The Future of Long Term Care, Including Assisted Living, Home Care and Legal Issues

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The Future of Senior Housing

I own a company, with a partner Wayne Kaplan, that owns and operates 25 assisted living and memory care communities in seven states and we are expanding and looking for more. By the way, if you know of any for sale let me know. I still have my license to practice law (and as a result, you'll get CLE credit for this portion of the presentation.) However, now I am full-time running the company and so I'm in a position to give you a pretty good insight into the senior housing business which I will do. Also at some point, I'll tell you how I transitioned from being a healthcare attorney, which I was for many, many years, into being a full-time businessman, in case you're interested in doing something along the same lines.

The senior housing industry segment is a large and expanding sector of the economy corresponding, of course, to the growth of the numbers of those who need it. I'm not going to spend a lot of time on statistics on the numbers of the aging population because you know them I'm sure. However, I will give you some figures on the senior housing industry itself. It is highly fragmented. There are few behemoths. Among the top 10, in terms of number of properties and number of beds, there are only four publicly traded companies. The largest, a publicly traded company, Brookdale Senior Living, headquartered in Nashville Tennessee, has over one thousand properties and recently acquired one of the other larger chains, Emeritus. Brookdale is having a great deal of trouble digesting that meal; its stock has suffered and its other metrics such as average census has as well.

Senior Housing Defined

Let me define and explain what senior housing comprises. It is generally viewed as consisting of three broad segments: independent living, assisted living, and skilled nursing. CCRCs, or Continuing Care Retirement Communities, are a combination of all three of these. Over half of the industry is nursing homes in terms of numbers of communities and numbers of beds. Independent living, according to the same criteria, is about 10% or 11%. CCRCs are 8% measured by number of communities and over twice that, or 20%, measured by the number of beds since they tend to be larger. By comparison, assisted living is 36% by number of communities but only 20% by number of beds, reflecting the fact that they tend to be, on the average, much smaller. Indeed, probably about two thirds of the assisted living sector is small "mom-and-pop" type of communities where one, two or maybe three locations are owned and operated by the same person or "mom-and-pop."

Independent living is, basically, multifamily housing for older folks. It is often age restricted to 55 years and older. It is usually strictly a monthly rental which can include one or more meals at a centrally located dining room as well as housekeeping services. Most importantly there is no assistance with the "activities of daily living." Very importantly it is not subject to licensure in any state. Here is where an interesting situation arises with the so-called "look-alikes."

Since licensing can be a time-consuming process and a heavy burden to shoulder operationally, it is tempting for some operators to create and operate a business that looks very much like it is a licensed assisted living facility, making many of the same services of assistance with activities of daily living available to residents, but not having a license from the state. This

is often done by having a home health agency come in and provide needed services to residents of an independent living building. Where it can get very sticky is if the same person or entity that owns and operates the independent living building owns and operates the home health agency that provides services to the residents of that building. NYSDOH does not like look-alikes and has taken some pains in the past to require them to secure licensure. Operators such as myself, who have gone to the time and effort of securing licensure, don't much like them either.

The reason and motivation for these look-alikes is that the independent living operator can keep residents longer in the building if a home health agency comes in to service them instead of the resident having to move to a higher level of care, such as assisted living or skilled nursing. Of course if that operator also owns the home health agency there are two streams of income to that operator and the home health agency has a captive population of customers.

The next segment of the senior housing business is **assisted living**. That, of course, is my sweet spot since we have a couple of dozen of those. By the way, memory care is usually considered part of the assisted living business. It certainly is not independent living and residents with memory care or Alzheimer's diagnosis are usually not quite sick enough to go into skilled, although it is a gray area as I will discuss further when we talk about skilled. Further by the way, the term "Alzheimer's" is sometimes thrown around loosely. I understand that the current state of medicine is that an Alzheimer's diagnosis can only be accurately done by an autopsy and there are a number of other reasons for memory loss, other than Alzheimer's, although I can't remember a lot of them. (That's supposed to be a joke.) However, you will frequently see discussions, signs, and advertisements for "Alzheimer's" facilities because the general public equates that with memory loss.

The major distinction between independent living and assisted living is, as mentioned, licensing which is required in every state for assisted living. Assisted living communities are called that because they provide assistance with the "activities of daily living." Those activities include bathing, dressing, medication management, grooming, transferring, toileting, and eating. There is no bright line test for admission to an assisted living facility although there is a requirement or test at the other end, for continued retention as a resident in assisted living.

What I mean is this. Anybody could walk into an assisted living facility and say, "sign me up, I want to move in." As a practical matter, potential residents usually have one or more needs for assistance with the activities of daily living. As a matter of fact, very few people move into any of our facilities willingly. This is another practical contrast with independent living. Frequently, someone 55 or older will voluntarily move into a nice gated community, independent living, where children are not allowed and they are not bothered with the hassle of maintaining their house and they can, if they wish, choose from a list of services available including dining, housekeeping and perhaps others. However, our residents and most assisted living residents move because they have to. (In the industry, assisted living is referred to as "need driven" for that reason.)

The typical potential resident has been living in their house for a very long time and the spouse (usually the husband) has passed away some time ago and the caregiver (usually a middle-aged daughter) has to exercise considerable influence to induce and produce a move to assisted living. What we usually see is that the potential resident, we will call her "mom," has not

been eating properly, the cupboard and the refrigerator are usually almost bare, not necessarily because of lack of money, but because of not getting out to buy supplies. Mom's friends have all passed away or moved away and she doesn't socialize but sits in the house all day watching television. She may have had a fall or two and for that, and perhaps other reasons, she has had to go to the emergency room a few times. At this age mom is taking usually half a dozen medications but the problem is, she's not taking them on a regular basis or at all. Ordinary tasks of life are neglected like paying bills, minor repairs around the house, etc. Mom either hangs around all day in a house dress or wears the same thing which is getting to look ragged and worn. I think you get the picture.

It's time to go to assisted living where all her needs are taken care of. All licensed assisted living communities are required to, and do provide: three nutritious meals a day; careful management of medications to make sure that they all are taken and at the right time; twenty-four hour a day and seven day a week supervision including case management and significant socialization provided if desired. (Usually not very long after a resident reluctantly moves in to assisted living, they have made new friends and are enjoying the socialization.)

So, in other words everything that was lacking and probably would cause an early demise, is provided, and for one fixed fee per month. In terms of the fee, or rent (and the topic of reimbursement will be discussed later on) while the amount varies from location to location, usually more in urban areas than rural areas, there are worksheets that the communities provide that show that the cost of living in an assisted living facility is comparable and sometimes actually lower than the cost of continuing to live in the old homestead.

I have mentioned that while there is no fixed criteria for entering an assisted living community there are state laws governing who can remain in an assisted living community, known as retention standards. State laws dictate that as a resident reaches higher levels of acuity, and they must be regularly assessed to determine this, at that point they must be discharged to a higher level of care, usually a nursing home. As might be expected, the Department of Health regularly and, of course at random, inspects licensed assisted living communities and one of the grounds for violation is that a resident needs a higher level of care and has not been discharged to a higher level of care.

At this point it's appropriate to describe specifically the New York state licensing system for what I have been calling assisted living. If one has a residence which gives assistance with the activities of daily living, a license is required, but that facility is licensed as, and is called, "an adult home." In order for such a facility to advertise and put a sign out calling itself "assisted living," there must be a second level of licensure procured called ALR or an Assisted Living Residence. It's a little strange but it is all in the name.

The next level of licensure is called EALR or, Enhanced Assisted Living Residence. What this means is a higher level of care can be provided, allowing residents to be retained longer before being released to some other facility such as a nursing home. The next and final level of licensure is called an SNALR which is a Special Needs Assisted Living Residence. As a practical matter, this is always for memory care (or as I mentioned before, what many people refer to as "Alzheimer's care"). Many ALR licensed communities provide some type of memory care, since it is an almost inevitable consequence of aging. However, without an SNALR license,

no community may advertise itself or have a sign saying it provides memory care or Alzheimer's care.

The last, and probably largest, segment of the senior housing industry in terms of number of beds, value of assets and sheer volume of payments including from the government, is the nursing home industry, which is often referred to as the **skilled** segment.

Unlike the other parts of the senior housing business where anyone can just walk in and rent, there are standards for admission to a skilled facility. This is determined by a prospective patient's score on a Patient Review Instrument or PRI which looks at a number of determinants measuring one's degree of illness. For this reason people in nursing homes are called patients because they are, basically, sick and in need of medical care. By contrast persons in assisted living communities are called residents. Assisted living is a "social model" not a "medical model." While we will discuss reimbursement for all the segments of senior housing later, it should be noted that Medicaid or government reimbursement is the principal source of income for the skilled sector. Many persons will start out paying privately out of their own pockets in a nursing home but the high expense usually exhausts assets and most people eventually go on Medicaid. I believe that, countrywide, Medicaid comprises about three quarters of the income for most skilled facilities. By the way, Medicare does cover the first 90 days of nursing home expense, provided it is immediately preceded by a stay in a hospital.

I mentioned that memory care can be a "gray area" in terms of where persons who have such a diagnosis can be housed and treated. Persons with this diagnosis are often found in licensed assisted living facilities, whether or not those facilities have the additional SNALR licensure. However, many are also in nursing homes. Such nursing home patients may have little or no physical impairment but qualify under the PRI analysis simply because of their cognitive impairment.

Continuing Care Retirement Communities, or CCRCs, are a combination of the three major segments of the senior housing business. By the way, sometimes you hear of these type of facilities referred to as "life care communities." Many years ago, earlier models of this type of care provided all needed care by all three levels for life for one large fixed payment and the term "life care" was more appropriate. A number of these facilities, many of which were located in California, went bankrupt because the residents lived too long and the cost of care exceeded the large fixed payment. Hence, the term has fallen into disuse.

By the way, most CCRCs countrywide are not-for-profit. This is also true, as you know with hospitals. That is not the case with nursing homes and assisted living communities most of which, but certainly not all, are for-profit.

The common and distinguishing characteristics of CCRCs is that there is an upfront fee called "an entry fee." Although practices vary, it is quite common for all or most of that fee to be returned if the resident dies or moves out. All CCRCs, however, also charge a monthly fee which usually covers maintenance and other charges. Accordingly, that decreases the probability that the CCRCs will go bankrupt because the resident outlives the initial entry fee. In these financial characteristics, CCRC is more like a condominium where there is a large payment, which is for ownership of the condominium, and continuing monthly payments for maintenance.

Reimbursement for Rent and Services

Reimbursement for services provided in these segments of the assisted living business is sharply different for each. Payment for independent living is private pay, always. As is well known Medicare and Medicaid by law can only be for medical treatment and, of course independent living is simply housing. This will be discussed later, so is assisted living but there is a difference provided by the Medicaid waiver programs.

Payment for nursing homes, depending upon whether nursing home is located, sometimes starts out as private pay but as noted because of the high cost, usually assets are exhausted and the patient is switched to Medicaid. In many areas in the country, the patient simply applies for Medicaid upon applying for admissions to the nursing home. Countrywide, about two thirds of nursing home residents are on Medicaid. As is well known there are income and asset limitations for eligibility for Medicaid and there is a small elder law specialty in working around these limitations by setting up trusts for assets owned by potential Medicaid nursing home applicants or transferring these assets to relatives all of which must be done before the five-year "look back" period of time.

Nursing home Medicaid reimbursement has been the subject of numerous studies and significant legislative concerns because of its enormous and increasing cost. Another presentation today will discuss a new approach to this.

As has been stated, assisted living, a social model, is housing just like independent living with, however personal care services. State law significantly limits provision of any medical services in a licensed assisted living community. Even in an EALR and SNALR licensed facility, it is not much more than case management, which is regular assessments to determine if a higher level of care is needed, and medication management (although EAR and SNALR license communities do employ RNs.) Accordingly, payment for assisted living is also private pay with a few exceptions.

Long-term care insurance covers assisted living but it is very small part of the income of any community at this point and probably well into the future.

Supplemental security income, or SSI, while not paid directly to any licensed facility, is income which a resident can use to pay for the cost of assisted living. This payment which in the old days used to be called "welfare," is available to residents whose income and resources are below a certain level. This is, unfortunately, something common to the elderly. The problem is that SSI is only $1,429 a month which is not enough to pay for the rent at almost any assisted living facility.

Aid and Attendance is payment made by the Veterans Administration to veterans and spouses of deceased veterans under certain circumstances. Generally, it is paid for any veteran who served anywhere at any time when there was a war on which, as we all know, is quite a bit of this country's history. It is only about $1400 a month. However, Aid and Attendance and SSI combined begins to be an amount that most assisted living facilities will accept.

Medicaid Waivers and ALP Beds

There is another significant source of reimbursement for assisted living communities in New York and that is Medicaid. Although as mentioned, by federal law, Medicaid can only be for medical services, there are "waiver" programs in every state, including New York, which allow Medicaid payment, under certain circumstances to be used for assisted living services. These Medicaid waiver laws came into effect a number of years ago driven by a couple of factors. The first was that Medicaid was, and is, for every state a major portion of the state budget and most of that Medicaid payment is for nursing home services. The second is that there was, and probably still is, a significant number of nursing home residents who can be adequately treated in assisted living communities. It is also a fact that the cost of assisted living is significantly less than the cost of nursing home care.

The combination of these factors led to pressure upon the federal government to grant "waivers" to the states to allow Medicaid to be paid to assisted living communities for assisted living services to persons who were not quite sick enough for nursing homes. This is believed to have saved states a lot of money. In New York these Medicaid beds are called ALP beds and are highly prized and coveted by most assisted living operators. The payment level is one half of the nursing home rate in a particular county where the assisted living facility is located. This is usually not much less than the private pay rate for those facilities.

The New York State Department of Health regularly sprinkles ALP beds around the state, where they are needed and they are hotly competed for by assisted living operators. The easy and obvious reason for this competition is the well-founded belief that there are lots of potential Medicaid residents around and it is easy to fill those beds. While this is true, and an ALP assisted living community of a certain size can stay in business and make money, there is another not so obvious but important business consideration. An ALP licensure requires that a home health agency be set up and maintained by the facility to provide services to the Medicaid residents. It is called a Licensed Home Care Services Agency or LHCSA and it provides homecare services such as nursing, PT, OT speech therapy etc. The staffing requirement of that agency and the staffing requirements to comply with the ALP licensure generally are significant requiring, among other things, 24-hour nursing staffing by RNs and LPNs. (By the way, RNs and LPNs are not, by law, required to be employed by New York licensed assisted living communities. Although many do employ them, they are not allowed to provide nursing.) Accordingly, while for a certain size ALP community, certainly 100 or 200 beds, profits and continued operation are possible, for a small, a ten or perhaps even a twenty bed ALP, because of the overhead, principally staffing costs, it is a money losing situation.

There are other issues as well for ALP beds but none as large as that discussed above. For example, in an assisted living facility, if a resident has to go to a hospital for a period of time, the rent is still due and must be paid. Medicaid does not pay the assisted living facility while the resident is in hospital. They obviously don't want to pay double. Moreover, and fairly significantly, when a resident moves into an assisted living community and cannot pay the rent but may be eligible for Medicaid, application is made and, hopefully it is granted by the Medicaid administration for Medicaid coverage. (If such application is not granted, the assisted living facility is stuck with a resident who cannot pay the rent. Needless to say, although it is

legally possible, for many reasons it is difficult and unpleasant to evict an assisted living resident for nonpayment of rent.)

However, even if Medicaid coverage is granted, there is a period of time, which can be months, before a check actually arrives from Medicaid. A private pay resident pays the first month's rent up front, just like renting an apartment which, basically, it is. These months of delay in payment for Medicaid resident multiplied by a number of Medicaid residents can add up to a large amount. Again, if there are 100 or so ALP beds it's not so much of a problem; not so if there is a small number of ALP beds.

The Future of the Senior Housing Industry

So that is the senior housing business as it exists. Now let's talk about its **future.** Let me start out by correcting one widely held misapprehension, that the so-called silver tsunami of baby boomers is upon us now and is creating a huge demand for senior housing. Not so; that won't happen for another 10 or 15 years. Baby boomers are those born immediately after the end of the first world war in 1945 when all those soldiers came home and started creating babies. 1945 is 72 years ago. The average age of the folks in our facilities, which are typical of most, is in the mid-80s.

Moreover, as time goes on and healthcare improves overall people are delaying retirement and working longer. Depressed economic circumstances also cause older people to remain on the job longer and in their homes longer, if they can. Of course depressed economic circumstances also means that potential residents are less likely to be able to pay the rent. Both of these factors combine to moderate demand. Not good news for the senior housing industry in general.

It is increasingly difficult for the senior housing business to attract workers. The majority of senior housing workers, the food-service workers and aides the direct hands-on caretakers, are low-paid and nearby fast food restaurants and even the shrinking bricks and mortar retail sector are hot competition for the same worker pool. There are two future possible trends that strongly influence the depth of that worker pool. If the economy gets worse those jobs will become more attractive to more people. In those areas where we have communities where the demographics show greater concentration of higher income population, while it may be a little easier to get private pay residents there, it is harder to get employees. If there is less immigration, although all licensed facilities are usually under pressure to hire only documented workers, that will mean it will be harder to get these kind of workers.

There will probably be increasing consolidation in the senior housing industry, especially in assisted living. As noted earlier, it is a highly fragmented portion of the senior housing industry, and many are quite small. For example, in Florida half of the assisted living communities are under six beds and 70% are under 20 beds. There will be limited consolidation by acquisition of the smaller properties by chains of communities because the smaller properties are simply not attractive acquisition targets. It is difficult if not impossible to run a stand-alone community of under 20 or 30 beds profitably. There are simply no economies of scale. In Florida, for example, there are a large number of people who have converted their homes into assisted living (and secured licensure for such) and they live there and provide services to their

few residents. As those owner/operators age out or pass away they will find very few potential buyers. This is unfortunate because a very small town that has such a very small assisted living community will then have no assisted living community.

Also, when the so-called “baby boomers” start looking for assisted living or even independent living their standards will be higher than those that satisfied residents of past years. They will look for larger living spaces and more amenities such as: more elaborate and up-to-date fitness centers; perhaps indoor pools; more elaborate common areas including small movie theaters; more technology such as Wi-Fi throughout the facility and more high-tech health saving and preserving gadgets. This is hard to do in a small assisted living facility. Those that can’t compete and attract paying residents will go out of business.

High-tech and health saving gadgets are becoming prevalent in the more modern assisted living and even an independent living communities. These include sensors which communicate to a central area and/or ring an alarm when a resident gets out (or falls out) of bed and other motion sensors and tracking devices to enhance the supervision capability of the frail elderly.

With respect to the concept of the “frail” elderly, a trend that has been increasing in recent years and will continue to increase, is higher acuity of persons moving into assisted living. In many cases those residents are persons who would have been in nursing homes many years ago. One of the drivers of this trend is increasing availability of technical devices and care approaches which enable people to stay in their homes longer, which any older person will always prefer to do. Therefore, when a move into assisted living becomes inevitable and unavoidable, their condition will be much worse and they will require much more care in the assisted living facility.

The Internet has had a huge effect on many segments of our economy. For example online marketing has dealt a blow, almost fatal, to many bricks and mortar stores. Not really for senior housing. Senior housing, all segments, is a local and hands-on type of business. It is sometimes described as “high touch not high-tech.”

For example, Internet marketing is a huge commercial area but it is of limited utility for most senior housing operators because they draw their residents from only 5, 10 or maybe 15 miles away. Thus, even radio or television advertising as part of the marketing budget, is usually not money well spent. Although many vendors aggressively try to convince senior housing operators of the absolute necessity of Internet marketing, including search engine optimization or SEO, our experience has proved it to be relatively useless because of the difficulty and probably impossibility to target the relatively tiny geographic area that is defined as the “primary market area” of a particular senior housing community. Of course the national operators such as Brookdale use all kinds of marketing media including television and the Internet because they have national brand. However, the smaller operators including even the smaller regional operators like ourselves usually do not use the Internet for marketing and probably will not do so in the future.

By the way, this is not to say that a good website is not important. It is of great importance in “selling” a community. We usually ask how a prospect has come to a particular community and most frequently it is word-of-mouth from neighbors or relatives of present

former residents. Many times a prospect says they looked at our website. However, when we ask how they got to the website, it is always that they got some local recommendation, for example from a neighbor, and then went to the website to check it. It is never through a search engine. The only time that Internet marketing and a search engine has ever come through for us, and I mention this because I think it's typical for many operators our size, is if there is a son or daughter who is posted on the job way far away from where mom lives and who believes that mom needs to move into assisted living and does a search for assisted living near where mom is. We have had a State Department employee in Indonesia who contacted us to acquire about availability of accommodations for a parent who was a few miles from one of our communities in New York. That State Department employee in Indonesia found us through the Internet. That's very rare however, and accordingly at least in our experience and from what we understand in the industry generally, Internet marketing is of little or marginal utility.

How will foreseeable future changes in laws or the economy affect the senior housing industry? Probably not a great deal. It was mentioned that when the economy dips so does our census because people stay in their homes longer and have a harder time finding money to pay the rent. It was also mentioned, however, that ours is a "need driven" business. People come to assisted living and nursing homes because they have no other choice and must do it. Independent living is more elective and optional and, in an economic downturn, that segment of the industry really suffers. The recent downturn beginning in 2008 adversely affected all segments of the economy. However, senior housing, and in particular assisted living, was as a percent less seriously affected than any other segment of the economy. It is certainly not recession proof but is certainly recession resistant.

An economic downturn also slows down development of new properties. Lenders become more cautious as do investors. Again, however, as evidenced by experience during that same recent recession of 10 years ago, while new construction in multifamily housing, office buildings or any other area may have ground to a halt, there was still some activity in the development of senior housing, simply because of the accurate perception that there continued to be a growing supply of future customers.

On the other hand, as the economy expands or even heats up, there is a quite different and somewhat distressing trend of "irrational exuberance" in development of projects for senior housing. There are clearly now certain areas of the country that are thought to be overbuilt, particularly for assisted living and independent living projects. The experienced and cautious senior housing developer will always do a conservative market study of the area where the prospective development project is located before taking any further steps to develop a new project. A market study, prepared and conducted by one of the many national experienced experts in this area, will use a combination of existing and projected demographics, the existing competition within the primary market area and, to the extent ascertainable, the planned or proposed similar projects to arrive at a needs analysis. The needs analysis will show that, for some period of time in the future there will be a need for a certain number of beds of assisted living, memory care, independent living or skilled, whatever is the proposed project by the developer. If the market study shows a need for 400 assisted living beds, for example, then the construction of some number, for example 100 or 200 beds, would justify the investment of time and effort to develop the project.

We frequently are called by developers, real estate brokers, or simply landowners who, hearing that there will be large numbers of old people in the country in the future, think that a particular parcel of real estate that they have would be ideal for senior housing. They go on to list all the benefits of their real estate, describing how it is near stores, bowling alley or some such thing. My first reaction is, do you have a market study, and if so send it over before I hear another word? Market studies are not expensive, a few thousand dollars, and all lenders and investors in senior housing required them. As a potential operator of any future development project we certainly do as well.

While the economic future of the country will certainly affect the future of senior housing, it is unlikely to have a huge positive or negative effect. The same is probably true with any legal changes on federal or state level.

There are a few federal laws that impact the senior housing industry. Certainly greater attention to, or more stringent inspection and regulation of, nursing homes is always popular with federal regulators and the public. However this is expected, anticipated and part of the cost and the burden of doing business in that industry segment. Nursing homes, and for that matter assisted living and memory care, are necessary and will never be so burdened that they will go out of existence.

The usual laws and regulations that affect all businesses in the country also affect the senior housing industry. For example, there were proposed changes in the federal employment regulations last year to change the definition of what employees were exempt from being paid overtime (time and a half) for working more than 40 hours a week. The wage level for employees subject to being paid overtime was proposed to be raised, thereby including many more employees who would not otherwise be classified as “exempt” employees and therefore would be subject to being paid overtime. While that proposed change is now under review and may not go forward, if it had and if it does, it would increase operational expenses for senior housing as well as, of course, every other business in the country. There were no other proposed or even discussed changes in federal regulation which would impact the senior housing industry that I know of.

Medicaid, which does support a great deal of the skilled sector and is a significant source of income to assisted living as well, could possibly be decreased on the federal level which will then affect the state level. It is unlikely that any change, specifically any decrease, would be so drastic as to drive a significant number of operators out of the business, although some would suffer economic pain. Any such Medicaid decrease would of, course drive operators to secure private pay residents in place of Medicaid residents. However, except for some large Medicaid operators in urban areas, for example operators of large multi-hundred bed facilities in New York City, a Medicaid decrease would not have significant impact on assisted living. While there are no proposed changes in institutional Medicare reimbursement, it is also a nominal source of income for the senior housing industry.

As mentioned, while the senior housing industry is required by law and usually does only employee documented immigrants, any significant constriction in immigration will, nonetheless, affect the availability of the lower paid, and by far the greatest number, of employees in the

senior housing industry. On the other hand a downturn in the economy would make more of those same type of employees available.

Healthcare benefits are a significant component of compensation expense which, itself, is by far the largest operational expense of senior housing. Repeal or significant modification of the Affordable Care Act, while probably having an adverse effect on the public at large and the employees in particular of senior housing industry, will decrease the financial burden on operators if it eliminates the legal requirements to provide any specific levels of healthcare benefits or, perhaps, any benefits at all.

State laws, on the other hand, are much more of concern, more visible and have much more effect on most segments of the healthcare industry and senior housing is no different. Indeed, even independent living is probably much more affected by local zoning and building regulations than by any federal legislation. New York State licensing regulations for skilled and assisted living are comprehensive and constantly changing but usually in, minor ways.

For example, there was a recent change in the regulations applicable to securing licensure for assisted living facilities in New York or change of ownership of such facilities. Both of these procedures have for many years required a long time, because of lack of staff at the state level. Recent regulations provided that if an applicant has secured a license or gone through a change of ownership procedure within the last two years, then such subsequent application within such two-year window, would take no longer than 60 days. There has been some confusion about the implementation of this new regulation. Virtually without exception, every applicant for licensure does so with a "special purpose entity," which entity is created and used solely for the purpose of operating that particular facility at that location. Therefore, such an "applicant" would never apply for another license or a change of ownership. It is thought now that NYSDOH will recognize reality and practicality and provide that the parent entity of applicants will be able to take advantage of this new shortened time frame.

Becoming a Businessman

Okay, now the bonus portion of the presentation: how to jump from one side of the desk to the other – from being a lawyer to being a client. My company uses lots of lawyers for specific purposes. Obviously, since both myself and my partner Wayne are lawyers, we are not about to call lawyer for something we can do ourselves. However, we also know our limitations. For specialized work such as real estate closings or employment issues and so forth we use lawyers local to where we have our properties. Any lawyer who becomes a businessman usually has the good sense to do that. However, a businessman who is also a lawyer does have certain advantages in negotiations and having a basic knowledge of the legal system.

I didn't start out as a healthcare attorney because when I started out there really wasn't any such specialty. I started work just out of law school for a law firm which was very large for that time, 100 lawyers, called Sullivan Cromwell. I did basic litigation at S&C and then spent some time in the public interest area up at Columbia University and started a project, which I still believe exists called Legal Services for the Elderly Poor. At about that time, Medicare and Medicaid money started flowing into the economy creating a lot of legal questions as well. That combination, of money and legal issues you will recall, gave birth to the health law specialty. I

then got another grant from the Office of Economic Opportunity for something I called the Health Law Project because I saw that many of the legal issues of the elderly poor were related to healthcare.

As that grant tailed off, many of my clients were in the healthcare area and that continued for many years after I and a few other healthcare lawyers founded Epstein Becker Borsody and Green. I'm sure many of you will understand that, as a healthcare attorney I dealt with many doctors, hospitals and businessmen who wanted to start new ventures, often in combination with each other. One of the first things they did is go to a healthcare lawyer for counsel, since it is such a heavily regulated area. I spent a lot of time advising startups and business venture combinations in the healthcare area, advising them as to many business-related issues including how, where, and whether to secure financing. I became very familiar with a number of sources of financing and they became familiar with me.

One of the important things to do when starting a business and being a businessman is to know how to get financing for the business you are starting or buying. Perhaps you have heard the expression "money talks," well it does, and loudly. Lots of people have great ideas and lots of people have a lot of talent, but to start and operate any venture takes financing and not so many people have that or can get it.

The best way to finance new businesses is to write a check from your savings or get the money from people you know. In the business area that's called "family and friends" financing and there are a lot of advantages to that, but if you don't have that you have to find other sources. Frequently, somebody with money or access to money who is looking to start a business, partners with a lawyer basically, to save money. The money source brings in the lawyer as a partner with the understanding that the lawyer will provide legal services for free to the budding business venture. If the money source has any sense, and most do, the lawyer will not get much of an equity interest for the free legal services. Also, of course that lawyer better have some current paying clients to support him until the business takes off and can pay him enough profits to do so. So, lots of lawyers take a "piece of the action," compensation in the form of stock, or options or something like that, when they help to start a new business. However, that's not really being a businessman or an entrepreneur, that's just another form of investment. Although the lawyer may have a little more personal interest and knowledge of the business that he has received an interest in, in exchange for helping to found it, he doesn't really have a hand on the tiller and a say in the operations.

In order to really jump over the desk and become a client and not a lawyer (although one can never really shed that legal training and the utility that it brings, as I mentioned) you have to give up part or all of your law practice and become full-time committed to operating the business that you own all or part of. However, you do need to have financing to start the business. If you start small enough and therefore need very little money you may be able to do it yourself, perhaps with a money partner who may give you not only a large ownership interest in the small, start up business but also a hand in the operations if you actually bring some knowledge and ability in that respect. However, all lawyers do not make good businessman, I'm sure that will not surprise you to hear. Indeed, having been involved in the growth, management and operation of a law firm that attained a certain size over the years I can tell you that many, many lawyers who have excellent legal skills have very poor business skills. For example, many excellent

lawyers are very bad about sending out bills to clients and even worse about collecting those bills. That particular function, billing and collecting, is pretty important to every business including the legal business.

Getting to my particular history in this respect of "jumping over the desk," I was fortunate to be introduced to my partner Wayne Kaplan by an investment banker we both used and he had a long and very good background and history in senior housing. This gave our new company the credibility it needed for access to capital. The second step was using REIT financing and syndications to investors for our initial acquisitions.

As most of you know a REIT is a real estate investment trust that acquires real estate and rents the real estate to a business that occupies the real estate and pays rent to the REIT. There are many kinds of REITs that specialize in different business sectors including of course, the healthcare sector. The way REIT financing works is as follows. A REIT may acquire a nursing home for $10 million and then triple net lease that nursing home to an operator who will pay rent, say 8% of the acquisition cost or $800,000 year, to the REIT. REITs need operators because they do not, and cannot, operate the properties they acquire. (There is a minor variation here created by the "REIT Investment Diversification and Empowerment Act" or RIDEA which allows REITs to share in the operation, but there's no need to get into details like that here.)

So, stopping right here, it looks like you could get into the business of owning and operating a senior housing property for free. The REIT buys it and leases it to you; you pay the rent; and hopefully there's something left over for you to take. There are a couple of pretty large bumps in the road on the way to this "free lunch," however. First, unless you have a long history with the REIT and even then it is unusual, there will be a security deposit required for the rent, just as if you rent an apartment. This is determined by credit considerations and analysis that the REIT makes of the soundness of the business that they are acquiring and the history of the owners, that would be you. It could be nine months, six months or perhaps as little as three months' rent. In the $800,000 year rent example that I gave above, you do the math. While, technically and legally, that security deposit is your money, you won't see it until the end of the lease which could be 10 or 15 years later so, in effect, that's the price of entry into the business.

But that's the easy part. The landlord REIT needs to make sure that the rent will be paid. While the nursing home, in my example, may be a solid business with a good history of sound operation, the skill, experience and capability of the operator is critical to the continued sound operation of the nursing home and, accordingly, the ability to pay the rent to the REIT. That is where the typical lawyer, getting into this business would usually need a partner with good operating experience. I had the good fortune to hook up with Wayne Kaplan who had that.

The other form of financing, which Wayne and I started out with, and you could as well, is syndication to investors. Similar considerations apply to raising money from private equity. Again let me give you an example. You want to acquire a nursing home for $10 million. It's fairly easy to get debt financing at up to 80% LTV (loan-to-value) from a number of sources, usually a HUD 232 guaranteed mortgage. Although, again HUD in doing its underwriting for that mortgage guarantee, looks at the operating experience of the owners, since they want to make sure that the debt is serviced and their guarantee will not have to be called upon, that is not the only time where operational experience is needed. In my example, for the $10 million

acquisition, although $8 million could be secured by the debt financing that we mentioned, there is $2 million of equity needed. Unless you can write a check for that, you can raise it by a syndication to investors (although most syndicators would not look at a syndication this small because the fees would not be enough for them) or you could go to the numerous equity sources that want to invest in senior housing. We are approached by many of them on a continuous basis, everything from foreign sovereign equity funds to family offices or numerous other kind of funds. However, the common characteristic, whether it is syndication to investors where the experience of the proposed operators who wish to acquire this nursing home is described in an Offering Memorandum to the potential investors or a sit down meeting with one of the private equity funds, the topic will be the experience in operating the nursing home to be acquired. Obviously those investors, just like the HUD underwriters who want to make sure that the insured debt will be serviced, want to make sure they will get a return on their investment and, of course, not lose their investment through incompetent management.

There is another wrinkle when seeking investment, especially from private equity but sometimes also in a syndication, and that is co-investment from the operator. In order to incentivize the operator to stick with it and not throw up their hands and walk away and also to assure attention to maximizing profits, some amount of investment by the operator is usually required. This is known as requiring "skin in the game," and is standard in the investment community. The amount of this required skin in the game can vary and usually does, according to the confidence that the money source has in the operator, but it is always something. In the example I have given of needed $2 million equity, it could be as little as 10% or $200,000.

By the way, in order to avoid putting in cash or as much cash skin in the game, an approach that I have often tried, with little success, is to offer a guarantee, including a personal guarantee, in lieu of cash. For example, in the recent past in discussing a $100 million acquisition; a 70% LTV debt arrangement and, therefore, a $30 million equity requirement; and a request for 20% skin in the game or $6 million which we did not happen to have lying around, I proposed a personal guarantee. I proffered what I thought was the excellent reasoning as follows. I argued that, instead of just merely putting in money which any operator, if things really got bad might make up his mind to walk away from, a personal guarantee would provide a great incentive for continued diligent attention to operation to turn around a sagging business, because otherwise the operator would have to come up with that money out of his pocket in the future. The money guys who I tried this argument out on, who had probably heard it before, said they were not interested in chasing somebody if the deal went south. Accordingly, you will have to reach into your pocket if you go to private equity or probably even a syndication to get the skin in the game equity portion of any acquisition or development.

What I think I have made clear is that when securing financing, either REIT financing or any other form of debt or equity, what it comes down to is the experience of the operator which, very sensibly, is a major determinant of the success of any business including, of course the healthcare business and, specifically, my business of assisted living and memory care and the other components of senior housing. If you don't have it you will have to find it in the form of a partner who has that experience. By the way, although this should be obvious, the operational experience has to be as close as possible to the business proposed to be acquired. In the early stages of my transition from full-time practicing lawyer to an entrepreneur I considered teaming up with some other operators who were very skilled and experienced in other businesses, even

some as close to senior housing as the hospital business, but it was no dice. In order for debt or equity sources to have confidence they need to have an operator who knows how to operate the very business under consideration for acquisition.

I think a lot of what I have said, especially in the last part of this discussion, is probably obvious to many of you and for that I beg your indulgence for having taken your time. Indeed, some of it may be at odds with your own knowledge and experience and for that I would be very grateful in the getting your input to correct or amplify my own knowledge. One of the things I have learned, which has contributed to my success in this business, is how little I know compared with many other people. Simply said, the more you know the more you realize how much more there is to know. With that I will close my presentation and thank you for your attention.

By the way, in the event that any of you want to learn more about the senior housing business I'm posting a link to a CLE presentation which we put on for the Health Law Section about a year and a half ago which provides more information. Here is the link: http://www.nysba.org/seniorhousing2016/.