its competition is particularly important for the Home to attract private-pay residents.

In addition to distinguishing characteristics, an assessment of competition includes examining competitors' 1) location, 2) the type/size of its facility, 3) its occupancy rate, and 4) the types of accommodations and fees available. The following three RCFs (the only comparable facilities) are within the Home's market area.\(^8\)

### Facility #1:
- **Name:** Berkeley Retirement Home
- **Status:** Private Not-for-Profit Resident Care Facility
- **Location:** 175 Berkeley Street; Lawrence, MA (approx. 1-2 miles from the German Home)
- **Units:** 20 Level IV beds
- **Accommodations:**
  - 17 Level III beds (in construction)
  - 10 private rooms with private baths
  - 14 private rooms with more than 2 persons/bath
- **Occupancy:** 100% (waiting lists)
- **Pblc Subsidies:** No
- **Fees:** $60-$75/day
- **Comments:** Attractive location. Institutional exterior appearance. Very attractive interior.

### Facility #2
- **Name:** Halcyon House
- **Status:** Private For-Profit Resident Care Facility
- **Location:** 175 Berkeley Street Methuen, MA (approx. 1-2 miles from German Home)
- **Units:** 20 Level IV beds (all women)
- **Accommodations:**
  - 1 private room with private bath
  - 5 private rooms with more than 2 persons/bath
  - 7 semi-private rooms with more than 2 persons/bath
- **Occupancy:** High 90s to 100%
- **Pblc. Subsidies:** No
- **Fees:** $60-$70/day
- **Comments:** Attractive location. Old house. Husband/wife owner/operator.

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\(^8\)Sources for comparable facility data come from the 1992 AMHA Assisted Living Survey, the Guide to Nursing and Rest Homes in Massachusetts 1992/93, and interviews.
Chapter VII: Feasibility Study of Conversion

**Facility #3**
Name: Sutton Hill Nursing & Retirement Center  
Status: Private For-Profit Multi-Level Facility  
Location: 1801 Turnpike St., North Andover, MA  
(approx. 15 miles from the German Home)  
Units: Level II, Level IV  
Accommodations: na  
Occupancy: Not available (likely 100%)  
Pblc. Subsidies: Accepts Medicaid  
Fees: $90-$190/day  

Note: For the purposes of this review, services among these three facilities, as well as in the German Home, are generally comparable.

**B. FINANCIAL FEASIBILITY ANALYSIS**

At this point, based on the above informal market analysis (which, for this exercise, I will assume confirms the need for the conversion project), the Home is unsure whether or not to go ahead with conversion because it unaware of how well it can afford, or if it can afford, the increased expenditures (debt service) necessary to convert. A financial forecast will help answer this question. However, the Home's future as a RCF is also questionable. For example, after reviewing the financial forecast (assuming conversion), assume the Board decides the risk to convert is too great. Alone, this conversion forecast offers little information unless it is compared with a forecast of future operations with no change. While alternative options may be available to the facility (see Chapter IX), it is necessary to construct two models of the Home's financial future, if it: 1) remains an RCF, or 2) converts to AL. With both forecasts, the Home is in a more informed position to make a decision.

The three key components of a financial forecast are: a) capital/development costs, b) a forecast of utilization, and c) forecasted financial statements.
a. Development Costs

Resident Care Facility (continue operation as is):

The development costs the Home anticipates, whether or not it decides to convert, are the summarized by the addition of a ramp and an elevator, and finish work. The following is the total estimated cost of this work (including labor, when applicable):

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elevator</td>
<td>$18,595</td>
</tr>
<tr>
<td>Handicap-accessible ramp</td>
<td></td>
</tr>
<tr>
<td>Finish work</td>
<td></td>
</tr>
<tr>
<td>(painting &amp; wallpapering)</td>
<td>5,000</td>
</tr>
<tr>
<td>Total</td>
<td>$30,595</td>
</tr>
</tbody>
</table>

Financing (Assuming $32,000 loan 9% interest rate, 5-yr term)

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financing</td>
<td>$32,125</td>
</tr>
<tr>
<td>Total</td>
<td>$38,350</td>
</tr>
</tbody>
</table>

Assisted Living:

In addition to the capital improvement costs in continuing operation as a RCF, for the Home, conversion to AL primarily means the addition of five bathrooms. Conversion development costs for this scenario are the following:

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elevator</td>
<td></td>
</tr>
<tr>
<td>Handicap-accessible ramp</td>
<td></td>
</tr>
<tr>
<td>Finish work</td>
<td></td>
</tr>
<tr>
<td>(painting &amp; wallpapering)</td>
<td>5,000</td>
</tr>
<tr>
<td>5 handicap-accessible bathrooms</td>
<td>@ $30,000/bathroom</td>
</tr>
<tr>
<td>Total</td>
<td>= $180,595</td>
</tr>
</tbody>
</table>
b. Forecast of Utilization

A forecast of utilization essentially predicts the occupancy rates the facility will be able to maintain.

Resident Care Facility:

The Home recognizes that occupancy problems must be addressed even if it remains a RCF. Future tenants will undoubtedly be frailer and require handicap-like accessibility (although its regulations do not permit non-ambulatory persons to reside in RCFs) throughout the facility. Valerie is certain that if a more accessible means were made available to second floor units, she could keep the facility's beds filled and maintain near 100% occupancy.

Assisted Living:

Converting to AL (in this case, adding the costs of additional bathrooms) will improve the marketability of the facility. Assuming the Home adds the ramp and elevator regardless of conversion, and undertaking finish work, whether or not additional bathrooms would attract more private-pay residents to the Home is questionable. Therefore, it is accurate to assume that the Home will also be able to maintain nearly the same occupancy as an AL facility as a RCF.
c. Forecasted Financial Statements

Forecasting the financial future of the German Home (both as a RCF and as an AL facility) would normally include: 1) a summary of assumptions made before forecasting, 2) statements of revenue and expenses (also known as "income statements"), 3) statements of cash flow, and 4) balance sheets. For the purposes of this investigation, in addition to outlining the assumptions I made prior to analysis, I have only forecasted statements of revenue and expenses to ascertain the financial viability of conversion. Please note that both forecasts are rudimentary projections of the facility's financial future. Given the future uncertainty of many line item variables, as well as the depth of my financial analysis in the case and my understanding of the facility's operations, these forecasts should be viewed as a limited picture of the potential financial future of the facility.

Additionally, while balance sheets and statements of cash flow are essential to the financial livelihood of any operation (particularly not-for-profits whom regularly maintain low cash balances), too many indeterminate independent variables exist to accurately predict the fund balance and cash flow at the end of year. (I have included the Home's Balance Sheets from 1989-1992 in Appendix C for illustrative purposes.) Moreover, forecasting statements of revenue and expenses over a ten-year period allows one to fairly accurately compare yearly revenue with expenses which ultimately determines the livelihood of an operation.

Resident Care Facility:

Forecasting the financial future of the Home, assuming continued operation as a RCF, is necessary for two reasons. First and foremost, it offers a picture of the future financial operations of the facility to compare with the option of converting to AL, and second, it assists in predicting the Home's future as a RCF. As mentioned above, without an understanding of its future operations as a RCF, the Home would be in a less informed position to judge the attractiveness of conversion.
In forecasting this financial future of the Home (see spreadsheet in Appendix C [pp. 125-126], assumptions were made concerning each line item. While the majority of assumptions are listed in the far right columns of the spreadsheet (p. 126), a set of general comments about the forecast is necessary. First, in estimating "net patient service revenue" (the most sensitive variable in the Statement), I have assumed the Home will be able to regain its high occupancies (around 98%) and that the majority of its revenues will be from public-pay clients. Up until FY1992, the Home experienced an approximate 5-6% increase per year in net patient revenues; to be conservative, the increase was estimated at 5%/year. Second, since I could not accurately estimate investment income, basic on figures from previous years, I conservatively choose $10,000/year. Third, in estimating operating expenses (except depreciation), estimates of cost increases per year from the Home's administrator were used (which oftentimes are conservative compared with historic costs). Forth, in estimating the debt financing necessary to convert, I spoke with a local commercial lending officer about the terms the Home would be lent money to finance the project. Fifth, it is important to note that I have assumed both the principle and the interest earned on the Home's investments will rarely be drawn upon.

As suspected from the outset, the Home future as a RCF looks grim; specifically because of the considerable deficits within the initial forecasted years. Simple financial analysis indicates that net patient service revenue is insufficient to cover costs. Substantially remedying this problem likely would translate into either an increase reimbursement rate or an increase in the percentage of private-pay revenues (both highly unlikely occurrences). The reason deficits decrease each year (surpluses after 1996) is essentially because the rate of increases in operating costs per year are less than rate in which net patient service revenue increases. In addition to the questionable nature of accurately predicting beyond a few years (even with more accurate figures), whether the Home would be able to maintain its operating costs between 3-5% is uncertain.
Chapter VII: Feasibility Study of Conversion

Assisted Living:

Forecasting the financial future of the Home as an AL facility requires an understanding of what changes financial changes will take place after conversion. In addition to the assumptions made in the RCF forecast which are carried through to this forecast, for the purposes of this exercise, changes in "net patient service revenue" (reflecting changes in reimbursement rate), and differences in debt service to finance conversion are the basic fiscal changes the Home anticipates.

First, the key reason why so much excitement has surrounded conversion to AL is the promise of increases in reimbursement rates. Currently (FY1992), the Home receives a reimbursement rate of $41.80/day/resident. After conversion, and upon de-licensing its beds, the Home can anticipate a reimbursement rate of approximately $51/day/resident (comprised of SSI and GAFCP subsidies). It is important to note that at this time, the availability of SSI for AL facilities is in doubt. However, while after conversion the Home can expect a 20% increase in reimbursement (FY1994), its rate increase thereafter will likely be the same if were operating as an RCF (utilizing the cost-adjustment factor set by the Rate Setting Commission.). While increases will likely reach 3%/year, I conservatively estimated a 2% increase/year.

Second, debt financing costs in converting to AL are significant when compared with capital necessary to finance the addition of only an elevator and a ramp (and finish work) in the RCF forecast. Ignoring interest on the declining balance, the Home will be paying approximately $27,400/year to finance conversion (assuming a loan with a conventional lender). This payment amount aptly illustrates the need for alternative financing options that would hopefully offer an extended amortization period and reduced interest rate.

A review of the spreadsheet (see Appendix C [pp. 127-128]) illustrates the results of the conversion to AL forecast. Assuming the conversion rate is instituted in the year of
conversion (1994) (therefore dismissing current prospective reimbursement methodology), the few first years after conversion looks fairly optimistic. However, the 20% increase, in addition to the 2% increase per year (conservative) is not enough to sustain operations for very long. After 1996, the Home's yearly deficit is expected to increase steadily.
CHAPTER VIII

MISMATCHES BETWEEN POLICY DESIGN AND IMPLEMENTATION
Chapter VIII: Mismatches between Conversion Policy Design and Implementation

The primary intent of this thesis has been to determine if a quality conversion to Assisted Living (AL) is attractive and feasible for Resident Care Facilities (RCFs) that primarily serve low-income persons. While confident in defining "feasible" as the ability to obtain capital necessary to convert, and the ability of revenues to finance conversion debt, what would constitute an "attractive" conversion in the eyes RCFs was less clear. Through interviews and the case study, I learned a RCF would judge the "attractiveness" of conversion as the ability to fulfill its mission in a more suitable fashion than within the system in which its currently operates. While some of the more short-sighted facilities defined "attractive" and financially "feasible" as synonymous ("if we can afford it, we'll do it"), most RCFs indicated an "attractive" alternative would include increases in reimbursement, the unraveling and reduction of regulation, and the assurance of long-term competitiveness in the residential care/long-term care marketplace.

Before discussing the mismatches between RCF/AL conversion policy design and implementation, it is useful to summarize the key variables influencing conversion. These variables incorporate both financial considerations as well as qualitative notions of appropriateness and desirability that influence RCFs' conversion decisions. In addition to factors specific to each facility, each organization's relationship to these variables (ranging from a favorable, to a poor, position) will ultimately determine its ability to convert.

I. KEY VARIABLES INFLUENCING THE ABILITY TO CONVERT

While all interdependent, my research identified five key variables influencing RCF conversion feasibility, a facility's: a) physical plant (layout of the building), b) financial capacity, c) mission, d) location, and e) regulatory status.
Chapter VIII: Mismatches between Conversion Policy Design and Implementation

a. Physical Plant

The physical design and the condition of the existing facility greatly influence the ability of RCFs to make both required and desired physical plant changes necessary to conversion. First, with the assistance of an architect, RCFs must assess if it is physically possible, at minimum, to alter the layout of the facility to meet requirements to qualify as AL providers. For many, the addition of one or two bathrooms will present a challenge because it can translate into cutting into residents' room which are relatively small at the outset. Additionally, will the physical plant allow for desired changes, such as the addition of an elevator, that are oftentimes as necessary as those mandated in state requirements? As mentioned earlier, physical plant changes often precipitate economy of scale problems that are integral components of economic feasibility.

Second, Massachusetts' RCF stock is old and need of rehabilitation. When considering conversion costs, the condition of the facility (i.e. structural soundness, efficiency of mechanical systems, exterior and interior appearance) must be evaluated to determine if conversion is not only feasible, but practical. When renovating older buildings, the opportunity costs of changes may be greater than tearing down the building and starting anew.

b. Financial Capacity

A facility's financial depth is a measure of its ability to convert within its own means (utilizing savings and investments), or fulfill lending criteria necessary to obtain capital to convert. Financial depth is generally a function of the relationships of a facility's assets to liabilities, and its revenues to expenses. In addition to investments and endowments (when applicable), RCFs' assets are within their buildings and properties. When used as collateral to obtain capital, these assets' net worth is vital. Further, the
Chapter VIII: Mismatches between Conversion Policy Design and Implementation

relationship of these assets to current liabilities must also be evaluated to determine the solvency of the organization.

Equally, if not more, important than the ratio of assets to liabilities, is the relationship of revenue to expenses. RCF revenue is most sensitive to the facility's clientele. In general, given current public reimbursement rates to RCFs (generally regarded as inadequate), the higher the percentage of publicly-subsidized persons a facility serves, the lower its relative total revenue. In general, facilities with a more balanced ratio of public- to private-pay persons exhibit greater financial depth (assuming private-pay revenues exceed and cross-subsidized public-pay revenues). On the other hand, expenses are highly variable among facilities but may be chiefly described as a function of resident acuity. Resident acuity determines the amount of services required which within past years has often involved the addition of costly medically-skilled staffing and services.

c. Mission

A RCF's mission determines both type of residents (i.e. level of acuity, presence of mental illness, among others) as well as resident income levels, that will be served in the facility. Most not-for-profit RCFs were philanthropically founded to serve an affinity group (i.e. members of a religious organization, ethnic culture, or community), yet were generally created to serve the low-income individuals. If a sufficient number of persons within a facility's affinity group will continue to fill beds and bring in sufficient revenue, then conversion may be attractive. However, given the economic motivations of contemporary AL sponsors to serve upper-income populations (necessary to receive adequate returns on investments), the missions of RCFs serving the poor currently rules them out as likely candidates for conversion to AL.

When questioning an experienced Executive Director who converted a Massachusetts RCF to AL about how this project would be affected had it had a higher percentage
of low-income persons, the response was: "...it would not have worked." I received the clear impression that AL developments with all (or even half) low-income individuals is an oxymoron unless better-paying public assistance programs are developed.

d. Location

Real estate agents chiefly recognize three key principles affecting the marketability of any business: "location, location, and location!" Chapter VII reviewed the importance, in addition to financial forecasts, of a market study as the first step in determining feasibility. For RCFs, this translates into not only confirming that an adequate number of elderly persons live in the market area, but that these potential clients have the ability and desire to live and receive services in the program of the converted facility. Since approximately 70% of all elderly housing with services clients are drawn for primary and secondary market area, the closeness of the match between whom the facility intends to serve the and the socio-demographic characteristics of the market area is key to successful operation. If one examines where RCF conversion to AL has successfully taken place in Massachusetts (in the attractive historic area of Salem), and where the first state-financed (MHFA) AL development will be built (in the affluent City of Newton), the importance of appropriate location is clear.

Even for RCFs that serve primarily low-income persons, location is also central to the notion of competition. While RCFs that serve the poor operate, for the most part, in "protected market," they also work to attract private-pay clients to their facilities to maintain their financial livelihoods. For example, assume the German Home embarked on the most thorough conversion which miraculously resulted an impeccably attractive facility with much-improved services. Does this mean that potential RCF/AL private-pay clients would consider the Home before a new AL development a few, or even many miles down the road located in more attractive area? Probably not.
Chapter VIII: Mismatches between Conversion Policy Design and Implementation

e. Regulatory Status

While not discussed in detail in this study, the extent to which regulation is incorporated into final AL legislation directly affects the ability and interest of RCFs to convert. First and foremost, regulation will be highly influenced by whether AL is classified as a medical/institutional model or a residential model in Massachusetts. In essence, if final legislation dictates that AL facilities must comply with even half the amount of regulation RCFs must operate in accordance with (for Massachusetts RCFs, a fine-printed 130-page book), not only will costs be driven up, but the interest in converting to a similarly inflexible, standardized model will be remote.

II. MISMATCHES IN POLICY DESIGN AND IMPLEMENTATION

In addition to interviews with practitioners, findings from the German Home's feasibility study indicate two specific reasons why, for most not-for-profits RCFs that serve a low-income clientele, conversion to AL will be unfeasible: 1) the absence of available capital for conversion, and 2) insufficient reimbursement revenues to successfully sustain operations after conversion. After discussing these more "quantitative" impediments to conversion, two overarching "qualitative" policy mismatches follow.

A. SPECIFIC IMPEDIMENTS TO CONVERSION:

1. Absence of Conversion Capital

While by no means exhaustive, Chapter VII discussed the primary potential sources of capital available for AL. This review essentially concluded that while a rental housing subsidy will likely become available for AL facilities (SSI), and an administrative and supportive services subsidy will be extended to AL facilities (the Dept. of Public Welfare's Group Adult Foster Care Program), capital that has been made available assist
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the RCF/AL conversion requires changes in the facility's physical plant that may not be supported by RCFs' revenue streams.

At this time, federal and state capital financing sources appear to be following earlier models of AL development in expressing almost exclusive interest in participating in more conventional AL models (i.e. requiring single room occupancy with private bathrooms) typically serving private-market upper-income elders. While Diane Flanders (Dir. of Long-Term Care at the DPW) indicated that the state is interested in offering capital to "well-positioned" (creditworthy) RCFs, she clearly indicated that conversion must be "suitable by MHFA standards."

Through its policies, the message the state appears to be sending to RCFs is: "If you can convert to AL without our assistance, then you are entitled to become an AL provider -- if not, then you had best consider exercising other options." Diane Flanders indicated that the "state is being careful not to tell RCFs what to do... and letting facilities choose." However, many question whether clearing the "conversion hurdle" is the state's method of qualifying potential RCF/AL converters. Some claim the absence of conversion capital is inviting natural attrition of poorer facilities out of the RCF market and out of the state reimbursement system.

Given the newness of AL model, funding sources appear fairly opened-minded about evaluating and financing potential AL projects. However, it remains to be seen if future lending criteria will be relaxed to not only allow for RCF conversion to AL, but funding for the development of new AL facilities that will serve more than a fraction of low-income individuals. A general consensus from past and present state policy makers is that lending requirements will not be relaxed, as one stated, "for a very long time." In *Best Practices in Assisted Living*, the authors conclude by stating:
"The majority of assisted living facilities have been financed through conventional means primarily serving middle and upper income populations.... There is an urgent need for more creative public and private funding of assisted living for low income elderly... a need to encourage and advocate reliable third party payment sources that increases less costly options for this group." 

2. Insufficient Reimbursement Revenues After Conversion

Even within its "bare-to-the-bone" conversion plan, results from the German Home's financial feasibility study indicate that increases in its reimbursement revenue (assuming that SSI will be available to AL facilities) will not sustain the facility's operation beyond a few years. In fact, there is a high likelihood that state financial assistance to persons seeking AL will not only exclude low-income elders, but also persons with moderate incomes. According to 1990 Census, 32% of Massachusetts elder households (75+ years) had annual incomes between $5,000 and $10,000/year and 34% had incomes ranges from $10,000 to $25,000. If a modest AL program cost $18,000/year ($1,500/month), then the majority of Massachusetts elders are destined to be excluded from AL. While the addition of SSI payments would certainly make AL available to more low-income elders, the Governor had refused to consider granting more moneys to the program at least until after AL legislation is passed.

B. OVERARCHING POLICY MISMATCHES

The inability of RCFs to access capital, and lack of sufficient revenue after conversion, are serious impediments the state must address if a significant number of RCF to AL conversions is expected to take place. However, two overarching mismatches in the design of RCF/AL conversion policy and its future implementation exist: 1) the

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1Regnier, Hamilton, and Yatabe, pp. 160-161.
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likelihood that conversion policy was never designed as an independent policy in its own right but likely as an AL policy afterthought, and 2) conversion policy does not adequately consider the differences between residential care and assisted living to enable RCFs to convert to competitive, and questionably even more appropriate and attractive, model than that which they currently offer.

In essence, the dilemma with these two mismatches is they extend beyond financial considerations (allocating more public moneys to the AL program) and delve into overarching systemic differences between residential care and assisting living that will not remedied by final AL legislation alone.

1. Conversion Policy as an Afterthought

To understand why conversion policy was likely a secondary consideration to the development of the Massachusetts AL model, one must again recognize the state's primary motivation in promoting AL; the reduction of long-term care expenditures. If the state can prevent or postpone institutional placement by subsidizing a small number of low-income persons (who would have been placed in nursing homes or RCFs) in middle- to upper-income AL developments (the MHFA model), then aggregate expenditures may be reduced. However, this assumes that the cost to subsidize a person in an AL will be less expensive than in a RCF. Whether or not this scenario will hold true remains to be seen.

What is clear is that AL conversion policy was not primarily conceived as a means to mainstream RCFs into the long-term care continuum. When posed with the question: "Is Massachusetts trying to transform its RCF industry into an AL industry?" Diane Flanders responded: "No, the state is trying to create a new industry [AL]." After all, if
Chapter VIII: Mismatches between Conversion Policy Design and Implementation

the goal is to reduce spending, why would the state design a policy that would precipitate aggregate cost increases by fostering a great number of conversions?3

In actuality, RCF conversion policy likely followed legislation originally designed to assist Level III nursing homes (ICFs) to convert to AL after the federal elimination of the ICF level of care. What is clear is that RCF/AL conversion policy was designed to assist the operations of a segment of the RCF stock (those serving more balanced income mix of elders) by offering this group increased reimbursement as AL providers. Simultaneously, many would venture to say that conversion policy was also designed to encourage the "weeding-out" of another segment of the state's RCF stock (facilities serving a high percentage of public-pay clients) from the state reimbursement system. Diane Flanders explained that among state officials there is "passive acknowledgment" that: "there will be no more 100% Medicaid facilities... no more 'Medicaid Mills'."

2. Converted Resident Care Facilities will not be "Assisted Living"

Chapter IV identified significant differences between residential care facilities and assisted living that Massachusetts conversion policy has not aptly responded to. First, there are fundamental differences in nature RCF sponsors and AL developers (i.e. their motivations and priorities, whom each serves, to name a few). It has been evidenced that many RCF administrators and boards lack the professional skills (primarily in the area of finances) to manage their facilities well. Many RCF are struggling to "professionalize" themselves while striving to preserve the elements they believe only a home-like "mom and pop" type facility can offer. Conversion policy appears to neither recognize nor address larger systemic problems within the RCF industry that most often will not be remedied increased reimbursement rates alone. However, perhaps the state recognizes these

3While the state should be able to reduce nursing home expenditures by subsidizing persons in AL facilities, whether the opportunity costs of subsidizing persons in AL facilities will be less than in RCFs is less clear.
Chapter VIII: Mismatches between Conversion Policy Design and Implementation

differences and is indirectly qualifying RCFs "converters" as those able to obtain capital. If so, the state may be making the assumption that RCFs are in financially tenuous positions because of mismanagement which may, or may not, be the case.

Second, it is unrealistic to assume that by minimally upgrading physical plants to meet state AL conversion policy requirements (i.e. adding bathrooms), RCFs will miraculously transform themselves into competitive AL models. In reality, for most RCFs serving the poor, there will be no difference between a RCF that becomes a DPW Group Adult Foster Care Program provider (which is the main requirement RCFs will need to meet to qualify as "AL"), than those that convert to AL. While physical plants will be upgraded and revenues will increase, RCFs will inevitably end-up with a "water-downed" model of AL. Unless converted RCFs can offer a distinct marketable feature (i.e. affiliation with an affinity group), they will increasingly struggle to not only compete for private-pay clients, but also for public-pay clients who may be eligible for low-income set-asides in new AL developments.

For the majority of RCFs that serve the poor, financial considerations aside, converting to AL will not assure long-term competitiveness in the residential care marketplace which therefore may question the value and appropriateness of converting at all. In fact, if policy is not designed properly, and conversion only prolongs the agony of eventual closure, then the state could potentially be doing more of a disservice to RCFs with this conversion policy, than offering no new policy at all.
CHAPTER IX

CONCLUSIONS/RECOMMENDATIONS
Chapter IX: Conclusions/Recommendations

This study investigated and discussed the key issues involved in the conversion of Massachusetts Resident Care Facilities (RCFs) into Assisted Living (AL). From this research, two general conclusions about conversion feasibility have emerged. First, the majority of Massachusetts RCFs serving primarily low-income residents will not only be unable to convert to resemble contemporary AL facilities, but they will also be unable to convert to an AL model defined by state RCF/AL conversion policy requirements. Second, and perhaps equally important, the futures of RCFs that serve the poor that continue to operate as RCFs are highly questionable.

After discussing these conclusions, this study closes by offering a set of recommendations first, to RCFs sponsors (owner, Boards of Directors, administrators and operators) to consider in future operations, and second, to state policy makers working not only on the development of RCF/AL conversion policy and AL policy, but also to those responsible for the operations of RCFs.

I. CONCLUSIONS

a. Resident Care Facilities Serving the Poor will Not be Able to Convert

Chapter VIII discussed the key variables influencing RCFs' ability to convert to AL. While many RCFs may be located in favorable areas enhancing their marketability (primarily their ability to attract private-pay residents), all RCFs serving the poor are likely affected by financial weaknesses and physical plant constraints making conversion to AL virtually impossible. Ignoring larger systemic differences between residential care and assisted living that question the appropriateness of conversion, in the absence of sufficient increase reimbursement to AL facilities and the capacity to obtain capital to finance conversion, most RCFs serving the poor will not be able to convert. Additionally, until reimbursement is increased for facilities also serving moderate-income persons (most moderate-income persons will not qualify the DPW's Group Adult Foster Program and are
Chapter IX: Conclusions/Recommendations

truly ignored in proposed policy), this group of RCFs may experience the greatest difficulty of all in converting.

b. The Future of Resident Care Facilities Serving the Poor is Uncertain

As suggested by RCF administrators, and past and current state officials, the view of the future of RCFs that almost exclusively serve the poor is pessimistic. In addition to findings from the German Home's financial forecast that paint a grim picture for its continued operation as a RCF (assuming reimbursement will continue to not adequately cover costs), state officials admit that facilities with a high percentage of poor persons will continue to be strongly encouraged to revise their mix of public-/private-pay clients, or leave to the system. Diane Flanders (Dir. of Long-Term Care, the DPW) somewhat reluctantly admitted: "the way the system encourages the mix [public-/private-pay] is by not paying well." In sum, within the next decade, it is highly improbable RCFs serving the poor will be in operation as RCFs.

II. RECOMMENDATIONS

a. To Resident Care Facilities

RCFs must break their traditional patterns of reacting solely when crises arise by fumbling to adjust to the changed climate thereafter. Instead, RCFs should begin planning for the future with a proactive approach that anticipates change, takes a critical look at opportunities and threats, and moves forward accordingly.

An on-going strategic planning process should begin by RCF management reevaluating its facility's current operations, understanding its strengths and weaknesses, assessing how its "measures up" to competition, learning about the policy environment in
which it operates, and lastly, determining how well it is positioned to respond in the future. In reevaluating operations, RCFs need to ask themselves:

1. **Whom do We Serve?**
   Examining your facility's customers involves careful examination of your mission statement, the characteristics of clients served, your referral sources, to name a few.

2. **How Do We Compare with Our Competition?**
   Getting out of the facility and visiting with other providers offering similar services (i.e. CCRCs, congregate housing, as well as AL facilities) in the market area is important in understanding what is taking place around you and necessary to critically compare your "product" to theirs'.

3. **What are the Market Trends and What Will be their Affects?**
   Understanding demographic and policy trends discussed earlier (i.e. the development of community-based alternatives and the tightening of nursing homes admission criteria) are important to understanding, and adapting to, changes in the marketplace.

4. **What Will Future Customers Want?**
   Recognizing that the next generation of elders will likely be in more favorable economic positions is key to recognizing changing purchasing power and consumer demands. Consumers will undoubtedly choose a facility that most closely resembles their past living circumstances, where needed services are offered, and where they believe the best value may be secured.

5. **How are we Positioned to Respond?**
   Evaluating how you will respond to changes includes evaluating the strengths and weakness of the organization. Strengths may include: availability of land, presence of an endowment, strong sources of referral, and high occupancy rates. Weakness may include an out-dated physical plant and location in an undesirable area.

At this point, RCFs will find themselves in either a strong, moderate, or weak organizational positions to determine their courses of action. First, those in strong positions (evidenced by strong sources of referral, consistent high occupancy rates, available capital, and high private-payer mix) may decide to continue operation in their present states (as RCFs) and even consider diversifying and joint venturing to become a
Chapter IX: Conclusions/Recommendations

Home Care or adult day care providers. Some RCFs, including not-for-profits with sizable endowments, are in fortunate positions to exercise these options. In fact, for RCFs with adequate revenue streams that have prudently begun adapting to changed market demands, conversion may be relatively easy.

Second, facilities in moderate positions (experiencing relatively minor problems with occupancy, feeling threatened by competition, or requiring updating of physical plants), may consider rehabilitating their physical plants and converting to AL. Judging by these characteristics (it is highly unlikely such a facility is serving high percentage of poor clients), it is accurate to assume this group as the state's target in its RCF/AL conversion policy.

Third, those in weak positions (often evidenced by location in an undesirable areas, little or no available capital, possessing rundown physical plants, serving primarily the poor) must consider developing a new business approach, changing use, selling, or closing down operations. Re-use alternatives may include halfway houses for alcoholics, group homes for the mentally ill, detoxification centers, hospice or respite service providers, and homeless shelters.

Lastly, RCFs must ask themselves: Can we afford to wait? Providers who understand changing needs and plan for the future will be in the 'driver's seat' and better positioned to avail themselves to advantageous opportunities, and will be able to make sound business decisions when the time arrives.

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1 Home Care is the largest state-funded program that provides community-based services to persons living in their home or other types of residential settings (i.e. congregate housing, RCFs). While there are a variety of types, adult day care centers are often programs where areas in elderly housing developments (such as in a HUD Section 202 project) are set-aside for the supervised care of elders who live in their homes, but spent part (or all) of their days with other elders doing a variety of activities.

2 The above recommendations were excepted from Susan McDonough's: "Options for the Residential Care Provider: Where Will You Be In The Next Five Years?"
b. To State Policy Makers

While my discussion to state policy makers is specifically directed toward those involved RCF/AL conversion policy, these recommendations inherently extend to those within the long-term care industry at large. Only when policy makers conceive of the role of RCF providers and that of emerging AL providers as part of a unified continuum (from community-based services on one end to nursing homes and hospitals on the other) will adequate and appropriate policy be formulated for all.

First, state policy makers must re-examine and re-evaluate the characteristics and needs of its RCF stock. My research indicates state officials have not seriously considered RCF operations for a decade. In the minds of many, RCFs have never been allowed to rise above the "poorhouse" stigma to be a seriously considered state resource. Since RCFs are a small group of poorly financed providers with relatively little clout, it has been easy for the state to have been distracted by larger imperatives and as a result, ignore changing needs of, and increase expectations placed on, RCFs.

Second, the state must define an appropriate role for its RCF stock and determine its relationship to other providers in the long-term care continuum; particularly in light of imminent AL development. If the state's intention is to assist as many RCF as possible to convert to AL, then policy must be amended to create capital financing alternatives to convert, and increase reimbursement revenues after conversion. However, if the state's intention is to reduce the number of publicly-subsidized RCF residents it is accountable to by inviting the attrition of "poorer" facilities out of the market, then it should assist in a planned, appropriate "phase-out" process. A phase-out process may include assisting RCFs to obtain higher a percentage of privately-subsidized residents (phasing-out only low-income clients), as well as assisting some RCFs to phase out of the system altogether. Continually under-reimbursing, increasing regulation, and devising other tactics to make
Chapter IX: Conclusions/Recommendations

operations increasingly difficult (as RCFs attest has been happening) is no way to insure, at minimum, that residents will receive quality care in the interim.

Lastly, if the RCF stock is to diminish, as it likely will, then the state must either demonstrate that other options are, or will be made, available for current and future RCF residents. Diane Flanders explained that while nearly one RCF has shut down per month in the past year, few problems have been experienced in relocating residents. According to Diane, in addition to 2,000 vacant nursing home beds, 1,000 of the 5,500 licensed RCF beds in the state's stock is vacant. However, throughout this study, I asked all interviewees: If RCFs close, where will their current and future residents be housed and cared for? First, no one expressed the belief that so many RCFs will close simultaneously that a deluge of residents with no place to go will occur. Second, while a variety of scenarios were suggested, no one indicated that RCF residents would be served in any one setting. The range of responses included:

- Some will qualify for institutional placement and will be placed in nursing homes (which ironically is exactly what the state, within its cost-containment initiatives, is trying to avoid);

- Some will be able to return (or remain) at home as community-based services systems develop (no demonstration programs have yet proven cost-effective);

- Few with higher incomes will live in AL developments (with low-income set-aside requirements);

- Some will take the places of persons currently living in congregate housing and like-settings who moved into AL facilities (assuming they will receive services from a program like the DPW's Group Adult Foster Care Program);

- Persons with mentally-ill diagnosis will be placed in group homes designed for the mentally-ill, and;

- Some will inevitably end up on the street.
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The bottom line is that the state must assess, in detail, whether or not these are legitimate, satisfactory, alternatives it is willing to endorse for current and future RCF residents.

Within its short history in a small number of states, AL has demonstrated itself as a welcomed resource for middle- to upper-income elders which is commendable development in its own right. However, among all the excitement surrounding this new model, the needs of low- and moderate-income elders requiring intermediate-type housing and personal care services have again, for the most part, been ignored. That is not to refute state's claim -- AL will help fill many gaps between institutional care and remaining at home. However, it is questionable whether many of these gaps will be filled by low-income RCFs residents the state may wish to have out of its reimbursement system. Among all the best intentions of policy makers looking to fulfill a growing population of elder needs with limited funds, each should work together to exercise as many options as possible to insure that low- and middle-income elders are not left to fall through the cracks.
RESOURCES

INTERVIEWS AND CONFERENCES/WORKSHOPS
In addition to participating in Residential Care Facility meetings (facilitated through my internship at the Association of Massachusetts Homes from the Aging since June 1992), listed below are the persons interviewed for this thesis and the related conferences/workshops I attended.

**Interviewees:**

- Anne Harrington -- Manager Editor, *Continuum*, Arlington, MA  
  Date: December 1, 1992

- Joseph Carella -- Administrator, The Swedish Home, Newton, MA  
  Date: February 16, 1993

- Thomas Grape -- General Manager, A/D/S Senior Housing, Cambridge, MA  
  Date: February 16, 1993

- William Carney -- President, Elder Living, Inc., Salem, MA  
  Date: February 24, 1993

- Margaret Naylor -- Administrator, Goddard House/Homestead Hall, Worcester, MA  
  Date: March 12, 1993

- James Mecone -- Partner, Mullen and Company, CPAs, Boston, MA  
  Date: March 18, 1993

- Susan McDonough, Partner -- Lanzikos, McDonough & Associates, Boston, MA  
  Date: April 1, 1993

- Mary Kalymun, Assistant Professor -- Department of Human Development, Counseling, and Family Studies, University of Rhode Island  
  Date: April 6, 1993

- Robert Mollica, Professional Staff -- The National Academy for State Health Policy, Portland, ME  
  Date: April 12, 1993

- Donna Yee -- Researcher, Center for Health Policy, Brandeis University, Waltham, MA  
  Date: April 21, 1993
Resources

- Diane Flanders -- Director of Long-Term Care, Department of Public Welfare
  Boston, MA
  Date: April 25, 1993

Related Conferences/Workshops Attended:

- The Association of Massachusetts Homes for the Aging's: Annual New England
  Conference, Hyannis, MA
  Dates: June 3-5, 1992

- The Association of Massachusetts Homes for the Aging's: "Emerging Issues in
  Supportive Residential Environments for Older People: A Closer Look at Assisted
  Living," Framingham, MA
  Date: June 23, 1992

- The Association of Massachusetts Homes for the Aging and the Department
  of Public Welfare's: Group Adult Foster Care Presentation, Newton, MA
  Date: October 20, 1992

- The American Association of Homes for the Aging's: 31st Annual Meeting and
  Exposition, Boston, MA
  Dates: October 26-29, 1992

- The Association of Massachusetts Homes for the Aging's: "Reimbursement,
  Resources, and Options for Survival for Residential Care Facilities,"
  Cambridge, MA
  Date: March 25, 1993


Massachusetts Department of Public Welfare Medical Assistance Program, (June 1992). "*Group Adult Foster Care Guidelines,*" Boston, MA.


APPENDIX A

SUMMARY OF GOVERNOR WELD'S ASSISTED LIVING LEGISLATION
Appendix A: Summary of Governor Weld's Assisted Living Legislation

The following is a reproduction of a November 16, 1992 publication:

**ASSISTED LIVING PROGRAM MODEL**

This document represents the consensus of the Departments of Public Health and Welfare, the Rate Setting Commission, the Executive Office of Communities and Development and the Executive Office of Elder Affairs on a program model for assisted living. This document presents the philosophy of assisted living, potential settings, the oversight model, and the baseline program model.

**Philosophy**

The services available through assisted living are intended to help residents remain as independent as possible in order to avoid premature institutional placement. Assisted living entities should adopt policies that enable residents to "age in place" (remain in a familiar living environment despite the physical or mental decline that may occur with the aging process) when resources are available to meet their needs and accommodate their preferences.

**Potential Settings**

Assisted living models may include, but are not limited to, such sites as elderly housing units with supportive services or other group living arrangements that private developers are interested pursuing. This option may also be available to any nursing facility or rest home wishing to convert to assisted living.

**Registry**

To be considered an assisted living entity by the Commonwealth, the entity must define the services the entity intends to offer, outline a plan for meeting residents' needs as they arise, and demonstrate the capacity to meet the baseline requirements described below.

**Consumer Advocacy**

The Ombudsman program of the Executive Office of Elder Affairs will provide a consumer advocacy role to those residents of assisted living entities in need of such support through an expansion of its current activities. The Ombudsman role will be one of conflict resolution, mediation and education at the local and state level.
Appendix A: Summary of Governor Weld's Assisted Living Legislation

protection issues that require further action, the program will refer these matter to other EOE programs as well as other appropriate oversight agencies, such as EOCD, local building inspectors, fire and safety authorities, etc.

Program Review

Assisted Living entities will be subject to annual on site review as part of the state's registration process. The Executive Office of Elder Affairs, plans to utilize regional and local community resources to periodically review the services and amenities provided to assisted living residents; review findings will be linked to EOCD's registration process and EOE's consumer information activities. Program review approaches will be consumer oriented and aimed at enhancing the quality of life for assisted living residents.

Baseline Model

All services described in this model may be provided directly or by contract.

1. Responsible Person

An individual shall be on the premises on a 24 hour basis. The entity shall provide an emergency response system to assure that residents have immediate access to the responsible person.

2. Assistance with Activities of Daily Living (ADLs - Bathing, Dressing, Feeding Transferring, Toileting)

The entity should provide direct assistance with or reminder to perform any activities of daily living that it holds itself out as providing in its registration. Such assistance include 24 hour response availability to meet unscheduled need, including emergencies. All assisted living entities need not provide assistance with all activities of daily living, but must provide assistance with a least bathing, dressing and ambulation. Assisted living entities are strongly encouraged to provide assistance with feeding, transferring, and toileting, as well.

3. Medication Administration

The entity allows self-administration, provides prompting and reminding. Unlicensed personnel may supervise the self-administration of medication. This supervision includes: reminding residents to take medication, opening bottle caps for residents, opening prepackaged medication for residents, reading the medication labels to residents, observing while they take medication, checking the self-administered dosage against the
Appendix A: Summary of Governor Weld's Assisted Living Legislation

labeling container, reassuring residents that they have obtained and are taking the dosage
as prescribed, and immediately reporting noticeable changes in the condition of a resident
to a resident's physician. These activities may be performed by any individual who has
been suitably trained as specified in section 9. Actual administration shall be performed
by licensed nursing or medical personnel.

Medications shall be properly stored based on the needs of the residents. In a multi-
bedroom units, a locked storage cabinets should be available for each roommate. In a
single bedroom unit, the bedroom door should lock.

4. Supportive Services

The entity shall ensure that adequate daily nutrition is available and appropriate to
residents' need and choices.

The entity shall provide access to household services essential for the health and comfort
of the residents. Such services may include laundry, floor cleaning, dusting, bed-making,
dish washing, vacuuming, cleaning kitchens and bathrooms, and shopping.

5. Resident Criteria

The target populations are the elderly and disabled.

6. Terms of Participation: Maximum Services Levels

The terms of participation shall be specified in a written agreement between the entity and
the resident. The contract (lease or agreement) shall address the following areas:
responsibilities of the resident, responsibilities of the entity, services included in the
assisted living package (must address ADLs, medication administration, supportive
services provided, services not provided, supervision, etc.) frequency of service delivery,
costs of standard and optional services. Specifics regarding the cost of and provision of
food must be addressed.

Although the baseline model does not define resident characteristics requiring care in
another setting, such characteristics may be specified in the written agreement. The
agreement shall define the responsibilities for finding alternative living arrangements in the
event it becomes necessary.

7. Service and Care Planning

In addition to the written agreement in #6 above, a service plan, with which the
resident/family agrees in writing, must be developed. The service plan shall address the
unique physical and psychosocial needs, abilities, and personal preferences of each

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resident. The service plan shall include a brief written description of the services to be provided, the modality of service delivery, the timing and frequency of service delivery, and the purposes and benefits of the services. The services plan shall include an assessment of personal care needs conducted by a licensed nurse. If personal care or nursing services are an identified need, an appropriate care plan must be developed by a licensed nurse.

The service plan shall be updated periodically by mutual consent of the parties to reflect current needs. Whenever personal care or nursing services are necessary, the entity must assure that a licensed nurse routinely monitors the care plan.

8. Resident Record

Documentation of service delivery as specified by the services and care plan must be maintained by the entity.

9. Training and Other Personnel Qualifications

The assisted living entity shall ensure that personnel providing personal care are suitably trained for the duties they are expected to perform. Suitable training shall include training in the ADLs the entity contracts to provide, and other such services as identified in the contract, such as training in medication supervision. Candidates for hire should provide reasonable assurance that they will take or omit no action that would place the health or safety of any resident at risk. The state agencies purchasing assisted living services may define the areas of training that are appropriate for their programs.

10. Physical Plant

The locations where services is delivered must meet the requirements of state sanitary code and applicable fire, safety and building codes. Because assisted living entities are residences, all units must have entry doors with locks.
APPENDIX B

SUMMARY OF FINANCING AND PUBLIC ASSISTANCE PROGRAMS FOR ASSISTED LIVING FACILITIES IN MASSACHUSETTS
ELDER CHOICE - ELDERLY HOUSING WITH SERVICES

PROGRAM OBJECTIVE

Elder Choice is a program designed to finance housing for the elderly that includes supportive services. It is intended to address the needs of frail elders by creating a supportive living environment which prevents institutionalization and allows residents to "age in place" to the maximum extent possible.

BACKGROUND

MHFA has a long history of financing conventional rental housing for older people. Through its Supportive Services Program, the Agency is assisting owners and managers of existing MHFA-financed developments to coordinate the provision of services to their aging tenants. As Massachusetts' elderly population grows target and older, so does the need for a range of housing options for elders. Therefore, the Agency is encouraging the development of housing which takes into account the needs of frail elders. By facilitating the provision of elderly housing with services through Elder Choice financing, MHFA intends to further enhance the quality of life for elders as well as provide supportive environments which can prevent or delay the need for elders to move to nursing homes.

PROGRAM CONCEPT

Housing financed through Elder Choice will differ from conventional rental housing in that it will include not only shelter but assistance with daily living. This assistance will take the form of services such as meal provision, housekeeping and transportation. In Elder Choice developments targeted to more frail elders, services provision can be expanded to include assistance in areas such as bathing and grooming.

MHFA will provide debt financing for Elder Choice developments. In order to make these developments an affordable option for low and moderate income elders, MHFA is actively pursuing additional sources of funds which can be used in conjunction with its mortgage to subsidize both the rental and service costs.
Appendix B: Summary of Financing and Public Assistance Programs for Assisted Living Facilities in Massachusetts

PROGRAM CRITERIA

1. At least 20% of the units in a development must be made available to low income residents (households with income no greater than 50% of area median gross income). Low income residents should pay no more than 30% of their income for rent. "Rent" refers only to shelter costs, including utilities. Total monthly charges that include services as well as shelter may exceed 40% of income.

2. While Elder Choice housing will typically include more shared space (such as common dining room) than conventional rental housing, each dwelling unit is required to have its own kitchen and bath facilities.

3. The Agency is currently reviewing several service provision structures including the following: a "basic package" available to all residents included in the monthly charge, an "a la carte" list from which residents may choose and pay for separately according to their needs, and a two-tiered system in which a "basic package" is available to all residents and included in the monthly charge, with additional services available at an additional charge. The acceptability of these or other service models may be dependent on criteria for service subsidy funds offered to low-income residents.

4. A market/feasibility study should be conducted to determine the need for the proposed housing. The study should include (but not limited to):

- a description of the target population(s), including level of "frailty" and service needs
- rents and charges for comparable housing
- local demographics showing target age group
- evidence of local interest in and acceptance of this type of housing in the community
- income studies showing affordability of monthly changes

5. The architect must provide evidence of design input by the management company and the service providers(s). Plans and specifications should incorporate those design aspects which contribute positively to daily life for frail elders, and facilitate service delivery. In addition, all Elder Choice developments must meet all federal and state accessibility laws and regulations.
6. Because of lengthy rent-up time required by this type of housing, additional security may be required of the developer until full occupancy is achieved. Preleasing may also be required.

7. The development team will need to provide evidence of satisfactory experience with the development, design and management of similar housing. In addition, the team must demonstrate in the delivery and coordination of services as those being proposed for this development.

8. The management company should prepare a plan for initial and ongoing assessment of residents' service needs and procedures for referral of residents once the proposed housing is no longer able to service their needs.

9. Regardless of whether services are provided by on-site staff, the management company should demonstrate an awareness of community-based services available to low-income elders, and a willingness to facilitate continued service delivery to incoming residents who are already clients of local service providers.
GROUP ADULT FOSTER CARE
FACT SHEET

I. **Purpose:** To provide room, board, and personal care services in a residential setting to elderly and/or disabled individuals who are at imminent risk of institutional placement.

II. **Provider Eligibility:**

   A) Each housing unit must meet HCFA definition of "home" or "domiciliary facility" in which no more than three individuals reside (not subject to institutional licensing requirements).

   B) Housing units must comply with all applicable local and state fire and safety codes;

   C) Nurse/Social Work/Personal Care model of service delivery must include:

         1) qualified program director;
         2) care plans developed and supervised by a registered nurse;
         3) personal care and 24-hour supervision;
         4) emergency response system to summon assistance at any time.

III. **Participant Eligibility:**

   A) Physician documentation and clinical review by Medicaid must confirm that recipient is at risk of institutional placement.

   B) The following categories of assistance will be covered:

         1) SSI/Aged (Supplemental Security Income for recipients 65 years of age or over)
         2) SSI/Disabled
         3) MA/Aged (Medical Assistance for recipients 65 years of age or over)
         4) MA/Disabled
C) Recipient must accept plan of care which limits use of home health and adult day care health services to short term respite or recuperative periods only.

IV. **Reimbursement**

A) The Department will reimburse the provider at established Adult Foster Care rates:

1) $13.60 per day for personal care, plus
2) $18.00 (average) per day for administrative service

B) The participant pays rent or room and board separately, as housing costs are not covered in the Medicaid payment.
The following is a reproduction of an Executive Office of Elder Affairs publication:

MANAGED CARE IN HOUSING
FACT SHEET

Purpose:

- To provide supportive care and related services in residential settings to elderly individuals who remain in the community as changes in Medicaid regulations governing nursing home eligibility.

- To promote the development of local networks which assure the coordination of health, social and residential services necessary to prevent or delay institutional placement.

Target Population:

- Elders eligible for the EOEA Home Care Program who are in need of a managed home environment due to the supervision and assistance with personal care tasks required to maintain them safely in a community residence. Medicaid eligible elders may be appropriate for service through Medicaid's Group Adult Foster Care Program.

Clients appropriate for assistance through this program may need:

- assistance with rising in the morning and/or going to bed at night

- assistance with toileting in the morning and before bed

- supervision of medication administration necessary in these hours

- assistance with nutritional management and compliance

- assistance with developing a structured daily living routine because of confusion and forgetful and/or wandering behavior
Appendix B: Summary of Financing and Public Assistance Programs for Assisted Living Facilities in Massachusetts

**Program Elements:**

- Clients must reside in a supported housing environment such as a housing complex, congregate facility or group foster care residence.
- 7 day/week, "extended" morning and evening hour personal care services which allow a person to "age in place"
- 24 hour emergency response system
- Coordinated and multidisciplinary client management team which includes Home Care Case Management, nursing and housing representation
- A "clustered" means of delivering services which promotes efficiencies while allowing the flexibility to provide innovative and individualized service packages

**Implementation:**

- Slots allocated by Home Care Corporations region
- Letters of Intent to be submitted by Home Care Corporations to Executive Office of Elder Affairs
APPENDIX C

THE GERMAN HOME’S BALANCE SHEET AND FINANCIAL FORECASTS
### BALANCE SHEET

<table>
<thead>
<tr>
<th></th>
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<td><strong>ASSETS</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
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<td>--</td>
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<td>Investments</td>
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<td>88,264</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Property, plant and equipment at cost less accumulated depreciation</td>
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<td>13,798</td>
<td>45,559</td>
<td>62,147</td>
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<tr>
<td><strong>Total assets</strong></td>
<td>250,263</td>
<td>255,936</td>
<td>268,081</td>
<td>275,452</td>
</tr>
</tbody>
</table>

| **LIABILITIES**      |          |          |          |          |
| Accounts payable     | 7,727    | 3,601    | 7,718    | 7,347    |
| Accrued expenses     | 15,705   | 16,627   | 20,409   | 15,584   |
| Deferred restricted amounts | 2,500    | 2,500    | --       | --       |
| Accounts payable     | 17,615   | 25,328   | 90       | 18,430   |
| (Margin account)     |          |          |          |          |
| **Total liabilities**| 43,547   | 48,056   | 28,217   | 41,361   |

| Fund balance         | 206,716  | 207,880  | 239,864  | 234,091  |
| Total liabilities and fund balance | 250,263  | 255,936  | 268,081  | 275,452  |
### STATEMENT OF SUPPORT AND REVENUE, EXPENSES AND CAPITAL ADDITIONS

(assuming continued operation as a RCF)

<table>
<thead>
<tr>
<th></th>
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<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
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<td><strong>SUPPORT &amp; REVENUE</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Net patient service revenue</td>
<td>329,648</td>
<td>392,180</td>
<td>437,975</td>
<td>442,316</td>
<td>466,643</td>
<td>492,309</td>
<td>519,386</td>
<td>547,952</td>
<td>578,089</td>
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<td>18,272</td>
<td>18,450</td>
<td>13,275</td>
<td>13,939</td>
<td>14,636</td>
<td>14,636</td>
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<td>1,000</td>
<td>1,000</td>
<td>1,000</td>
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</tr>
<tr>
<td>Prior year retro. income</td>
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<td>--</td>
<td>--</td>
<td>--</td>
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<tr>
<td>Misc. income</td>
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<td>571</td>
<td>428</td>
<td>3,660</td>
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<td><strong>Total support &amp; revenue</strong></td>
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<td>438,730</td>
<td>456,853</td>
<td>460,141</td>
<td>482,582</td>
<td>508,944</td>
<td>536,753</td>
<td>566,088</td>
<td>597,032</td>
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<td><strong>EXPENSES</strong></td>
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<td></td>
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<td>Dietary</td>
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<td>110,640</td>
<td>113,805</td>
<td>121,508</td>
<td>125,761</td>
<td>130,162</td>
<td>134,718</td>
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<td>144,313</td>
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<td>Nursing</td>
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<td>121,471</td>
<td>126,352</td>
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<td>139,303</td>
<td>146,258</td>
<td>153,582</td>
<td>161,261</td>
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<td>Admin. &amp; general</td>
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<td>75,235</td>
<td>79,530</td>
<td>93,805</td>
<td>97,557</td>
<td>101,459</td>
<td>105,518</td>
<td>109,739</td>
<td>114,128</td>
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<td>Plant expenses</td>
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<td>41,789</td>
<td>43,879</td>
<td>46,073</td>
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<td>Housekeeping &amp; laundry</td>
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<td>42,806</td>
<td>44,801</td>
<td>46,593</td>
<td>48,457</td>
<td>50,395</td>
<td>52,411</td>
<td>54,507</td>
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<td>Restor. &amp; recre. therapy</td>
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<td>25,663</td>
<td>46,483</td>
<td>46,854</td>
<td>48,728</td>
<td>50,677</td>
<td>52,704</td>
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<td>57,005</td>
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<td>Depreciation</td>
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<td>1,896</td>
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<td><strong>Total operating expenses</strong></td>
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<td>475,853</td>
<td>498,951</td>
<td>519,691</td>
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<td>7,246</td>
<td>7,246</td>
<td>7,246</td>
</tr>
<tr>
<td><strong>Total expenses</strong></td>
<td>396,822</td>
<td>428,118</td>
<td>453,835</td>
<td>475,853</td>
<td>498,951</td>
<td>526,937</td>
<td>548,571</td>
<td>571,138</td>
<td>594,680</td>
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<tr>
<td><strong>Excess (deficiency) of support and revenue over expenses before capital addition (deletions)</strong></td>
<td>(38,505)</td>
<td>10,612</td>
<td>3,018</td>
<td>(15,853)</td>
<td>(16,369)</td>
<td>(17,939)</td>
<td>(11,818)</td>
<td>(5,051)</td>
<td>2,352</td>
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<tr>
<td><strong>Capital additions (deletions)</strong></td>
<td>9,108</td>
<td>6,326</td>
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<td>Unrealized loss on invest.</td>
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<td>Net loss on invest. transact.</td>
<td>24,771</td>
<td>(9,394)</td>
<td>3,675</td>
<td>3,690</td>
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<tr>
<td><strong>Total capital deletions</strong></td>
<td>63,276</td>
<td>1,218</td>
<td>6,693</td>
<td>(12,022)</td>
<td>(16,369)</td>
<td>(17,993)</td>
<td>(11,818)</td>
<td>(5,061)</td>
<td>2,352</td>
</tr>
<tr>
<td><strong>Deficiency of support and revenue after capital additions (deletions)</strong></td>
<td>(38,505)</td>
<td>10,612</td>
<td>3,018</td>
<td>(15,853)</td>
<td>(16,369)</td>
<td>(17,939)</td>
<td>(11,818)</td>
<td>(5,051)</td>
<td>2,352</td>
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### STATEMENT OF SUPPORT AND REVENUE, EXPENSES AND CAPITAL ADDITIONS
(Assuming continued operation as a RCF)

<table>
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<tr>
<th>Projected Year</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>Assumptions</th>
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<tr>
<td></td>
<td>609,884</td>
<td>643,428</td>
<td>678,816</td>
<td>716,151</td>
<td>755,540</td>
<td>797,094</td>
<td>840,934</td>
<td>5.5% increase/year</td>
</tr>
<tr>
<td>1998</td>
<td>17,790</td>
<td>18,679</td>
<td>19,613</td>
<td>20,594</td>
<td>21,624</td>
<td>22,750</td>
<td>23,840</td>
<td>5% increase/year</td>
</tr>
<tr>
<td>1,000</td>
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<td>1,000</td>
<td>1,000</td>
<td>1,000</td>
<td>1,000</td>
<td>1,000</td>
<td>1,000</td>
<td>$1000/year</td>
</tr>
<tr>
<td>1,000</td>
<td>1,000</td>
<td>1,000</td>
<td>1,000</td>
<td>1,000</td>
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<td>None</td>
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<td>1,000</td>
<td>1,000</td>
<td>1,000</td>
<td>1,000</td>
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<td>$1,000/year</td>
</tr>
<tr>
<td>629,674</td>
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<td>149,364</td>
<td>154,592</td>
<td>160,003</td>
<td>165,603</td>
<td>171,399</td>
<td>177,398</td>
<td>183,607</td>
<td>3.5% increase/year</td>
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<tr>
<td>1999</td>
<td>169,324</td>
<td>177,790</td>
<td>186,679</td>
<td>196,013</td>
<td>205,814</td>
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<td>226,910</td>
<td>5% increase/year</td>
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<tr>
<td>2000</td>
<td>118,693</td>
<td>123,441</td>
<td>128,379</td>
<td>133,514</td>
<td>138,854</td>
<td>144,408</td>
<td>150,185</td>
<td>4% increase/year</td>
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<td>2001</td>
<td>50,795</td>
<td>53,335</td>
<td>56,001</td>
<td>58,802</td>
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<td>68,070</td>
<td>5% increase/year</td>
</tr>
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<td>56,688</td>
<td>58,955</td>
<td>61,313</td>
<td>63,766</td>
<td>66,316</td>
<td>68,969</td>
<td>71,728</td>
<td>4% increase/year</td>
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<td>2003</td>
<td>59,285</td>
<td>61,657</td>
<td>64,124</td>
<td>66,688</td>
<td>69,355</td>
<td>72,130</td>
<td>75,015</td>
<td>4% increase/year</td>
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<td>2004</td>
<td>6,843</td>
<td>6,843</td>
<td>6,843</td>
<td>6,843</td>
<td>6,843</td>
<td>6,843</td>
<td>6,843</td>
<td>$1000/year</td>
</tr>
<tr>
<td>1,000</td>
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<td>1,000</td>
<td>1,000</td>
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<tr>
<td>611,992</td>
<td>637,613</td>
<td>664,342</td>
<td>692,228</td>
<td>721,324</td>
<td>751,682</td>
<td>783,358</td>
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<td></td>
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<tr>
<td>2000</td>
<td>7,246</td>
<td>7,246</td>
<td>7,246</td>
<td>7,246</td>
<td>7,246</td>
<td>7,246</td>
<td>7,246</td>
<td>$32,000 principal, 9% i rate, 5-yr term</td>
</tr>
<tr>
<td>2001</td>
<td>619,238</td>
<td>644,859</td>
<td>671,588</td>
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<td>758,928</td>
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<tr>
<td>2002</td>
<td>10,436</td>
<td>19,249</td>
<td>28,842</td>
<td>39,271</td>
<td>50,593</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>$0 (cannot make an accurate estimate)</td>
</tr>
<tr>
<td>2004</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>$0 (cannot make an accurate estimate)</td>
</tr>
<tr>
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<td>0</td>
<td>0</td>
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<td>2005</td>
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<td>19,249</td>
<td>28,842</td>
<td>39,271</td>
<td>50,593</td>
<td>62,871</td>
<td>83,417</td>
<td></td>
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</table>
## STATEMENT OF SUPPORT AND REVENUE, EXPENSES AND CAPITAL ADDITIONS
(Assuming conversion to Assisted Living in FY1994)

<table>
<thead>
<tr>
<th></th>
<th>Actual Year</th>
<th>Projected Year</th>
</tr>
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<tbody>
<tr>
<td>Net patient service revenue</td>
<td>329,648</td>
<td>392,180 437,975 442,316</td>
</tr>
<tr>
<td>Investment income</td>
<td>23,158</td>
<td>18,272 18,450 13,275</td>
</tr>
<tr>
<td>Unrestricted donations</td>
<td>2,401</td>
<td>27,707 0 890</td>
</tr>
<tr>
<td>Prior year retro. income</td>
<td>1,703</td>
<td>0 0 0</td>
</tr>
<tr>
<td>Misc. income</td>
<td>1,407</td>
<td>571 428 3,660</td>
</tr>
<tr>
<td><strong>Total support &amp; revenue</strong></td>
<td>358,317</td>
<td>438,730 456,853 460,141</td>
</tr>
<tr>
<td>Dietary</td>
<td>113,286</td>
<td>110,640 113,805 121,508</td>
</tr>
<tr>
<td>Nursing</td>
<td>110,101</td>
<td>121,814 121,471 126,352</td>
</tr>
<tr>
<td>Admin. &amp; general</td>
<td>62,378</td>
<td>75,235 79,530 93,805</td>
</tr>
<tr>
<td>Plant expenses</td>
<td>44,371</td>
<td>46,072 45,014 37,904</td>
</tr>
<tr>
<td>Housekeeping &amp; laundry</td>
<td>42,398</td>
<td>44,572 42,806 44,801</td>
</tr>
<tr>
<td>Restor. &amp; recre. therapy</td>
<td>20,296</td>
<td>25,663 46,483 46,854</td>
</tr>
<tr>
<td>Depreciation</td>
<td>2,939</td>
<td>1,046 1,896 3,843</td>
</tr>
<tr>
<td>Interest expense</td>
<td>1,053</td>
<td>3,076 2,830 786</td>
</tr>
<tr>
<td><strong>Total operating expenses</strong></td>
<td>396,822</td>
<td>428,118 453,835 475,853</td>
</tr>
<tr>
<td>Long-term debt</td>
<td>0</td>
<td>0 0 0 0</td>
</tr>
<tr>
<td><strong>Total expenses</strong></td>
<td>352,451</td>
<td>382,046 408,821 437,949</td>
</tr>
<tr>
<td>Excess (deficiency) of support and revenue over expenses before capital addition (depletions)</td>
<td>(38,505)</td>
<td>10,612 3,018 (15,712)</td>
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<tr>
<td>Capital additions (depletions)</td>
<td>9,108</td>
<td>6,326 2,782 0</td>
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<tr>
<td>Unrealized loss on invest</td>
<td>15,663</td>
<td>(15,729) 899 3,690</td>
</tr>
<tr>
<td><strong>Total capital additions</strong></td>
<td>24,771</td>
<td>(9,394) 3,675 3,690</td>
</tr>
<tr>
<td>Deficiency of support and revenue after capital additions (depletions)</td>
<td>(63,276)</td>
<td>1,218 6,693 (12,022)</td>
</tr>
</tbody>
</table>
## STATEMENT OF SUPPORT AND REVENUE, EXPENSES AND CAPITAL ADDITIONS

(assuming conversion to Assisted Living in FY1994)

<table>
<thead>
<tr>
<th>Projected Year</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
</tr>
</thead>
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<td>609,004</td>
<td>621,185</td>
<td>633,608</td>
<td>646,280</td>
<td>659,206</td>
<td>672,390</td>
<td>685,838</td>
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<tr>
<td>Assumptions</td>
<td>20% increase in 1994, 2% increase /yr thereafter</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>1998 Assumptions</td>
<td>17,790</td>
<td>18,679</td>
<td>19,613</td>
<td>20,594</td>
<td>21,624</td>
<td>22,750</td>
<td>23,840</td>
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<td>1,000</td>
<td>1,000</td>
<td>1,000</td>
<td>1,000</td>
</tr>
<tr>
<td>2000 Assumptions</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>2001 Assumptions</td>
<td>1,000</td>
<td>1,000</td>
<td>1,000</td>
<td>1,000</td>
<td>1,000</td>
<td>1,000</td>
<td>1,000</td>
</tr>
<tr>
<td>2002 Assumptions</td>
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<td>1,000</td>
<td>1,000</td>
<td>1,000</td>
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<tr>
<td>2003 Assumptions</td>
<td>1,000</td>
<td>1,000</td>
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<td>1,000</td>
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<td>1,000</td>
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<tr>
<td>2004 Assumptions</td>
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<td>1,000</td>
<td>1,000</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>628,794</th>
<th>641,864</th>
<th>655,221</th>
<th>668,874</th>
<th>682,830</th>
<th>697,095</th>
<th>711,678</th>
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</thead>
<tbody>
<tr>
<td>1998 Assumptions</td>
<td>149,364</td>
<td>154,592</td>
<td>160,003</td>
<td>165,603</td>
<td>171,399</td>
<td>177,398</td>
<td>183,607</td>
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<tr>
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<td>177,790</td>
<td>186,679</td>
<td>196,013</td>
<td>205,814</td>
<td>216,105</td>
<td>226,910</td>
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<tr>
<td>2000 Assumptions</td>
<td>118,693</td>
<td>123,441</td>
<td>128,379</td>
<td>133,514</td>
<td>138,854</td>
<td>144,408</td>
<td>150,185</td>
</tr>
<tr>
<td>2001 Assumptions</td>
<td>50,795</td>
<td>53,335</td>
<td>56,001</td>
<td>58,802</td>
<td>61,742</td>
<td>64,829</td>
<td>68,070</td>
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<tr>
<td>2002 Assumptions</td>
<td>56,688</td>
<td>58,955</td>
<td>61,313</td>
<td>63,766</td>
<td>66,316</td>
<td>68,969</td>
<td>71,728</td>
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<tr>
<td>2003 Assumptions</td>
<td>59,285</td>
<td>61,657</td>
<td>64,124</td>
<td>66,688</td>
<td>69,355</td>
<td>72,130</td>
<td>75,015</td>
</tr>
<tr>
<td>2004 Assumptions</td>
<td>6,843</td>
<td>6,843</td>
<td>6,843</td>
<td>6,843</td>
<td>6,843</td>
<td>6,843</td>
<td>6,843</td>
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<tr>
<td></td>
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<td>1,000</td>
<td>1,000</td>
<td>1,000</td>
<td>1,000</td>
</tr>
</tbody>
</table>

|                  | 617,859 | 643,480 | 670,209 | 698,095 | 727,191 | 757,549 | 789,225 |
| 1998 Assumptions | 27,362  | 27,362  | 27,362  | 27,362  | 27,362  | 27,362  | 0       |
| 1999 Assumptions | 0       | 0       | 0       | 0       | 0       | 0       | 0       |
| 2000 Assumptions | 0       | 0       | 0       | 0       | 0       | 0       | 0       |
| 2001 Assumptions | 0       | 0       | 0       | 0       | 0       | 0       | 0       |
| 2002 Assumptions | 0       | 0       | 0       | 0       | 0       | 0       | 0       |
| 2003 Assumptions | 0       | 0       | 0       | 0       | 0       | 0       | 0       |
| 2004 Assumptions | 0       | 0       | 0       | 0       | 0       | 0       | 0       |

|                  | (16,427) | (28,978) | (42,349) | (56,583) | (71,723) | (87,816) | (77,547) |
| 1998 Assumptions | 0       | 0       | 0       | 0       | 0       | 0       | 0       |
| 1999 Assumptions | 0       | 0       | 0       | 0       | 0       | 0       | 0       |