Joint Center for Housing Studies
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Affordable Assisted Living:
Surveying the Possibilities

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The Volunteers of America is a national, nonprofit, spiritually-based organization providing local human service programs, housing, assisted living, and long term care.

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Executive Summary

The growing number of frail seniors in the U.S. has prompted considerable concern over the provision of long-term care. Seniors are living longer and staying healthier than at any point in history, yet most seniors reach a point when they need some assistance with activities of daily living[1]. Because of demographic and lifestyle changes, such as increased mobility, smaller family sizes, and the increased proportion of women in the workforce, seniors are less likely to move in with adult children as a means of receiving such needed assistance. Over the past decade, a private market in assisted living has emerged to address this intermediary stage between independent living and skilled nursing facilities. Assisted living facilities offer a combination of housing, supportive services and personal care (not including medical care) that enables frail seniors to maintain maximum independence while receiving the assistance they need. While assisted living has become an increasingly popular option with upper- and middle-income seniors, the high costs of the product put it out of reach of low- to moderate-income groups. However, as the number of frail seniors at all income levels increases, the housing and care needs of lower-income seniors must also be addressed. In particular, this will require a discussion of how public funds can and should be used to cover a portion of the housing and care needs of low-income seniors. Currently assisted living receives minimal public funding, although Medicaid funds are used extensively for nursing home expenses. As consensus grows that assisted living offers a more desirable environment to consumers, as well as potential cost savings to the government, there should be a concerted effort to provide assisted living that is affordable to seniors of limited means.

This paper examines the demand for affordable assisted living, lessons from the private-pay market, and specific challenges of assembling a financing package to subsidize the development

[1] Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) are the recognized benchmarks for assessing whether seniors need assisted living services. A discussion of ADLs and IADLs is included at the end of this paper.

and operation of affordable assisted living facilities. Key findings from the paper are presented below.

Section 1 reviews the senior population, focusing on factors that are relevant to the potential market for assisted living, and particularly for an affordable product. There is a large and growing number of frail seniors who require assistance with daily activities. Many of those seniors cannot afford private pay assisted living.

- Of the 35 million seniors in the U.S., 35 percent are between 75 and 84, while 12 percent are over age 85. The need for assistance increases dramatically with age. Although only 4.5 percent of the senior population resides in nursing homes, 18 percent of seniors age 85 and older live in nursing homes. An estimated 1.4 million seniors received assistance with two or more activities of daily living in 2000, and this number is expected to rise to 2.7 million by 2030.
- Over nineteen million seniors (nearly 55 percent of the senior population) have annual incomes of less than $15,000. Another 7.5 million seniors (22 percent) have incomes less than $25,000. These seniors would require significant financial assistance from families or government to afford private-pay assisted living.
- Physical needs tend to be higher for low-income seniors. Older renters are more likely to need assistance than older homeowners, and subsidized older renters have higher rates of physical difficulty or disability than unsubsidized older renters.

Section 2 examines lessons from the private-pay industry. The experience of the private-pay industry reveals that assisted living is a costly, operationally complex product.

- Fees at most private pay assisted living facilities range from $2,000-$4,000 per month, with a national average of $2,159. Roughly 35 percent of this pays for housing, the

remaining 65 percent for services including meals. Assuming that seniors are willing to pay around 80 percent of their income for a combination of housing and services, a post-tax annual income of $32,385 would be needed to afford the average private-pay facility.

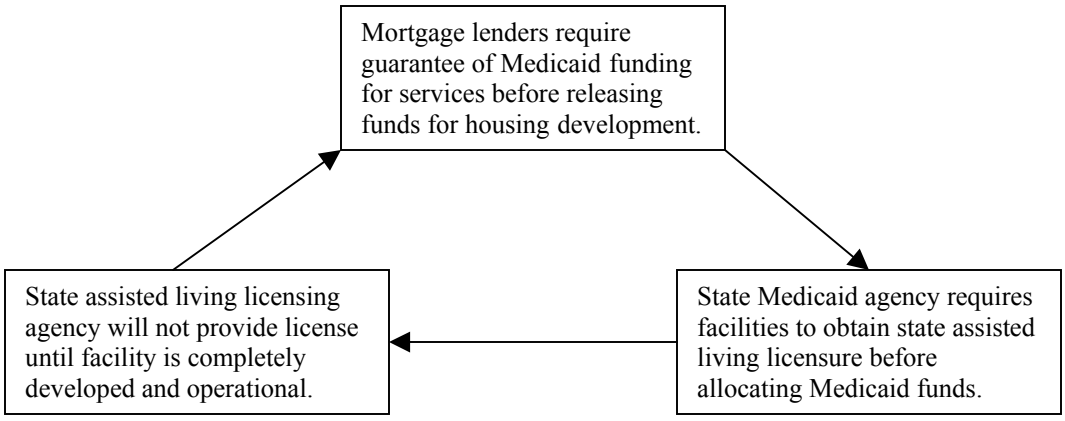
- Average nursing home fees are over twice as high as average assisted living facility fees. However, to date public funding has been more widely available to cover the costs of nursing homes than assisted living facilities. In 2001, government funding accounted for only five percent of the revenue in assisted living, compared to 70 percent of the revenue in nursing homes.
- The combination of housing and supportive services makes assisted living operationally difficult. Providers need expertise in housing development, housing management and service provision, or must find partners that complement their strengths.
- Seniors are reluctant to leave an independent living situation, and the decision to do so is driven more by poor health, retirement, or the death of a spouse than by economic variables such as income and housing prices. Seniors generally prefer to remain in their current homes, indicating a potential need for assisted living services in seniors facilities generally intended for independent living.
- During the 1990s, the private-pay market experienced problems with demand estimation, resulting in over-supply and financial difficulties for many facilities. As a result, lenders and investors are nervous about further support of assisted living in both private and public markets.

Section 3 presents the various funding mechanisms that can be used to develop and operate affordable assisted living. To bring down the costs of assisted living into a range affordable to low- and moderate-income seniors, project sponsors must access a variety of subsidies for

housing development, housing operation, and service provision. The various subsidy programs are not easily combined, adding more difficulty to developing an already complex product.

- Most subsidies cover only part of the costs of assisted living. For instance, low-income housing tax credits can be used to lower the costs of development, but do not cover housing operation or services. Even programs designed to facilitate the development of assisted living, such as HUD's Assisted Living Conversion Program, cover physical development or rehabilitation and housing operations but not services. Assembling a package of funding sources is difficult, time-consuming, and costly. At best, the complexity of financing delays the development process and drives up costs. At worst, it discourages potential sponsors from attempting to develop affordable assisted living at all.
- The various eligible public funding sources are administered through a number of different federal, state and local agencies, including the federal Department of Housing and Urban Development; state housing finance agencies, local housing authorities, and state Medicaid administering agencies. Each agency – indeed, each program – maintains different income eligibility standards, different sponsor eligibility requirements, different application timelines, and different levels of understanding of assisted living as a product.
- Each state sets its own regulatory guidelines for assisted living. Some states follow a primarily medical model in which assisted living is quite similar to a skilled nursing environment. Other states follow a primarily residential model.
- Funding for the service component of assisted living is generally provided a few years at a time. By contrast, development of the physical facility requires a long-term mortgage loan plus long-term housing subsidies. Sponsors, lenders and providers of housing subsidies are reluctant to commit development funds up front when there is a risk that the service funding may not be renewed.

- The fragmentation of oversight results in regulatory confusion, political instability over the reliability of funding, and further exacerbates the concerns of private lenders and investors who view assisted living as a risky undertaking. The graphic below illustrates a typical Catch-22 situation in developing affordable assisted living.



To address the problems created by the complicated and poorly integrated housing and health care funding systems, several states have begun initiatives to facilitate the development of affordable assisted living. Section 3.6 outlines initiatives taken by Florida, Maine, Massachusetts and Michigan.

- Because so many of the funding programs are administered through state agencies, state governments are well positioned to link explicitly housing and service funding sources. Michigan has a pilot program that reserves Section 8 vouchers for Medicaid waivers recipients. Florida is experimenting with project-basing Medicaid for a more stable source of revenues.
- Successful efforts require coordination between state agencies. In Massachusetts and Florida, the departments of Elder Affairs have taken the lead on state initiatives, working closely with the state housing finance agencies, Medicaid administering agencies, and project sponsors, including local housing authorities.

- Targeted state funding programs are intended to enhance provision of assisted living and may be part of a fiscal effort to make better use of Medicaid funding. Maine has made a concerted effort to shift spending on long-term care towards home- and community-based care as a means of covering more people with limited funds. Medicaid is a crucial source of funding for services, but budget shortfalls are pressuring many states into tighter allocation of Medicaid even as the size of the senior population is expanding.

Despite the seemingly overwhelming challenges to developing affordable assisted living, a number of public agencies and not-for-profit organizations have managed to develop affordable assisted living or similar housing-with-supportive-services arrangements. Section 4 of the paper presents profiles of several projects that were successful in navigating the complex regulatory frameworks and multiple finance systems to assemble the necessary funding for assisted living that serves very-low, low and moderate-income seniors. The project profiles illustrate both the complexities involved in developing affordable assisted living and the ingenuity of project sponsors in adapting to their varied and complex environments.

- Each project uses a unique combination of funding sources, but all include separate sources for housing development, housing operation and supportive services. Two projects rely entirely on federal funds, the others use a combination of federal, state, local, and foundation sources. As might be expected, the complexity of financing packages depends on the underlying costs; the two most complex deals are in the high development cost areas of Cambridge, Massachusetts, and San Francisco.
- All projects rely at least partially on Medicaid funds to cover service provision. Several sponsors reported that the amount of reimbursement was insufficient to cover actual costs of services and had sought other supplements.

- The model of service provision is often driven by state regulation of assisted living. Only two of the projects profiled are licensed as assisted living; two are registered but not licensed and one combines independent living apartments with a licensed adult day health center.
- A variety of financial and regulatory problems can cause significant delays in the development process. One project had difficulty obtaining local zoning approval, another experienced delayed release of funds from HUD.
- Each project was built on the relative strengths of the team members. Development and management teams were assembled to include expertise in financing, housing management, service provision, and health care. All lead developers had strong existing ties to current or potential residents, funding agencies and the community at large.

Finally, Section 5 offers some possible policy options and recommended strategies to facilitate what is currently an uphill task. Any effective effort to promote the development of affordable assisted living will require greater coordination between all the players as well as targeted initiatives by government agencies, foundations, research and professional organizations, and project sponsors.

- The federal government should modernize and reposition existing affordable senior housing stock, add services to senior housing, support production programs, and reduce financial risks to private lenders and investors.
- State governments should coordinate administration of multiple funding streams, attempt project-basing of operating subsidies, spearhead coordinated initiatives, develop flexible regulation of facilities, and facilitate the appropriate application of Medicaid funds for assisted living.

- Foundations, research and professional organizations should facilitate conversations between project sponsors and government funders, provide technical and financial assistance to both sponsors and state agencies, collect and disseminate information about ongoing efforts, fund demonstration grants to test promising approaches, and sponsor and conduct additional research.
- Project sponsors should identify strengths, form strategic partnerships, become familiar with the regulatory environment, investigate possible funding sources, be aware of private-pay market activity, network with other project sponsors, and develop reserves to deal with funding gaps.

To date the response to the housing and health care needs of seniors has been a patchwork effort. Identifying a large market of frail seniors with the need for supportive housing but a desire to maintain their independence, the private-pay market has developed a product that has attracted many middle- and upper-income seniors, albeit with some initial overestimation of demand. Not-for-profit organizations and public agencies have attempted to provide a similar model of supportive housing for low- and moderate-income seniors, but are struggling with unwieldy and poorly coordinated housing and health care finance systems and a perennial shortness of funds. Although coordinating efforts across the various dimensions and agencies will not be easy, this is not a problem that can be ignored or left to sort itself out. After all, the growth of the senior population over the past decade is just a precursor to the retirement of the baby boomers, beginning in 2010. The next eight years offer an opportunity to develop a more coherent approach to seniors' housing and health care needs before the true test of our financial resources and commitment to our older citizens arrives.

Introduction

The past decade has seen tremendous growth in specialized senior housing and retirement communities, in response to a graying population. The aging of America has also prompted greater discussion of health care issues, including long-term care. Within the discussion of long-term care, there has been a demand shift towards greater choice of home- and community-based options for providing supportive services, rather than institutional settings such as nursing homes. A significant milestone in that shift was the 1999 case *Olmstead vs. L.C.* (527 U.S. 581), in which the U.S. Supreme Court ruled that states must provide services in the most integrated setting appropriate to the needs of qualified individuals with disabilities, a category that includes seniors. To date much of the specialized senior housing and care market has been been driven by and marketed to the middle class and well-to-do. However, with a burgeoning senior population of all income levels, the discussion must also address the needs of low- and moderate-income seniors. The current housing and health care systems are poorly designed to provide a range of housing and care choices for seniors of limited means. However, as consensus grows that non-institutional care is preferable for those seniors who can afford it, we must begin to examine how to provide and pay for similar options for an affordable market.

This paper examines issues around the provision of affordable supportive housing for seniors. It reviews the elements of demand for supportive housing, lessons from the private-pay market, and specific challenges faced in the affordable market. In particular, the paper will focus on the various funding sources that can be used to subsidize development and operation and the financial and regulatory difficulties encountered when using these funding sources. Project-level profiles will illustrate several financial models that have been used, and the paper will offer some policy recommendations that would allow for easier development of affordable assisted living. This paper should serve as the beginning of a discussion; it is not intended to cover all issues related to affordable assisted living in great depth. Rather, this should provide the framework for

conversations at the Fannie Mae Foundation / Robert Wood Johnson and Volunteers of America forum. Likewise, the models do not represent all possible permutations of funding sources, but illustrate some of the more promising methods of funding.

Section 1 Overview of senior population

1.1 Demographic trends

Size and growth of the senior population

The demand for specialized seniors' housing and supportive services is driven by a number of demographic factors, chiefly size of the senior population, marital status, living arrangements, and geographic distribution. The current size and expected future growth of the senior population[2] is a topic of widespread attention; data from the 2000 Census confirms that at 35 million people, the absolute number of seniors is larger than it has ever been. The number of seniors is predicted to grow modestly between now and 2010, then will burgeon between 2010 and 2030 as the baby boomers reach age 65. The age distribution among seniors is itself aging; as life expectancy has increased, there are more seniors in the 75-84 and 85-plus age groups than at any point in history.[3] The Figure below shows the distribution of seniors in 2000 by age.

Figure 1.1: Senior population in 2000 by age

Age group	Number (millions)	Percent total population	Percent senior population
Total US population	281.4	100%	
Total 65 plus	35.0	12.4%	100.0%
65-74	18.4	6.5%	52.6%
75-84	12.4	4.4%	35.3%
85 and older	4.2	1.5%	12.1%

Source: Administration on Aging, Profile of Older Americans

[2] In this paper, the term "seniors" refers to persons aged 65 and older. Any discussions of other age distinctions (for instance, "older seniors" aged 75 and older) will include specific age definitions.
[3] Administration on Aging, *A Profile of Older Americans*, Washington, DC: U.S. Department of Health and Human Services, 2001.

Clearly, the need for supportive services increases with age; an increase in the number of seniors in the 75-84 and 85+ age groups will result in more demand for housing with services. The Figure below shows past evidence on the increasing usage of nursing homes with increasing age.

Figure 1.2: Nursing home residents by age distribution

Age group	Percent in nursing home
Total 65 plus	4.5%
65-74	1.1%
75-84	4.7%
85 and older	18.2%

Source: Administration on Aging, Profile of Older Americans

Marital status and living arrangements

Besides age, demand for supportive housing is heavily influenced by a combination of marital status and living arrangements. As will be discussed further in Section 2.3, most of the seniors who move into assisted living are not married and live alone. In 2000, about 55 percent of older non-institutionalized persons lived with their spouse, while nearly one-third lived alone. These percentages vary considerably by gender. Nearly three-quarters of senior men are married and living with a spouse, only 17 percent live alone. Among senior women, 57 percent are single (widowed, divorced, or never married) and 40 percent live alone. The proportion living alone increases with age for both men and women. It is difficult to predict whether the proportion of seniors living alone will increase in the future; the number of seniors who are divorced or separated grew by over from 1.5 million to 2.6 million between 1990 and 2000, and is expected to increase further, but the number of widowed seniors is expected to decline. In addition the current gender discrepancy among seniors (nearly 60 percent of seniors are women, and the percentage increases with age) is expected to decline.[4] Currently the market for seniors' supportive housing serves mostly single women living alone, but there may be increased demand in the future from single men and older married couples.

[4] Administration on Aging 2001.

Housing tenure

Housing tenure also figures into seniors' demand for supportive housing. Seniors who own their homes are less likely to move, but if they do so, often have greater ability to pay, since home equity represents a significant portion of many seniors' assets. In 1999, eighty percent of households headed by seniors were homeowners and 20 percent were renters. The median year of construction of homes owned by older households was 1962 and the median value was $96,442; homes owned by seniors are slightly older and lower value than for homeowners as a whole. About three-quarters of older homeowners in 1999 owned their homes free and clear. Among both renters and owners, many older households incurred high expenditures for housing; 55 percent of older renter households and 39 percent of older owners exceeded 30 percent of their monthly income on housing.[5] Section 2.3 of this paper discusses further implications of housing status on the demand for assisted living.

Geographic distribution

The aging of the population will have disparate impacts on different states, an important consideration since many of the potential subsidies for senior housing come out of state budgets or are administered by state agencies. According to the 2000 Census, about half of all persons 65 and older (12.8 million persons) lived in nine states: California, Florida, New York, Texas, Pennsylvania, Ohio, Illinois, Michigan and New Jersey. In nine states (Florida, Pennsylvania, West Virginia, Iowa, North Dakota, Rhode Island, Maine, South Dakota, and Arkansas), the senior population constituted 14 percent or more of the total state population; nationally seniors are 12 percent of the population. The distribution of elderly across urbanized areas is roughly

[5] U.S. Department of Commerce, U.S. Department of Housing and Urban Development, *American Housing Survey for the United States in 1999, Current Housing Reports*, Washington DC: U.S. Government Printing Office, 1999.

similar to the population overall: 50 percent lived in suburbs, 27 percent in central cities, and 23 percent in non-metropolitan areas.[6]

Racial and ethnic composition

The ethnic make-up of the senior population is expected to change dramatically in the future, which is also likely to have implications for the demand for affordable supportive housing. While minorities currently make up a smaller proportion of the elderly population than for the overall population, this is expected to change over the next few decades. Minorities are predicted to rise from 16.4 percent of all seniors in 2000 to 25.4 percent in 2030. The elderly Latino population is expected to grow by 328 percent, African-Americans by 131 percent, while white non-Hispanic elderly will increase by 81 percent.[7] A report on the seniors' housing industry by the National Investment Council reports differences by elderly ethnic groups in health and in financial assistance from adult children, two factors that strongly influence demand for supportive housing. For instance, African-American seniors are more likely to receive financial help from their children than are white seniors, while Hispanic seniors are less likely to receive such aid.[8] The relationships between race and ethnicity and demand for supportive housing have not been fully explored, but such research will be important in helping the seniors' housing industry adjust to future market conditions.

1.2 Financial profile of seniors

In addition to the size of the senior population, demand for specialized housing products depends largely on ability to pay, that is, the income and wealth of consumers. There are two potential markets for assisted living: seniors with sufficient income or wealth to afford private-pay facilities, and seniors whose low income and assets make them eligible for public subsidies. As

[6] Administration on Aging 2001.
[7] Ibid.
[8] National Investment Center for the Seniors Housing and Care Industries, *The Case for Investing in Senior Housing and Long Term Care Properties*, Annapolis, MD: NIC, 2001.

will be discussed in Section 2.1, the market for private-pay assisted living includes seniors with annual incomes of at least $15,000 or assets worth at least $50,000.[9] Most seniors with incomes between $15,000 and $25,000 will require either liquidation of assets or financial assistance from family to afford private-pay facilities. Eligibility for public subsidies depends on the exact program and may vary by geographic location, so is difficult to define based on national statistics. One benchmark is federal Supplemental Security Income; in 2002, eligibility for a single person was set at annual income $6,372 or less and assets of $2,000 or less.[10] As the financial profile presented below demonstrates, substantial numbers of senior households have very low incomes and/or very low assets. In addition, substantial numbers of senior households do not have sufficient income and/or assets to afford private-pay assisted living but have too much income to qualify for subsidies.

Distribution of income

The senior population as a whole is in better financial shape than at any point in history, with fewer seniors living in poverty and substantial numbers of seniors with considerable wealth. In 2000, the median per capita income for seniors was $13,769; for senior men it was $19,168, for women $10,899. Among households headed by seniors, median household income for whites was $33,467, for African-Americans $27,952, and for Hispanics $24,330. The figure below shows the income distribution of seniors.

Virtually all seniors with incomes below $15,000 will be unable to afford private-pay assisted living. In addition, many of those with incomes between $15,000 and $35,000 will be unable to afford private-pay assisted living unless they have significant assets that can be liquidated and/or receive financial assistance from family members. As a result, perhaps as many as two-thirds of senior households would require subsidies in order to afford assisted living.

[9] Ibid.
[10] Social Security Administration, *Desktop Guide to Supplemental Security Income Eligibility Requirements 2002*, www.ssa.gov.

Figure 1.3: Income distribution of seniors, 2000

Annual household income	Percent of households
Under $5,000	7.7%
$5,000-$9,999	26.2
$10,000-14,999	20.8
$15,000-24,999	21.4
$25,000-34,999	9.8
$35,000-49,000	6.5
$50,000 and over	7.7

Source: Administration on Aging, Profile of Older Americans

Poor and near-poor seniors.

One starting point for estimating the potential market for affordable assisted living is the senior population defined as poor or near-poor. Just over ten percent of seniors had incomes below the federal poverty line ($8,860 for one person) and another seven percent were classified as near poor, with incomes up to 125 percent of poverty ($11,075).[11] The poverty rates were higher for African-American (22.4 percent) and Hispanic seniors (18.8 percent) than for white seniors (8.9 percent). Women had a higher poverty rate (12.2 percent) than men (7.5 percent). Older persons living alone or with non-relatives had a poverty rate of 20.8 percent, compared to those living with families (5.1 percent). Elderly living in central cities and rural areas experienced higher poverty rates than those living in the suburbs.[12] Although the market for affordable assisted living must be adjusted further for age and health, a preliminary calculation of all poor and near-poor seniors gives a potential market of 5.6 million seniors. The Seniors Commission estimates that, of these 5.6 million seniors, 1.3 million live in government-subsidized rental units.

Retirement savings.

Reflecting the financial demands of longer life expectancies, the Survey of Consumer Finances reports that retirement-related reasons for saving have increased consistently in importance. In 1989 about 20 percent of families listed retirement as their primary reason for saving, by 1998 this had risen to around 35 percent, the single most important reason. Many families have a

[11] U.S. Department of Health and Human Services, *HHS Poverty Guidelines 2002*, spc.os.dhhs.gov/poverty.
[12] Administration on Aging 2001.

variety of retirement assets, including defined-benefit or defined-contribution pension plans. Over 40 percent of families had some type of pension coverage through a current job of the family head or spouse. Older households are more likely to have defined-benefit pensions, while younger households more often have account-type plans with contributions from both worker and employer.[13]

Wealth.

Wealth is almost equally important as income in determining the market for assisted living. The stock market boom of the 1990s brought substantial increases in wealth to Americans of all ages, although many of these gains have been reduced if not completely erased in the past few years. According to the 1998 Survey of Consumer Finances, median net worth rose for all age groups between 1995 and 1998; median net worth rose particularly strongly for families in the 65-and-older groups. As the Figure below shows, net worth for seniors is higher than for families of all ages, but starts to decline in later years as seniors spend their assets in retirement.

Figure 1.4: Median net worth by age of household head

Age of household head	Net worth, 1995	Net worth, 1998
All families	$60,900	$71,600
55-64	$122,400	$127,500
65-74	$117,900	$146,500
75 +	$98,800	$125,600

Source: Kennickell, Starr-McCluer and Surrette, *Recent Changes in U.S. Family Finances*

While the Figure above is more relevant to the market for private-pay than affordable assisted living (and the value of underlying assets have certainly decreased in recent years), it is worth noting that over 95 percent of seniors reported holding some asset in 1998. Perhaps reflecting greater risk aversion, senior households are more likely than the overall population to hold

[13] Kennickell, Arthur B., Martha Starr-McCluer and Brian J. Surrette, *Recent Changes in U.S. Family Finances: Results from the 1998 Survey of Consumer Finances*, Washington DC: Federal Reserve Board, 2000.

certificates of deposit and bonds, but are less likely to own stocks, mutual funds, and retirement accounts, as shown in the Figure below.

Figure 1.5: Percent of families holding assets, by age of household head and asset type

Type of asset	All families	65-74	75+
Any financial assets	92.9%	95.6%	92.1%
Transaction accounts	90.5	94.1	89.7
Certificates of deposit	15.3	29.9	35.9
Savings bonds	19.3	16.1	12.0
Bonds	3.0	7.2	5.9
Stocks	19.2	21.0	18.0
Mutual funds	16.5	18.0	15.1
Retirement accounts	48.8	46.1	16.7
Life insurance	29.6	39.1	32.6
Any non-financial asset	89.9	92.0	87.2
Primary residence	66.2	81.5	77.0
Other residential property	12.8	18.4	13.6
Any asset	96.8	98.5	96.4

Source: Kennickell, Starr-McCluer and Surrette, *Recent Changes in U.S. Family Finances*

Figure 1.6: Median value of assets, by age of household head

	Median value of holdings		
Type of asset	All families	65-74	75+
Any financial assets	$22,400	$45,800	$36,600
Any non-financial asset	$97,800	$109,900	$96,100
Any asset	$123,500	$165,200	$135,000

Source: Kennickell, Starr-McCluer and Surrette, *Recent Changes in U.S. Family Finances*

For many seniors, the transition to assisted living involves selling their homes. Primary residence is the most commonly held type of non-financial asset and for most households, represents the largest share of total assets. Households aged 75 and above have homeownership rates of 77 percent, while over 80 percent of households aged 65-74 own their homes. Households in these top two age groups are also more likely than younger households to own other residential property. Households in the oldest and second-oldest groups hold assets with value over $130,000 and $160,000, respectively. Seniors also have lower levels of debt than younger households, much of which can be attributed to paying off mortgages.[14] However, there is some

[14] Ibid.

evidence that upon reaching retirement age, the baby boomers will hold higher levels of debt than past generations of seniors.

The presence of assets is an important determinant of seniors' ability to afford assisted living, yet asset ownership comes with some complications. Seniors in private-pay assisted living often liquidate assets, yet the high fees can consume a lifetime of savings quickly. The National Investment Center estimates that assets of $50,000 will enable a senior to pay fees for two to three years.[15] For low-income seniors, holding assets other than a primary residence will generally result in loss of eligibility for government assistance programs. For instance, eligibility for Supplemental Security Income is precluded by assets over $2,000 for a single person, $3,000 for a couple. Many seniors sell their homes prior to moving into assisted living; although the proceeds from the sale of a home can allow a senior to pay for assisted living, this is an emotionally difficult experience and is often delayed until health status is considerably deteriorated.

1.3 Health status and predictions

Seniors at all ages are getting healthier, but with the growth of the senior population, the total number of seniors with disabilities will continue to grow in coming years. According to the Census Bureau and the National Center on Health Statistics, just over one-quarter of older persons assessed their health as fair or poor in 1999, compared to nine percent for all persons.[16] Two common measures of seniors' health status are the ability to perform acitivities of daily living (ADLs), such as bathing, dressing, eating, and toileting, and instrumental activities of daily living (IADLs), such as phone use, laundry, shopping, and money management. Over fourteen percent of seniors require assistance with ADLs and 21.6 percent have difficulty with IADLs. Data from the Lewin Group indicate that the number of elderly receiving assistance with two or

[15] National Investment Center 2001.
[16] Administration on Aging 2001.

more ADLs in 2000 was estimated at 1.391 million, and is forecast to rise to 2.719 million by 2030.[17] As the Figure below shows, limitations on ability to perform these activities increase with age.

Figure 1.7: Prevalence of chronic disability among seniors

Age	Nondisabled	Only IADL impaired	ADL impaired
65-74	88.5%	3.1%	8.4%
75-84	73.1	5.5	21.4
85+	40.2	7.2	52.7

Source: National Investment Center, *The Case for Investing in Senior Housing*

Disability from chronic illness is also widespread among seniors. Over half of those over 80 report one or more severe disabilities. Most seniors report at least one chronic condition, and many have multiple conditions; most commonly occurring are arthritis, hypertension, hearing impairments, heart disease, cataracts, and orthopedic impairments.[18]

Health care costs represent a significant expenditure for many seniors. In 1999, older persons incurred an average of $3,019 in out-of-pocket health care costs, an average of $1,554 (51 percent) for insurance, $706 (23 percent) for drugs, $601 (20 percent) for medical services and $158 (5 percent) for medical supplies. These costs are one-third more than the average health care expenditures of the total population ($1,959 in 1999). Health care expenditures represent 11 percent of total expenditures for older Americans.[19]

Not only are low-income seniors financially vulnerable; physical needs tend to be higher for lower income seniors as well. An AARP analysis of the Census Bureau's 1994-95 Survey of Income and Program Participation shows 20 percent of older renters have some need for assistance with ADLs, compared with 12 percent of older homeowners. Twenty-six percent of

[17] National Investment Center 2001.
[18] Administration on Aging 2001.
[19] Ibid.

older renters who receive housing subsidy report physical difficulty/disability, compared with 18 percent of unsubsidized older renters.[20]

Summary

The size and predicted growth of the senior population imply increasing demand for supportive housing, although the impacts of an aging population will vary by state. Currently the market for supportive housing is predominately made up of single white, non-Hispanic women living alone, but these demographics are likely to change in the future. About 17 percent of seniors, 5.6 million persons were defined as poor or near-poor in 2000. These seniors will require financial assistance from families or government programs in order to afford assisted living. Another 21 percent of seniors, 7.4 million persons, may be unable to afford private-pay facilities but have incomes too high to qualify for subsidies. A vast majority of seniors hold some type of assets; some have sufficient wealth to pay for their housing and service needs in whatever setting they choose. However, the fees at private-pay assisted living can deplete retirement resources in a few years, while even modest assets will disqualify some low-income seniors from receiving federal aid. Although the health of seniors by age has generally improved, due to the size of the senior population, well over one million seniors receive assistance with ADLs or IADLs, and many more are in need of such services. The prevalence of physical disability among low-income seniors indicates a particular need for affordable supportive housing for this group.

Section 2 Private-pay market for assisted living

2.1 Overview of assisted living

Position in senior housing market

The senior multifamily housing industry includes a variety of levels of housing and care, ranging from independent living apartments to skilled nursing facilities. Assisted living is one segment of

[20] Kochera, Andrew, *Serving the Affordable Housing Needs of Older Low-Income Renters: A Survey of Low-Income Housing Tax Credit Properties*, Washington, DC: AARP, April 2002.

this spectrum; the average assisted living facility contains 60 units, mostly small efficiency apartments, with common spaces such as dining areas, commercial kitchens, recreation and meeting spaces. Assisted living facilities offer a similar environment to older board-and-care facilities, but generally contain more dwelling units, common spaces and property amenities. Services provided at assisted living facilities typically include meals, hospitality services, housekeeping, transportation, medication management, security, and assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADLs include bathing, dressing, eating, toileting, and transferring; IADLs are activities such as laundry, phone use, shopping, and money management. Some facilities provide specialized care for residents suffering from Alzheimer's or dementia.

The Figure below indicates where assisted living falls in the senior housing and care continuum. Industry groups have developed a set of four broad categories, distinguished by types of services offered; the Figure below shows the level of services and costs associated with each category.

These categories are useful for certain purposes: they allow industry analysts to assess market demand for somewhat standardized products, and many states regulate or license senior housing depending on the level of care provided. However, a single facility may cross several categories (indeed, Continuing Care Retirement Communities are designed to provide services across a range a need levels). Moreover, use of in-home health services may allow seniors in independent living apartments to receive the level of care equivalent to assisted living.

Figure 2.1: Senior Living Categories

	Seniors Housing	Seniors Housing & Hospitality	Seniors Housing & ADL Care	Seniors Housing & Medical Care
Monthly fee	$600-$1,200	$1,400-$2,000	$2,400-$3,000	$2,800-$4,000
Service cost	0%	45%	65%	75%
Housing cost	100%	55%	35%	25%
Services offered	Real estate	Real estate Meals, transport, housekeeping	Real estate Meals, transport, housekeeping, ADL care, IADL care	Real estate Meals, transport, housekeeping ADL care, IADL care Medical care
Types of housing	Seniors apartments Active adult communities Owner-occupied	Congregate care Facilities Independent living units in CCRC facilities Board-and-care	Assisted living facilities Assisted living units in congregate care facilities	Nursing homes Skilled nursing units in congregate care, CCRCs, Hospitals

Source: National Investment Center, Case for Investing in Seniors Housing

Fee comparison with nursing homes

The fees charged by assisted living facilities cover a combination of housing and services, and may be offered as a package or "a la carte." According to a recent survey of assisted living facilities conducted by MetLife's Mature Market Institute, base rates vary widely by geographic area; the lowest average monthly cost was in Jackson, Mississippi, at $592, the highest was New York City at $3,697. The national average monthly base price was $2,159.[21] As the Figure above shows, roughly 35 percent of the monthly fees are used for housing, with the remaining 65 percent for services.[22] At facilities serving residents with Alzheimer's or related disorders, about twelve percent of the sample, monthly rates including specialized care range from $1,450 to $6,800, with a higher percent of the fees representing service costs.[23] Most assisted living facilities are primarily run on a private-pay basis and receive very limited funds from government

[21] MetLife Mature Market Institute, *MetLife Survey of Assisted Living Costs 2002*, www.metlife.com.
[22] National Investment Center 2001; Legg Mason Wood Walker Inc. Health Care Equity Research Group, *Senior Housing and Care Industry Report*, Baltimore, MD, 2001.
[23] MetLife Mature Market Institute 2002.

sources; in 2001 government funding accounted for only about five percent of the revenue in assisted living.[24]

One reason for increased attention to assisted living is the cost comparison with nursing homes, a more established form of housing and care for frail seniors. Skilled nursing homes provide medical care in addition to the level of care typically provided in assisted living, are generally regulated as medical rather than residential facilities, and are considerably more expensive. MetLife's Mature Market Institute conducted a similar survey for nursing homes: the average daily rate for a semi-private room in a nursing home was $143, for a private room $168. This gives average monthly costs of $4350 and $5110 for nursing homes, at least twice the cost of assisted living.[25] As will be discussed in Section 3.4.1, the costs of skilled nursing facilities for low-income seniors have long been eligible for payment under Medicaid, while Medicaid has only recently begun to cover the costs of assisted living. Government funds account for nearly 70 percent of the revenue in nursing homes, which is more than 14 times greater than in, assisted living.[26] The Medicaid regulations have often resulted in low-income seniors being placed in nursing homes even if their physical needs do not require that level of care, since this is one of the few supportive housing options that that is covered by government assistance.

Resident profile

According to a survey conducted in 1998 by the National Investment Center for Seniors Housing and Care Industries and the Assisted Living Federation of America, the average assisted living resident is 82 years old, has an annual income of $19,250 and needs help with 1.6 ADLs. About two-thirds of assisted living residents are women; approximately 97 percent of assisted living

[24] Legg Mason Wood Walker 2001.
[25] MetLife Mature Market Institute, *MetLife Survey of Nursing Home and Home Care Costs 2002*, www.metlife.com.
[26] Legg Mason Wood Walker 2001.

residents are white;[27] 46 percent of residents moved into assisted living facilities from their own homes.[28] The income distribution of assisted living residents is somewhat surprising; initially industry analysts had set the minimum income at which seniors could afford private-pay assisted living at $25,000 annually, given annual cost estimates of an equal amount. However, the 1998 income survey revealed that two-thirds of residents had incomes under $25,000, and many residents reported annual incomes insufficient to pay the minimum average fee reported by facility administrators. The Figure below shows the income distribution.

Figure 2.2: Resident income distribution of assisted living residents (1998) and all seniors (2000)

Income range	Percent of residents	All seniors (2000)
Less than $5,000	11.3%	7.7%
$5,000-$9999	12.0	26.2
$10,000-14,999	16.8	20.8
$15,000-24,999	23.9	21.4
$25,000-34,999	13.2	9.8
$35,000-49,999	9.4	6.5
$50,000 or more	11.4	7.7

Source: NIC/ALFA National Survey of Assisted Living Residents (1998), Administration on Aging, Profile of Older Americans (2000)

The NIC/ALFA Survey found that besides personal income, forty percent of residents received financial assistance from a variety of sources, including cash or in-kind services from family and friends, private long-term care insurance, and public funds. The most common source of government aid, reported by 13.5 percent of residents, is Supplemental Security Income, a federal assistance program for low-income seniors. Liquidation of assets, particularly the sale of primary residence, is also a significant source of funds for many assisted living residents. The Figure below shows the sources of resident payments.

[27] National Investment Center for the Seniors Housing and Care Industries and Assisted Living Federation of America, *National Survey of Assisted Living Residents*, Annapolis, MD, 1998.
[28] MetLife Mature Market Institute 2002.

To determine how much seniors can afford to pay for assisted living, it is illustrative to look at average expenditures of senior households. As the Figure below shows, the main expenditures of households aged 75 and above are housing, food, healthcare and transportation.

Figure 2.3: Resident sources of assisted living payment

Source	Percent of residents
Self	75.2%
Government	19.4
Family	15.8
Insurance	4.4
Other	3.2

Source: NIC/ALFA National Survey of Assisted Living Residents

Expenditures of Age 75+ Households, 1997

Item	Average Amount	Percent Total
Total	$20,279	
Food	$2,897	14.2%
Housing (includes utilities, upkeep, etc.)	$7,107	35.0
Apparel and services	$735	3.6
Transportation	$2,785	13.7
Healthcare	$2,799	13.8
Entertainment	$861	4.2
Personal care and services	$378	1.9
Reading materials and education	$209	1.0
Tobacco	$87	0.4
Miscellaneous	$463	2.3
Cash contributions	$1,485	7.3
Personal insurance and pensions	$473	2.3

Source: NIC, Income Confirmation Study of Assisted Living Residents

Assisted living facilities differ somewhat in whether to price services separately or as a package, but most fees include housing, food, and some level of personal care. The National Investment Center estimates that seniors moving into assisted living should be able to spend between 60 and 80 percent of their income on standard fees, retaining the remainder for expenditures not included in the package of services.[29] For comparison, in the preceding Figure, expenditures for food, housing, transportation and health care comprise 76.7% of total expenditures.

[29] National Investment Center for the Seniors Housing and Care Industries, *Income Confirmation Study of Assisted Living Residents and the Age 75+ Population*, Annapolis, MD: NIC, 2001.

Summary

Assisted living offers frail seniors a package of housing, personal care, and supportive services in between independent living and skilled nursing facilities. The fees at private-pay assisted living facilities are quite high, averaging $2,159 per month, so seniors with annual incomes less than $25,000 will require additional financial assistance to afford these fees. However, assisted living facilities are considerably less expensive than skilled nursing facilities, although nursing homes traditionally receive much more public funding through Medicaid. Allowing frail seniors who do not need the level of care provided in skilled nursing facilities to choose assisted living could provide a more desirable living environment to seniors and potential cost savings to the government.

2.2 Industry overview and structure

The 1990s was a period of tremendous growth in the private-pay assisted living industry. Analysts cited optimistic demographic trends, indicating a potential market of 2.5 to 4.5 million seniors, with demand for 100,000-300,000 new units annually.[30] As with other industries enjoying the economic expansion, both debt and equity capital were readily available. As a consequence, the assisted living industry overestimated demand and developed too many beds too quickly, often with ill-conceived business models and poor site selection. In response to the overbuilding, the late 1990s have been described by analysts as "disastrous years" for the assisted living industry, characterized by high vacancy rates (10 to 20 percent), the collapse of stock prices and bankruptcy filings by two publicly traded firms. The fallout may not be over; many of the firms in trouble have significant amounts of debt maturing in the next few years, continuing to place them at risk for bankruptcy.[31]

[30] Doctrow, Jerry L., Glenn R. Mueller and Lauren Craig, "Survival of the Fittest: Competition, Consolidation and Growth in the Assisted Living Industry," *Journal of Real Estate Portfolio Management* (5:3) 1999.
[31] Legg Mason Wood Walker 2001.

Besides overbuilding, in the past few years assisted living facilities have also faced difficulties with liability insurance. Following several high-profile expensive lawsuits of nursing homes, insurers have drastically raised the premiums on nursing homes and assisted living facilities across the nation. The problem has been particularly pronounced in Florida; a Florida Department of Insurance survey of insurers conducted in 2000 revealed that 62 of the 79 companies surveyed refused to write any more policies for nursing home and assisted living facilities in Florida, and 23 companies had withdrawn from the market altogether.[32] The annual cost of liability insurance for one assisted living facility in Largo, Florida, rose from $144,584 in 2000 to $1,675,600 in 2001.[33] The difficulty of affording insurance – or even obtaining a policy – contributes to the financial problems of existing facilities and prevents new ones from opening, and states other than Florida may well have to confront the question of insurance in the near future.[34]

Despite the sector's financial difficulties, assisted living has clearly become a large and important part of the senior housing industry. In 1999, an estimated $15.7 billion was spent on assisted living care, roughly 11 percent of total spending on senior housing and care. The exact number of beds in assisted living facilities is difficult to obtain, particularly when including assisted living beds in congregate care or continuing care retirement communities. An industry study by Legg Mason Wood Walker estimates a capacity of 778,000 beds by the end of 1999,[35] while the recently released Seniors Commission report estimates 644,415 current residents in assisted living and board-and-care facilities.[36] Skilled nursing facilities are the largest sector but assisted living is the fastest growing segment of the market; between 1991 and 1999, 415,787 new beds were

[32] Peterson, Lindsay, "Insurers deserting nursing homes," *Tampa Tribune*, September 22, 2000.
[33] Stirgus, Eric, "Insurance may boost nursing home cost," *St. Petersburg Times*, February 21, 2001.
[34] Sixel, L.M., "High liability costs hit nursing homes," *Houston Chronicle*, March 2, 2002.
[35] Legg Mason Wood Walker 2001.
[36] Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century, *A Quiet Crisis in America, Final Report to Congress*, 2002.

added. About 80 of resident capacity is composed of recent, purpose-built facilities, the remaining 20 percent is found in board-and-care facilities, generally fewer than 30 units and often of older construction.[37]

Summary

Over the past decade, private-pay assisted living has emerged as a large and important part of the senior housing market. The industry has undergone some growing pains, due to overestimation of demand, overbuilding, and is still in the process of filling existing stock. Recent woes include rising insurance costs that threaten already shaky financial firms in overbuilt markets.

2.3 The market for assisted living: Converting demographics into demand

The previous two sections reveal the paradox of senior housing: the population of frail seniors is large and growing, and a substantial number of seniors have the financial resources to purchase specialized housing and services, yet far fewer seniors have chosen such housing than the market anticipated. Why has the actual demand not lived up to expectations? In fact, the difficulty of predicting elderly demand for specific types of housing has confounded researchers and industry experts for well over a decade. A series of academic research papers commissioned by the National Bureau of Economic Research on the economics of aging has revealed the flaws in many long-standing assumptions of housing demand for the elderly population.

Seniors' housing demand is not primarily driven by responses to economic conditions. Steven Venti and David Wise concluded that the elderly, who are often house-rich and cash-poor and may be "overhoused" in their current situation, do not in fact convert housing equity to finance current consumption, as theory suggests they should. Instead, the elderly are as likely to increase housing equity as to decrease it when they move (moving to similar sized or valued homes rather than downsizing). Moreover, they find that many elderly with little income also have little

[37] Legg Mason Wood Walker 2001.

housing equity, often because their homes are in neighborhoods with low housing values. Moreover, some elderly may choose to stay in their homes out of bequest motives. Greatly to their dismay, the two economists conclude that the two most important triggers for elderly residents to sell their homes are retirement and the death of a spouse, rather than economic reasons of price or income constraints.[38] This conclusion is reinforced by a study by Feinstein and McFadden using the Retirement History Survey, who finds that demographic shocks are more important to elderly housing decisions than wealth or capital market access.[39] Borsch-Supan finds that the elderly are actually less sensitive to economic conditions of housing markets than are younger households. Using American Housing Survey data, Borsch-Supan observes that while relatively high housing costs caused low-income young households to "double-up" in the early 1980's, the elderly are unlikely to live with distant relatives or non-relatives, and that only one-third of households with at least one elderly person do not live independently (American Housing Survey data excludes the institutional population). He also concludes that the decision to live with children or near relatives is driven primarily by marital status and health, rather than economic conditions. Somewhat surprisingly, perhaps, he also finds that adult children who receive parents into their homes have income of twice the average household income. Although high-income children are likely to have larger homes and thus space to care for aging parents, this suggests that less affluent children, who presumably cannot contribute to the costs of maintaining parents living independently or in private-pay senior housing of some sort, also cannot afford to care for parents in their own homes.[40]

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[38] Venti, Steven F. and David A. Wise, "Aging, Moving and Housing Wealth," in David A. Wise, ed., *The Economics of Aging*, University of Chicago Press: National Bureau of Economic Research 1989.
[39] Feinstein, Jonathan and Daniel McFadden, "The Dynamics of Housing Demand by Elderly: Wealth, Cash Flow and Demographic Effects," in David A. Wise, ed., The Economics of Aging, University of Chicago Press: National Bureau of Economic Research 1989.
[40] Borsch-Supan, Axel, "Household Dissolution and the Choice of Alternative Living Arrangements Among Elderly Americans," in David A. Wise, ed., *The Economics of Aging*, University of Chicago Press: National Bureau of Economic Research 1989.

Seniors prefer independent living to institutional care, and are reluctant to move from their existing homes. A more recent study by Borsch-Supan, McFadden, and Schnabel using the 1990 Longitudinal Study on Aging finds a "the positive income elasticity of privacy;" as the financial circumstances of the senior population overall has improved, an increasing proportion of seniors are choosing to live alone. The survey of 2,193 persons aged 76 or above provides an overall picture of this population: 63 percent live independently, 29 percent live with children or other relatives, and 8 percent live in nursing homes. The mean annual personal income was $7,700 with mean financial assets worth $36,000.[41] Sixty-three percent of those surveyed were homeowners. Among homeowners, over 85 percent had no outstanding mortgage debt. Borsch-Supan et al find a mixture of economic and demographic variables that impact housing choice among elderly. Health clearly has the most significant impact on whether elderly live independently or with others. Controlling for health status, three factors increase the likelihood of living with children rather than in an institution: the number of adult daughters, financial wealth and homeownership. Seniors with more education are also more likely to live independently.[42]

Summary

All of the studies described above highlight the difficulty of estimating demand for specialized senior housing: seniors are reluctant to leave an independent living situation, and the decision to do so is driven mostly by poor health, retirement, and the death of a spouse. Although the likelihood of ceasing independent living clearly increases with age, it is difficult to predict exactly at what age any given senior will require a change in housing situation. Moreover, the typical economic variables – income, wealth, prices, interest rates – that drive housing demand

[41] The median income and asset value numbers are much lower, apparently due to a large number of seniors reporting no income or assets. The mean values are presented here because they are closer to national statistics; the median values may represent sample bias and a low response rate.

[42] Borsch-Supan, Axel, Daniel McFadden and Reinhold Schnabel, "Living Arrangements: Health and Wealth Effects," in David A. Wise, ed., *Advances in the Economics of Aging*, University of Chicago Press: National Bureau of Economic Research 1996.

for younger households play at best a secondary role in seniors' housing choices. It is possible that future generations of seniors may show greater product acceptance of assisted living; the baby boomers are more accustomed to relocating than their parents and may have less psychological reluctance to leave their homes. Thus far, however, attempts to model seniors' housing demand using conventional variables and readily available information have resisted economists' best efforts.

2.4 Revised senior housing demand model

Despite the difficulties discussed in the empirical academic work, developers and industry analysts have spent much of the past decade attempting to estimate demand and then provide the appropriate type and quantity of supply. A recent study by Doctrow, Mueller and Craig suggests some of the errors of the past and outlines a corrected model for estimating demand. Doctrow et al point out two key problems with previous demand estimates. First, potential demand does not convert directly into effective demand, as the theory papers by Venti, McFadden, and Borsch-Supan discover. According to Current Population Survey estimates, fewer than five percent of seniors move from their current residences each year, compared with about 16 percent of all households. Even assuming that moves are more frequent among seniors over age 75, an entry of ten percent of the older senior population each year into assisted living facilities is fairly generous. Second, 45 percent of the assisted living units turn over every year, as seniors move into skilled nursing facilities or die.[43]

Taking into account past errors, Doctrow et al outline a model of estimating potential demand for assisted living, driven by the size of the senior population, ability to pay, and level of disability. Based on the profile of typical assisted living residents outlined in the National Investment Center/Assisted Living Federation of America survey, Doctrow et al define the target population

[43] Doctrow, Mueller and Craig 1999.

as age 75 or older, with annual income of $15,000 or greater,[44] and needing help with at least one ADL or IADL. The Figure below shows estimated demand for new units, based on estimated on the age-, income-, and disability-eligibility senior population, current assisted living and nursing home occupancy, existing supply, and annual turnover rates.

Figure 2.4: Estimated Effective Demand for Assisted Living, 2000

1	Unmet potential demand	3,407,000	Age, income, disability-eligible seniors
2	Annual move-in rate	7%	Estimated
3	Annual effective demand	238,490	Line 1*Line 2
4	Annual transfers from existing assisted living, skilled nursing facilities	43,000	Estimated
5	Total annual effective demand	281,490	Line 3+Line 4
6	Existing supply	626,000	Estimated
7	Stabilized occupancy rate	93%	Estimated
8	Annual turnover rate	45%	Estimated
9	Existing units available annually	261,981	Line 6*Line 7*Line 8
10	Net demand for new units	19,509	Line 5 - Line 9

Source: Doctrow, Mueller and Craig, Journal of Real Estate Portfolio Management

The estimated annual demand for successive years rises slightly; anticipating that a higher percentage of age, income, and disability-eligible seniors will enter assisted living each year. However, the authors cite estimates of between 40,000 and 50,000 new units scheduled to come on line in 1999 and 2000: new development in excess of effective demand.[45]

A similar demand model, although with slightly different estimates, can be found in the National Investment Center's *Case for Investing in Seniors Housing in* 2001. The potential market is defined as seniors over age 75, requiring assistance with two to three ADLs, non-homeowners, with income greater than $15,000 (or assets over $50,000). Adjusting by level of consumer acceptance by age cohort and ADL needs, the National Investment Center report arrives at an estimated effective demand for assisted living of 511,163 in 2000, an estimate more than 200,000

[44] In an interview with the author, Doctrow confirmed that residents with incomes of $15,000 either have assets to liquidate or receive additional financial assistance from family or government programs.
[45] Doctrow Mueller and Craig 1999.

higher than the Doctrow et al estimates. This indicates the sensitivity of the demand models to parameter estimates (such as turnover rates and current occupancy rates). The National Investment Center report also provides estimates of demand for publicly subsidized assisted living. Considering seniors who meet the age, health, and tenure requirements but fall below the $15,000 income cutoff, the NIC demand model estimates a demand of 194,983 seniors for a more affordable assisted living product.[46]

Summary

Assisted living can provide an appropriate package of housing, personal care, and supportive services appropriate for frail seniors for whom independent living is difficult but who do not require the level of care provided by skilled nursing facilities. However, seniors are often reluctant to move out of independent living situations. In choosing to move into assisted living, poor health, retirement, and the death of a spouse are the most important factors. During the hey-day of the 1990s, developers and investors overestimated the willingness of seniors to move into assisted living facilities and underestimated the rate of turnover. These errors in judgment led to excess supply, slower than expected fill rates, and financial difficulties across the industry. Predictions for the future suggest that consumer preference of assisted living to nursing homes and greater acceptance of the product may increase demand somewhat. However, Doctrow et al warn that consumers are becoming more discriminating and that successful facilities must offer high quality products and services.[47] So far the high costs of assisted living and low levels of public subsidy received by the industry have limited access to assisted living to seniors with relatively high income and wealth, or those receiving financial assistance from families. However, there is a segment of the senior population that fits the age and health definitions of the market, and does not need the level of care in skilled nursing facilities, but cannot afford private-pay facilities. The remainder of this paper looks at how this "affordable" assisted living market is

[46] National Investment Center, *Income Confirmation Study*, 2001.
[47] Doctrow, Mueller and Craig 1999.

served, the types of public subsidies available, and particular difficulties in providing affordable assisted living.

Section 3 The market for affordable assisted living

3.1 Overview of affordability challenges

As the previous section outlines, currently assisted living is primarily a private-pay industry, characterized by relatively large development firms and operators that cater to high-to-moderate income seniors with a range of housing options. However, increasing attention has been paid to the needs of low-to-moderate income seniors, many of whom already face housing affordability problems and whose physical needs are becoming more pressing as the population ages. These seniors form the market for affordable assisted living, that is, assisted living that makes use of public subsidies to keep the costs affordable to low-to-moderate income residents. This market is difficult to define exactly in terms of income, since costs vary greatly by geographic location and some subsidy eligibility is determined by local income comparisons, but the previous section on private-pay assisted living suggests that seniors with incomes up to $15,000 would generally form the market for an affordable product.

In some ways, the market for affordable assisted living makes use of more flexible and varied products than the private-pay market. The private-pay market is dominated by new construction purpose-built facilities. The affordable market consists of several different models, including new construction, purchase, rehabilitation or reconfiguration of existing facilities, or adding supportive services to the current stock of subsidized housing properties. The property-level profiles in Section 4 illustrate each of these models. The variety of ways to provide housing and services has a number of advantages. First, a flexible approach allows sponsors to adjust to local housing market conditions. For instance, there has been some discussion of affordable providers purchasing private-pay facilities experiencing financial difficulties. Although sponsors would

need to consider whether these facilities are well located to serve lower-income seniors or failed because of inherent design flaws, this could offer an alternative to new construction. Second, many project sponsors want to add services or facilities to serve existing residents, thus allowing them to age in place, a preferred outcome for most seniors. Third, organizations attempting to operate assisted living for the affordable market can build on existing capacity and expertise. Many of the project sponsors are public or not-for-profit agencies that have expertise at managing affordable housing, are familiar with various HUD program requirements, and have existing relationships with local service providers. It is important to note that not all of the affordable housing-and-service models described above and in the following sections are technically "assisted living facilities;" many affordable housing properties offer a high level of personal care and supportive services but choose not to be licensed or registered as assisted living. This paper will discuss the full range of "supportive housing," meaning a bundle of housing and supportive services equivalent to assisted living, but special attention will be paid to regulated or licensed facilities because of the additional concerns that these facilities face.

The market for affordable assisted living presents some similar challenges to the private-pay market, as well as some difficulties typical of the broader affordable housing industry. The main challenges for private-pay assisted living facilities are correctly estimating actual demand, marketing to seniors and their families, and developing greater familiarity with and acceptance of the product. Providers of affordable assisted living have the added difficulties of assembling financing packages to subsidize both development and operations, thus making the facilities affordable to very-low, low and moderate-income seniors. Since assisted living represents a combination of housing, personal care, and supportive services, funding subsidies must usually be obtained from a variety of different government agencies, private lenders and charitable organizations, each with its own set of eligibility rules and funding regulations. At best, the difficulty of assembling such complex financial structures drives up the cost of development; at

worst, the contradictory regulations and remaining gaps in affordability make these projects financially infeasible. The sections below describe the types of public funding programs that can be used for affordable assisted living, the regulations surrounding each funding source, and areas that could benefit from regulatory reform.

3.2 Regulation of assisted living

The regulations affecting assisted living facilities vary considerably across states, in number, type, and content of regulations. Some states, such as California and Washington, regulate almost every detail of operation, from staff educational requirements to mandatory discharge conditions to physical plant. Other states, such as Alaska, have limited state specification for operation.[48] The Figure below gives an overview of some of the state variations in assisted living regulation.

Figure 3.1: Assisted living regulation: overview

Classification				
About half the states use the term "assisted living," another 10 to 12 use the more medical "residential care facilities", while still others are classified as "Boarding Homes", "Homes for the Aged," or "Managed Residential Communities."				
Staffing				
Administrator	Nearly all states regulate necessary qualifications for assisted living facility administrators, but these qualifications range from age (over 21) to education (some require high school degree or equivalent, others BA and/or RN), to specific training and exams			
Staff-to-resident ratio	30 states regulate the staff-to-resident ratio, with a minimum of 1:15, maximum 1:6; a number of states require "Sufficient" staff on duty.			
Services				
	Mandatory	Number of states	Permitted	Number of states
	ADL care	49	Give medication	45
	Transportation	30	Intermittent nursing	37
	Laundry	46	Home health	6
	Recreation	45		
	Health related services	34		
	Housekeeping	41		
	Medication mgt (cueing)	43		

[48] American Seniors Housing Association, *Seniors Housing State Regulatory Handbook 2002*, Washington, DC: American Seniors Housing Association, 2002.

	Daily meals	33 (average 3)		
Physical plant				
	Number of states	Minimum	Maximum	Average
Minimum number of units	38	1	21	4
Max unit occ	41	1	5	2.7
Unit size, single (sq ft)	43	70	250	115
Unit size, multi (sq ft/bed)	43	60	250	97

Source: American Seniors Housing Association, *Seniors Housing State Regulatory Handbook 2002*

The agency with primary oversight of assisted living also varies considerably by states. Although this might seem like a trivial detail, different agencies may bring institutional biases to the regulation, often influencing whether assisted living is treated more as a residential or a medical facility. The Figure below shows the distribution of overseeing agencies.

Figure 3.2: Agency of oversight

Primary Agency/Department	Number of States
Health	29
Health and Aging	4
Human/Social Services	8
Combination: Health and Social Services	3
Elder Affairs	3
Other (Licensing, etc)	4

Source: American Seniors Housing Association, *Seniors Housing State Regulatory Handbook 2002*

The degree to which assisted living facilities are regulated is a matter of considerable debate among developers, services providers, consumer advocates, as well as seniors and their families. As with all types of regulation, stringent code and extensive state oversight may be able to ensure a higher quality of care for residents, but often leads to higher costs of provision. States that mandate larger minimum room sizes and more extensive physical plant will have higher land and construction costs; requiring a higher presence of qualified medical staff on site will raise operations costs. Affordable providers are sometimes pushed into a strategy of reducing service levels to avoid being licensed as an assisted living facility. In addition, if state licensing limits

the types of services that may be provided in assisted living facilities, turnover may increase as residents are forced to move into facilities licensed to provide higher levels of care. Indeed, some providers, such as the Council of Senior Centers and Services of New York City, engage in considerable political advocacy with the state legislature and regulating agencies in attempts to shape regulation to their liking. Assisted living occupies a peculiar position between housing and health care, between independent living apartments and nursing homes; each state defines this gray area differently and providers adjust to fit their state's unique regulatory environment.

3.3 Housing finance and regulation

As described in the market overview, the combination of housing, personal care, and supportive services makes assisted living an expensive and operationally difficult product. Private providers cover their costs through resident fees, but for seniors with low or moderate income, $2,000 per month, facilities are simply unaffordable without substantial assistance from family or government subsidy. Nearly all-affordable assisted living development projects make use of at least one federal housing subsidy; most layer several of these subsidies (as is typical for affordable elderly independent living housing as well). Below is a brief description of the federal subsidy programs that can be used for senior housing, eligibility requirements and other relevant regulations, and the potential to use each source for assisted living.

3.3.1 Public housing

Designated elderly public housing serves residents 62 and older with low- and very-low incomes, up to 50 percent of area median income. Additionally seniors can live in non-designated public housing that serves a variety of ages at the same income range. Currently there are an estimated 600,000 to 700,000 senior residents in public housing properties nationwide. Buildings designated as elderly may have some accessibility features, such as ramp or level entrances and some wheelchair-accessible units, but generally do not have physical configuration for assisted

living facilities. Traditionally public housing for both elderly/disabled and families has provided bricks-and-mortar with few services, but over the past few years there has been greater emphasis on housing authorities partnering with community-based organizations to provide services to public housing residents. There are no social service or personal care requirements at elderly buildings, and the level of services actually provided depends on the initiative of individual management, e.g., housing authority directors, managers, and staff. Although public housing offers a "deep" subsidy (covering rents above 30 percent of resident income), which is relatively unusual among the housing programs, there are several difficulties to using public housing as the base for assisted living. Most public housing is quite old, much of it built during the 1950s and 1960s; even the properties that have been retrofitted for added accessibility often exhibit poor design and may be in high poverty neighborhoods with poor access to services, health care and transportation. Because of the building age and design problems, as well as lack of services, elderly public housing properties often have high rates of vacancy and have difficulty competing with other subsidized properties, such as Section 202s.[49] Additionally, there has been no new construction of public housing for over a decade, so any use would have to be through conversion of existing properties. Several housing authorities have expressed interest in convert public housing into assisted living, possibly using HOPE VI funds for physical conversion. To date, however, no such conversions have been completed under HOPE VI. The profile of Helen Sawyer Plaza in Section 4 describes the first use of assisted living in public housing. Conversion of public housing, although problematic in some respects, is one means of facilitating – and funding – aging in place for very-low and low-income seniors.

3.3.2 Section 8 tenant-based rental assistance (Housing Choice Vouchers).

Overview of Section 8 rental assistance

[49] Author interview with MaryAnn Russ, Principal Associate, Abt Associates Inc.

Section 8 rental assistance serves the same income population as public housing, up to 50 percent area median income, and also provides an operating subsidy to cover the gap between Fair Market Rent or actual rent and 30 percent of the tenant's monthly income. Section 8 rental assistance can be project based; when a resident vacates, the subsidy remains with the unit for the benefit of the next resident. Section 8 rental assistance can also be tenant based; when a resident vacates, the subsidy remains with the household for use in its next home. Some tenant based Section 8 can be attached to a project (generally termed 'project-based vouchers') in an arrangement that combines the resident's ability to retain the subsidy when relocating, with referral of another Section 8 recipient to fill the vacancy.

The Housing Choice Voucher program

Tenant-based assistance, also referred to as vouchers (officially, the Housing Choice Voucher program), is assigned to income-eligible residents and can be used at private rental properties that meet HUD's fair market rent standards and have participating landlords. The Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century final report cites HUD estimates that approximately 255,000 senior households hold Section 8 vouchers (17 percent of 1.5 million total vouchers).[50] Both project-based and tenant-based Section 8 assistance is often used in combination with other subsidies, such as low-income housing tax credits, for senior housing. Unlike public housing, the Section 8 program continues to receive expansions through budget allocations. Using HUD's estimate that 17 percent of vouchers go to seniors, the Seniors Commission estimates 4,420 incremental vouchers for seniors in fiscal year 2002 and 5,780 vouchers in fiscal year 2003. Local housing authorities are responsible for assigning Section 8 allocations to various projects, and in most urban areas developers wishing to use project-based assistance face competition for their allocation. As with public housing, there is no requirement that Section 8 properties provide social services or personal care to elderly residents,

[50] Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century 2002.

and again the actual level of service provided varies by property. Section 8 can be quite useful in affordable assisted living projects as a relatively secure operating subsidy, but there is one significant regulatory difficulty.

Use of Section 8 vouchers in assisted living

The Housing Act of 2000 expanded the use of Section 8 to cover the shelter portion of assisted living, but assisted living rents often exceed the amount that the voucher will cover. The voucher program includes maximum rents (termed the 'payment standard'); to a limited extent, voucher recipients may pay rent in excess of the payment standard, but program rules provide that no more than 40% of the household's adjusted income may be paid for rent and utilities. Assisted living facilities have relatively high development costs and thus relatively high rents due to the level of building amenities and common spaces. As a result, the rents for assisted living facilities often exceed the voucher payment standard. In order to live in such a facility, voucher recipients would need to pay out of pocket the amount by which the rent exceeds the payment standard. Some providers have sought waivers that allow residents to exceed the 40 percent rule in order to use Section 8 vouchers in assisted living facilities, as highlighted in the Michigan state initiative in Section 3.6.3. An alternative solution would be to allow exceptions to the payment standard for assisted living facilities. This difficulty aside, it is likely that Section 8 will continue to be an important operating subsidy for residents in affordable assisted living.

3.3.3 Section 202 Supportive Housing for the Elderly.

Program background

Since 1959, HUD's Section 202 program has provided development subsidies for new construction of elderly housing. The program has had a number of different forms; in its current form Section 202 combines 40-year capital advances with Project Rental Assistance Contracts that subsidize rents above 30 percent of resident incomes. Some earlier Section 202s receive

rental subsidies under Housing Assistance Payments instead, and the oldest projects (including Bethany Towers, profiled in Section 4), may have no guaranteed rental assistance, or may have rental assistance for only some units. Like public housing and Section 8, Section 202 projects serve households with incomes up to 50 percent of area median income, and at least one family member must be 62 years or older. Only non-profit 501(c)3 organizations are eligible to serve as development sponsors for projects receiving Section 202 grants. Over 300,000 units have been constructed under Section 202; production rates peaked in the late 1970s and the 2002 Notice of Funding Availability announced funds for an estimated 5,816 new units. However, most 202 properties are somewhat newer than public housing, often smaller (50-100 units), may have more amenities or better design, and often are located in more desirable neighborhoods.

Many owners/managers of Section 202 properties have extensive experience in housing development, property management, and social service provision. Drawing on this depth of organizational capacity and expertise, most 202 properties offer some supportive services to their residents, such as meals programs, social services, or health screening through visiting nurses. Such properties are an important model of providing high levels of "supportive housing" without being licensed as assisted living. For instance, Jewish Community Housing for the Elderly in Brighton, Massachusetts, provides an extensive array of services, including food service, social activities, transportation, fitness, library services, citizenship classes, tenant councils, recreational activities and wellness programs.[51] Services offered at 202 facilities are funded by a mix of sources: participation fees, charitable donations, local service agencies, volunteers, state or local programs, Older Americans Act funds, and more recently, Medicaid.

Assisted Living Conversion Program (ALCP)

[51] Information provided by Ellen Feingold, President, Jewish Community Housing for the Elderly.

Section 202 properties have been experiencing the aging and increasing physical needs of their long-time residents, as well as aging of the buildings. Recognizing this growing need, in Fiscal Year 2000, HUD instituted an Assisted Living Conversion Program (ALCP), providing grants to owners of Section 202 properties[52] for physical conversion into assisted living facilities. Section 202 properties were initially designed for elderly residents, but typically only a minority of units are accessible to wheelchair users. Section 202 properties typically also lack the property amenities or facilities (such as commercial kitchens) of assisted living facilities. The ALCP program provides funds for the physical upgrades and modifications needed to meet federal accessibility and state licensure standards. However, the HUD funds cannot be used for the service component of assisted living; applicants must demonstrate commitments from other funding sources – such as Medicaid waivers and any other combination of previously referenced sources – to cover these costs. This has proved to be a difficult hurdle for potential applicants to the program, caught in a commitment loop between various funders. In the first two years of funding, 25 sponsors received grants worth a total of $40.7 million; grant amounts ranged from $268,668 to $4.2 million with an average size of $1.7 million.[53] The considerable variation in total and per unit amounts is not surprising, given the difference in type and amount of work requested. Some projects have relatively minimal work needed, such as modification of bathrooms, while others need to construct substantial new common space, such as kitchens and upgrade building systems. Construction began in late 2001; the first projects are nearing completion in fall 2002. The total amount of funds allocated is less than the amount budgeted for a single funding year, due partly to newness and unfamiliarity with the program.[54] In Fiscal Year 2002, the Notice of Funding Availability announced that $78 million in grant funds were available under ALCP for conversion from existing eligible elderly residential properties.

[52] The ALCP program can also be used by eligible owners of Section 236, Section 231, Section 232, Section 221(d)3, and Rural Housing Service Section 515 projects. These programs are discussed further in 3.3.6.
[53] HUD, Assisted Living Conversion Program Awardees, www.hud.gov/content/releases/assistedliving.pdf.
[54] Author interview with Faye Norman, Housing Project Manager, HUD.

Advantages of the Assisted Living Conversion Program are that it builds on demonstrated organizational expertise and existing physical facilities, and provides another opportunity for current residents to age in place. The American Association of Housing and Services for the Aging has been working with grantees and monitoring the ongoing progress of the program; a recent article written highlights some of the difficulties with ALCP encountered by grantees in the first two years.[55] The physical conversion can be challenging, given the age of the buildings, level of upgrades required, and the need to relocate residents during construction. A number of grantees cite unexpected cost increases due to vacancy losses from delays in the availability of HUD funds, rising insurance costs and contractor fees, and unexpected state and local licensing requirements. Grantees can request additional amendment funds from HUD to cover such cost increases; the process involves a dialogue with the field office and depends on continuing availability of funds. To date, ten of the thirteen fiscal year 2000 grantees have requested amendment funds totaling $4.2 million, mostly for inflation of labor and materials costs. State regulations for assisted living have also presented problems, since HUD requires grantees to obtain state or local licensure as assisted living facilities. A few grantees were already licensed for assisted living and for them this requirement presents no problems, but not all states have a corresponding category, or the age of many of projects raises difficulty in meeting physical tests such as hallway width. The licensing requirement adds another element of risk to the project, since licensure cannot be obtained until after the facility is operational, but failure to obtain the license results in default on the HUD funds. Many of the owners are based in traditional housing and are reluctant to go through the licensing procedure. Another substantial hurdle is the funding for the service component; Colleen Bloom of AAHSA reports that each grantee has developed a unique approach to financing the service component. Medicaid waivers are perhaps the most widely sought means of paying for services but do not cover assisted living in all states and may

[55] Van Ryzin, Jean, "From Independent to Assisted Living: Not-for-Profit Senior Communities Blaze a Trail in Assisted Living Conversions," *AAHSA Best Practices* (1:3), Summer 2002.

be insufficient to cover the full costs of services. Grantees have used a variety of funding sources, from private foundation grants to resident fees, cross-subsidization in properties with a broader range of incomes, or specific state grants (in Texas and Massachusetts).[56]

As might be expected from a fairly new program, both HUD and individual grantees appear to be going through a learning process with the Assisted Living Conversion Program. Applicants have learned more about state licensing requirements, are getting a more accurate sense of cost estimates, and are developing relationships with the HUD field office, state and local licensing, Medicaid, and housing finance agencies. Most of the current grantees are fairly small, locally based organizations. Although a successful grantee must be quite sophisticated in assembling the necessary licensure and funding package, organizations need not have the financial backing and organizational capacity of the larger national non-profits in order to make use of ALCP. For HUD, the program requires greater familiarity with assisted living, a difficult task given the state variations and service component. A review of the geographic distribution of current grantees reveals some of the difficulties of ALCP; a predominance of grantees are from the Northeast and Midwest, due in large part to favorable regulatory environments and the availability of service funds. Two states noteworthy by their absence are California and Oregon. Oregon had previously been thought of as a leader in the assisted living field and has encouraged transitioning residents from nursing homes into assisted living, but recently has experienced budget cutbacks. California has a larger absolute number of seniors than any state in the country (and 10 percent of the nation's elderly),[57] but its assisted living regulations are perceived as quite onerous.

Summary

HUD's Section 202 program can be used in several ways to provide affordable supportive housing. Many sponsors of existing projects currently offer extensive services without licensure;

[56] Author interview with Colleen Bloom, American Association of Housing and Services for the Aging.
[57] Administration on Aging 2001.

funds are also available for limited new construction and under the assisted living conversion program, for physical reconfiguration and modernization of aging properties. The ALCP program has the advantage of building on existing organizational and physical capacity, but there are still some regulatory difficulties with program administration. Moreover, the program will still require additional sources of subsidies for the service component.

3.3.4 Low Income Housing Tax Credits (LIHTC)

Program mechanics and overview

Since its inception in 1986, LIHTC has become the primary federal subsidy for production of affordable housing units for residents of all ages. Tax credits are allocated to the states on a per capita basis; state housing finance agencies then award credits to individual developers following a competitive application process. The sale of tax credits by developers to investors provides equity for development; investors purchase a ten-year stream of federal income tax benefits. Tax credit properties must have at least 20 percent of units affordable at 50 percent of area median income or at least 40 percent affordable at 60 percent area median income. Although in theory the LIHTC program can result in mixed-income communities, in practice more than 80 percent of properties developed serve entirely low-income residents, due in part to scoring criteria by credit allocating agencies.[58] During the first ten years of the program, roughly 550,000 to 600,000 units were placed in service.[59]

Physical facilities of senior LIHTC properties

A survey of over 1,500 tax credit properties conducted by the American Association of Retired Persons in 2001 discusses the use of LIHTC to serve seniors in particular. Nearly one-fourth of all LIHTC properties were developed primarily for seniors, and forty-two percent of properties

[58] Kochera 2002.
[59] Cummings, Jean L. and Denise DiPasquale, *Building Affordable Rental Housing: An Analysis of the Low Income Housing Tax Credit*, Boston: City Research, 1998.

had some units intended for seniors. The median size of LIHTC properties intended for seniors was 32 units. Thirty percent of LIHTC senior properties had a non-profit sponsor, somewhat higher proportion than tax credit properties in general. Properties for seniors are much more likely to be in suburban or rural location than mixed-resident properties. Properties intended for seniors reported very low vacancy rates, and most maintain a waiting list with average wait time of 8 months. The AARP survey suggests that many tax credit properties intended for seniors offer a variety of accessibility features that make then appropriate for frail seniors, but most lack the supportive services necessary for assisted living. Over 80 percent of senior tax credit properties had some type of meeting room or other common space for residents to gather, a feature rare among non-senior or mixed-resident tax credit properties. Large properties were more likely to have such accessibility features and common spaces.[60] The Figure below shows the frequency of accessibility features in units and buildings.

Figure 3.3: Frequency of accessibility features

Building		Unit	
Ramp/level entrance	91%	Grab bars in bathroom	65%
Emergency phone	84%	Lever door handles	63%
Grab rails in public hallways	60%	Extra-wide entry door	55%
Entrance security	44%	Extra-wide interior doors/halls	54%

Source: Kochera, *Serving the Affordable Housing Needs of Older Low-Income Renters*.

Services at senior LIHTC properties

While the physical facilities of LIHTC properties are well designed for seniors' independent living, most senior properties lacked supportive services. While 47 percent of residents in senior tax credit properties had access to community-based service coordinators, only 21 percent of properties had a service coordinator assigned solely to that property, and nearly one-third of residents had no access to a service coordinator. Fifty-four percent of LIHTC properties did not offer any services to residents; larger properties were much more likely to offer services than

[60] Kochera 2002.

smaller properties. Of those properties surveyed that offered services, the most common types of service was social and recreational activities (41 percent), while programs of assistance with IADLs were relatively infrequent (only 16 percent offered meals, 20 percent transportation, and 13 percent housekeeping services). Since the tax credit program does not offer an operating subsidy that can be used to pay for service costs, those properties offering services found support from a variety of different sources. Sixty-two percent received financial support from charitable organizations, 61 percent from city or state programs, and 37 percent from Medicaid waiver programs.[61] The use of multiple subsidies by tax credit properties will be discussed in further detail later.

Regulatory confusion over assisted living

Due to regulatory uncertainty and investor/syndicator antipathy to assisted living, the LIHTC has been used quite infrequently for assisted living facilities, despite being the largest production subsidy for affordable senior housing (and indeed all affordable housing). As a development subsidy, LIHTC can be used to develop the physical facilities for assisted living, but to be eligible for the subsidy must be classified as "residential rental property." The exact classification and range of services under the heading of assisted living varies by state, but project eligibility is determined by federal tax law and administered by the Internal Revenue Service. In response to confusion over whether assisted living was an eligible use of tax credits, in 1998 the IRS issued a Revenue Ruling saying that assisted living facilities may be treated as residential rental property if there are no continual or frequent nursing services available to residents. This definition is somewhat hazy and could be open to conflicting interpretations by state credit allocating agencies, investors, syndicators and investors. Relatively few assisted living facilities have been

[61] Ibid.

developed under the LIHTC program; only two percent of senior tax credit properties are classified as assisted living facilities.[62]

Additional subsidies

It is quite common for LIHTC properties to layer other subsidies – both development and operating – on top of the credits, and this practice is especially notable in senior properties. The financial complexity of tax credit deals has drawn attention (and criticism) since the program's early days.[63] The amount of total development costs obtained from the sale of credits varies with the price of the credit; a survey of recent LIHTC developments indicated that about 45 percent of total development costs resulted from the sale of credits, 40 percent from a primary loan, and the remaining 15 percent from secondary loans and subsidies known as "gap" financing.[64] The average number of gap financing sources has declined over time as the price of credits increased and conventional lenders have become more familiar with project, willing to make larger loans.[65] The AARP survey does not fully capture this information, since it looks at properties developed from the program's inception in 1986 through 1998. However, it appears that properties intended primarily for seniors continue to require extensive layering of subsidies to make projects economically feasible. The AARP survey shows that 83 percent of older resident properties received some additional state, federal or local subsidy, compared with two-thirds of LIHTC properties overall. The most common additional source was low-interest Rural Housing Service mortgages (51 percent). Others included waiver or reduction of property taxes (15 percent), HOME (12 percent), Community Development Block Grant (6 percent), state/local loan or grant (9 percent), tax-exempt bond-financing (7 percent), Federal Home Loan Bank loans (5 percent),

[62] Ibid.
[63] Stegman, Michael, "The Excessive Costs of Creative Finance: Growing Inefficiencies in the Production of Low-Income Housing," *Housing Policy Debate* (2:2), Spring 1991.
[64] Schuetz, Jenny and Laura Talle, *The Effects of Syndicators and Risk Management on Equity Pricing of the Low Income Housing Tax Credit*, MIT master's thesis, 2001.
[65] Ernst and Young Kenneth Leventhal Real Estate Group, *Low-Income Housing Tax Credits: The First Decade*, published for the National Council of State Housing Finance Agencies 1997.

reduced cost or free land (4 percent). Rural Housing Services loans dropped off following program cuts in 1994.

However, as discussed in Section 3.3.5, tax-exempt bond financing has become increasingly common. The most common form ('volume cap' tax-exempt bonds) is allocated by states and includes low-income housing tax credits that are exempted from the state's tax credit allocation ceiling. In addition, non-profit 501c3 organizations can issue tax-exempt bonds that are not subject to an allocation or cap, but these bonds do not include tax credits.

Besides the development subsidies listed above, 31 percent of tenants in senior properties received project-based rental assistance (Section 8 or local programs), while 12 percent received tenant-based rental assistance. These number compare to 25 percent of residents in LIHTC properties overall who receive direct rental assistance; project-based assistance is more common in primarily senior properties, while tenant-based assistance is less common.[66]

There are a number of potential benefits of using the LIHTC program for affordable assisted living. The LIHTC program is one of the most politically popular affordable housing programs, and is by far the largest production subsidy currently in place. Around 70,000 affordable rental units – around 13,200 of which are intended for older residents – are completed annually under LIHTC, a production rate that significantly outpaces Section 202 new development.[67] A substantial industry of developers, syndicators, consultants and investors has grown up around LIHTC, providing not only expertise in development and management but a broad base of political support that seems likely to ensure the continuation of the program. Providers of affordable assisted living, like other affordable housing types, will certainly look to tax credits for development subsidy. However there are also several weaknesses of using LIHTC. Intended as a development program, LIHTC does not provide any subsidy for supportive services. Typically,

[66] Kochera 2002.
[67] Ibid; Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century 2002.

the level of subsidy provided under the LIHTC program is not adequate to produce assisted living facilities with rents affordable to low-income seniors, because of assisted living properties' high development costs due to extensive common areas. The complexities of the tax credit program and need for gap financing result in high soft costs of development. Moreover, tax credit projects are dependent on convincing private investors that the project will be financially viable for the length of the tax benefits to investors (at least 10 years). Because funding for supportive services is typically provided for a shorter period, and because an affordable assisted living facility would not be viable in the absence of service subsidies, LIHTC investors have been reluctant to embrace assisted living as a viable class of LIHTC properties.

Summary

The LIHTC program is by far the largest development subsidy for affordable housing, and as such is an important resource for affordable assisted living. However, existing projects have very low levels of service provision, unlike Section 202 properties. Assisted living is a seen as a risky use of tax credits, due to regulatory confusion from the IRS over eligibility, political uncertainty over continued availability of Medicaid funds, and the poor performance of private-pay assisted living. Moreover, tax credits require considerable additional subsidies for development, housing operation, and supportive services in order to reach the target income population. If tax credits are to be a feasible option for subsidizing assisted living, the market and regulatory risks that worry investors must be lowered.

3.3.5 Tax-exempt bonds

Multifamily tax-exempt bonds are an increasingly important source of development subsidies. However, because the rents affordable to extremely low-income seniors are below the rents achievable with bond financing alone, bonds also must be paired with an operating subsidy to

reach the target income population. There are two primary forms of tax-exempt bond financing for multifamily properties.

Volume-cap tax-exempt bonds

States are able to authorize the issuance of a limited amount of 'private activity' tax—exempt bonds, for purposes including industrial development, single family mortgage revenue bonds, and multifamily mortgage revenue bonds. Multifamily volume-cap bonds also include 4 percent LIHTCs. Multifamily volume-cap bonds are issued on a project-specific basis and must involve a public entity, such as a housing finance agency or housing authority. The proceeds of multifamily volume-cap bonds, and the proceeds from the associated LIHTCs, are used by private developers. Volume-cap tax-exempt multifamily bonds must meet the affordability guidelines of tax credits (at least 20 percent affordable at 50 of percent area median income or at least 40 percent affordable at 60 percent if area median income).

501c3 tax-exempt bonds

501(c)3 bonds are issued exclusively by non-profits. There are no limits to how much can be issued, although the non-profit must retain 100 percent ownership of the property (syndication is not permissible). 501c3 tax-exempt multifamily bonds must have at least 20 percent of the units affordable at 50 percent of area median income, and at least 75 percent of the units (including those affordable at 50% AMI) affordable at 80 percent of area median income. As shown in the profile of John Whitaker Place in Section 4, 501c3 tax-exempt bonds have fewer regulatory requirements than volume-cap tax-exempt bonds, and are more readily available (needing no allocation). However, because 501c3 bonds lack the 4 percent tax credits, 501c3 bonds are not as powerful a form of subsidy as volume-cap tax-exempt bonds.

3.3.6 Other federal housing finance programs

In addition to the programs described above there are also a number of programs that can be used in combination to aid in development or further bring down the project rents. Some of the more commonly used additional programs are described below.

FHA mortgage insurance

The Federal Housing Administration (FHA) offers a variety of mortgage insurance programs that cover the construction or rehabilitation of affordable senior housing. Most mortgage insurance programs are designed to cover long-term (up to 40 years) mortgages that can be financed with Government National Mortgage Association Mortgage Backed Securities. Mortgage insurance is designed to lower the cost of capital by decreasing the risk to lenders, thus allowing the borrower to obtain more favorable interest rates. Most have project-based rental assistance as well. The following mortgage insurance programs are used for elderly housing.

Section 221(d)(4) is an FHA mortgage insurance program that can be used by for-profit and not-for-profit sponsors for new construction or rehabilitation of multifamily rental or cooperative housing for moderate-income families, seniors, and the handicapped.

- Section 221(d)(3) is an FHA mortgage insurance program that can be used only by not-for-profit sponsors, for the same purposes as Section 221(d)(4), but providing a larger loan amount in relation to total development costs. In fiscal year 2001, the Department insured mortgages under Section 221 for 179 projects with 32,343 units, totaling $2.1 billion. Most of these loans were insured under Section 221(d)(4). An earlier version of the program, in place from 1962-1978, utilized a below-market interest rate mortgage loan (generally at three percent) to enable below-market rents. A number of seniors' properties were developed, typically with an early form of rental assistance called Rent

Supplement, typically covering all units. Most Rent Supplement contracts were converted to project-based Section 8 beginning in the 1970s.

- Section 231 is an older FHA mortgage insurance program that covers new construction or rehabilitation of multifamily rental housing specifically for seniors and persons with disabilities. It can be used by for-profit and not-for-profit developers. Section 231 has been essentially replaced by Section 221(d)3. In fiscal year 2001, the Department insured six projects with 664 units, totaling $5 million.
- Section 232 is an FHA program that insures mortgages that cover the construction and rehabilitation of nursing homes and assisted living facilities. Section 232 can be used by for-profit, public, and not-for-profit sponsors. This is the only FHA insurance that specifically addresses assisted living. In fiscal year 2001, the Department insured mortgages for 198 facilities with 23,120 units, totaling $1.3 billion.
- Active from 1968-1978, Section 236 combined FHA mortgage insurance of a market interest rate mortgage loan, with a monthly Interest Reduction Payment subsidy to reduce the effective mortgage interest rate paid by the project to one percent, and to thereby produce below market rents. Section 236 seniors properties typically included an early form of rental assistance called Rental Assistance Program (RAP), typically covering all units. Most RAP was converted to project-based Section 8 beginning in the 1970s.

Section 8 New Construction and Substantial Rehabilitation (1976-1984)

The NC/SR program provided project-based Section 8 assistance for up to 100% of the units, at a contract rent sufficient to support the feasibility of the development using a market interest rate mortgage loan. Roughly half of NC/SR properties had FHA-insured mortgage loans (most often under Section 221d, but also including loans insured under Sections 220 and 231), typically with 20 year project based Section 8 contracts. The remaining NC/SR properties had tax-exempt bond

financing from state or local issuers, typically with project based Section 8 contracts having the same term as the bonds (typically 30 to 40 years).

Rural Housing Service loans.

Rural Housing Service Section 515 loans through the Department of Agriculture provide loans at one percent interest for a 50-year term and must serve very-low income residents. Rural Housing Service funding has declined to about 1000 units of new production per year, about half used for seniors.

Gap financing under HOME and CDBG

Frequently the larger housing programs described above are combined with smaller amounts of subsidy from other federal programs, for so-called "gap financing." The most commonly used sources of gap financing are HUD's HOME and CDBG programs. Both HOME and CDBG are federal block grant programs that can be used in conjunction with a variety of other subsidies. The HOME program provides federal block grants to state and local governments, targeted specifically to create affordable housing for low-income households. State and local governments can use HOME funds for grants, direct loans, loan guarantees or other forms of credit enhancement, or rental assistance or security deposits. Under the Community Development Block Grant program, federal funds are allocated to states and localities for use in various community planning and development activities. Some sample uses of HOME and CDBG funds include: a HOME soft loan to a developer for an LIHTC project or a city grant of CDBG funds to a housing authority as part of a HOPE VI redevelopment project.

Service coordinators

Through the Service Coordinator program, HUD provides funds for Service Coordinators to assist seniors and persons with disabilities living in federally assisted multifamily housing. Owners of Section 202, Section 236, and Section 221(d)3 properties may apply to cover service

coordinator salaries and benefits as well as administrative and training expenses. Service coordinators assess resident needs, identify and link residents to appropriate services from community agencies, and monitor the delivery of services. In fiscal year 2001, HUD awarded 217 grants for a total of $25.79 million. These grants will serve 242 developments, with a total of 22,083 units.

Summary

A wide variety of funding sources are available to finance the development and operation of affordable housing for seniors. The primary vehicles for new construction are low-income housing tax credits and tax exempt bonds; projects developed using these development subsidies generally require operating subsidies to be affordable to very-low and low-income seniors, as well as subsidies for any supportive services. New construction can also take place through the Section 202 program, which, like public housing and Section 8, provides deep rental subsidies but does not provide funding for supportive services. The Seniors Commission estimates that over 1.3 million seniors live in government-subsidized rental units. Although HUD is beginning to recognize the need to introduce supportive services into existing senior properties, the current housing programs have some regulatory requirements that make it difficult to accommodate the service component.

One further consideration of the housing finance programs described is that none are entitlements; public, not-for-profit and for-profit sponsors must go through a competitive application process for limited funds. In a sense this pits providers of affordable senior housing against providers of affordable family housing, assisted living against independent living. States and localities may set aside allocations for seniors' needs, or award higher scores in applications for programs serving seniors, but these set-asides

come out of the general pool of housing funds. Without special designations for seniors, the funding availability will depend on determination of state and local housing priorities.

3.4 Health care finance and regulation

3.4.1 Medicaid

Overview of HCBS waivers

The primary subsidy for the service component of assisted living comes from Medicaid. Medicaid is the jointly funded cooperative venture between the federal and state governments to provide health care to eligible persons. The program is administered through state agencies, and income eligibility, type of services covered, and rates of reimbursement vary by state. Medicaid funds can be used to pay for such services either through home-and community-based service (HCBS) waiver programs or state Medicaid plans. In addition, some states use general revenues for assisted living services. The use of Medicaid for these services is fairly recent; prior to 1981, Medicaid offered long-term care benefits almost exclusively through institutional settings, such as nursing homes. However, home- and community-based care is increasingly viewed as a preferable alternative to institutional care, for reasons of cost and flexibility to the states as well as preferences of the individuals receiving long-term care. Section 1915(c) of the Social Security Act of 1981 allowed states to offer a broad range of home- and community-based services to Medicaid-eligible individuals who might previously have been served in institutions. Seniors are one of several target populations, along with developmentally disabled or mentally retarded individuals and persons with AIDS, that can be covered by HCB waivers. States must apply to the U.S. Department of Health and Human Services for HCB waivers, also known as 1915(c) waivers, demonstrating that the waiver program will meet a "budget neutrality" test, i.e., that spending under the waiver program will not exceed the amount that the state would have spent without the waiver for long-term care benefits. Waivers are initially approved for three years and

must be renewed every five years. States may also limit waivers to specific geographic areas, or enact limited pilot programs.[68]

State coverage of assisted living

Each state designs its own waiver program, enumerating eligible services, rate and means of reimbursement, and income eligibility, within guidelines issued by the federal Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) at the Department of Health and Human Services. The waivers can cover a wide variety of non-medical, social and supportive services. Services listed in the Act are case management, homemaker services, personal care, adult day health, habilitation and respite care. States can also choose to include a variety of other services provided in non-institutional settings. However, there are also clear restrictions on what Medicaid waivers may cover; they may not be used to pay rent or the costs of raw food (but can cover food preparation). Although few states explicitly cover assisted living, most include coverage of services provided in assisted living either through waivers or the Medicaid state fund, as shown in the Figure below.[69]

Figure 3.4: State coverage of assisted living, 2002

Type of coverage	List of states
State funds	CT, ME, MN, ND, SD, VA[70]
Medicaid State plan	AR, ID, FL, MA, ME, MI, MO, NC, NY, SC, VT
Medicaid Waiver	AK, AZ, CO, CT[71], DE, DC, FL, GA, HI, IA, ID, IL, IN, KS, MD, ME, MI[72], MN, MS, MT, NE, NH, NJ, NM, NV, OR, PA, RI, SD, TX, UT(1915(a)), VT, WA, WI, WY
Planned	CA, LA (pilot)
Under consideration	AL
No coverage	KY, OH, OK, TN, WV

Source: Mollica, *State Assisted Living Policy 2000* and personal communication.

[68] American Public Human Services Association, *Medicaid Home- and Community-Based Waivers: A Look at the States in 1998*, http://medicaid.aphsa.org; Coleman, Barbara, Wendy Fox-Grage and Donna Folkemer, *State Long-Term Care: Recent Developments and Policy Directions*, Denver, CO: National Conference of State Legislatures 2002.

[69] Mollica, Robert, *State Assisted Living Policy 2000*, National Academy for State Health Policy, www.nashp.org.

[70] Virginia no longer has a waiver that covers assisted living but uses state funds for people previously served.

[71] Connecticut and Pennsylvania have pilot waiver programs.

[72] Michigan includes coverage in unlicensed housing sites that may be marketed as assisted living.

Reimbursement

States have established complex systems of reimbursing services; some states have a flat rate per day, others have tiered reimbursement for various levels of service. The rates vary widely by state and sometimes by geographic location within states.[73] As might be expected, reimbursement rates are highly controversial, with providers (particularly in high cost areas) claiming that rates do not cover the full cost of services.[74] In the face of budget shortfalls, state legislatures are attempting to contain costs and implement incentives for providers tailor services to residents' actual needs.

Figure 3.5: Reimbursement standard

Method of payment	States
Care plan	AR, IA, ID, KS, ME, MI, MO, MT, ND, NH, PA, WI
Case mix	MN, NC, NY
Cost based	ME
Flat	CO, FL, GA, HI, MA, MI, MS, NE, NM, NV, RI, SD
Regional variations	IL
Setting	NJ, TX
Tiered	AK, AZ, CT, DE, ID, MD, OR, UT, VT, WA

Source: Mollica, *State Assisted Living Policy 2000*

Income eligibility

The waivers also allow states to expand the income eligibility of the population served, that is, to cover assisted living services for individuals who would not normally be eligible for Medicaid. States can also include a "spend down" provision under which recipients with high medical expenses may be eligible for Medicaid even if their income would normally disqualify them. One further means of expanding eligibility is the use of Miller Trusts, which allow individuals to put their income into a trust and receive payment from the trust of an amount below the state's

[73] Mollica 2000.
[74] Coleman, Fox-Grage and Folkemer 2002.

income cap. The Figure below shows the various income levels, spend-down allowances, and use of Miller Trusts set by states for waivers targeted at elderly populations.[75]

Figure 3.6: Income eligibility (as of 1998)

Income limits	List of states
100% SSI	CA, MA
200% SSI	NV
300% SSI	AK, AR, CT, FL, IA, KS, MD, PA, RI, SD
Other	IL, MN, NH, OH, UT
Miller trusts	AK, IA, SD
Spend down	AR, CA, FL, IL, KS, MA, MN, MO, NH, NV, OH, RI, UT

Source: Author analysis of APHSA database

State fiscal impacts

One of the driving concerns behind Home- and Community-Based Service waivers is the potential for reducing the growth of state expenditures on long-term care. Since institutional care through nursing homes is generally more expensive than home- and community-based care, HCBS waivers ought to allow coverage of more persons at a lower level of care for a fixed cost. However, overall cost savings are difficult to determine, depending on range of income eligibility, level of reimbursement, and any rate increases over time. The American Public Human Services Association (APHSA) keeps a database on 1915(c) waivers and periodically surveys states about their enrollment and estimated costs of the programs. The most recent survey in 1998 shows a trend towards increasing enrollment in waivers and an increase in per capita costs; however, the survey encompasses all target populations, not merely elderly, and the authors estimate that the cost of treating individuals in institutions would far exceed per capita costs under the waiver programs.[76] State legislatures are worried about the potential "woodwork effect" and subsequent explosion of costs from making waivers an entitlement to all income-eligible persons; states often choose to set up demonstration programs or limit waivers to a specific geographic area, or

[75] American Public Human Services Association 1998.
[76] Ibid.

otherwise cap the number of waivers available each year. Some states, such as Michigan and Florida, have reached their caps and have lengthy waiting lists of eligible persons. Such uncertainty over access to Medicaid funds reinforces the unwillingness of lenders to invest in assisted living projects that depend on Medicaid for operating subsidies.

To cope with tight budgets, some states have explored alternative ways of paying for assisted living. Maine has opted to fund demonstration sites out of the state general revenue plan. The National Conference of State Legislatures cites Pennsylvania's use of lottery revenues and tobacco settlement revenues to fund long-term care services, while Indiana funded the state-funded CHOICE program at $40 million in FY 2000. Another source of funds is the Older Americans Act, which distributed $1.25 billion in FY 2001 through the Area Agencies on Aging, often an important partner in affordable assisted living ventures.[77]

Florida has recently begun limited attempts at project-based waivers, in order to encourage development of assisted living facilities. Ordinarily waivers are allocated to income- and disability-eligible individuals, rather than to facilities. Thus if a waiver recipient leaves a facility, there is no guarantee that the new resident will have a waiver (for instance, if the waiver program has reached its cap). By assigning waivers to facilities, the project receives a guarantee of continued service funding as long as residents meet the income eligibility standards. Thus project-based waivers provide a more reliable operating subsidy, which should reassure lenders and investors about the longer-term financial stability of the project.

Administration

Waivers may be administered through a variety of agencies as designated by the state; it is not entirely clear whether the type of administering agency has a substantive effect on the use of waivers. However, it has been suggested that public health departments, for example, may have

[77] Coleman, Fox-Grage and Folkemer 2002.

an institutional bias towards treating assisted living more as a medical facility than a residential one. Some agencies may be more predisposed to working with housing finance agencies and other departments involved in the affordable assisted living development process. The Figure below summarizes the administering agencies in charge of elderly-targeted waivers.

Figure 3.7: Agency of oversight

Primary Agency	List of states
Dept. of Health	VA, DC
Subdivision on Aging	NH,MD
Dept. of Human/Social Services	AR, RI, IA, UT, MN, CT, SD
Subdivision on Aging	MO, AK, NV
Dept of Elder Affairs	MA, CA, OH, PA, FL, RI, IL, KS, ME

Source: Author analysis of APHSA database

Summary

Although waivers are generally acknowledged to be an improvement in both expanding options for seniors and decreasing nursing home expenditures, states now face several challenges as they try to slow rising Medicaid costs. The sluggish economy has increased the number of people seeking public assistance with health care costs, shortages of care workers have driven up costs of service delivery, court decisions have stimulated demand for community-based alternatives among several populations including seniors, and the aging of the population increases the number of persons needing assistance. Spending on home- and community-based waiver programs has increased from $10.6 billion in fiscal year 1999 to $14 billion in fiscal year 2001, although still a fraction of the $42.7 billion in Medicaid nursing home expenditures. Still, the National Council of State Legislatures predicts that states will continue to explore cost-cutting measures, revising income eligibility requirements, capping enrollment, and maintaining long-term care per diem prices.[78] The uncertainty surrounding Medicaid waivers, particularly in the current economic environment, is a significant obstacle to development of affordable assisted

[78] Coleman, Fox-Grage and Folkemer 2002.

living, since most projects rely heavily on such waivers to subsidize service provision. Lenders and investors are wary to commit funds to a project whose main source of service subsidy may not be available when needed or may be inadequate to cover costs.

3.4.2 Supplemental Security Income (SSI)

Supplemental Security Income provides additional income to low-income elderly and disabled populations. It is a federal program administered through the Social Security Administration, but states may provide optional supplements. The exact amounts of the supplements and eligibility requirements differ across states. The eligibility criteria are quite important because the same criteria are generally used to determine Medicaid eligibility as well. Some states include SSI supplements that raise the level of income for all recipients; others specifically cover room and board provisions, which may be used at assisted living facilities. In most states, SSI recipients are automatically eligible for Medicaid, although a few states have Medicaid income eligibility levels below the SSI income cutoff. Some states have a "spend-down" provision under which recipients with high medical expenses may be eligible for SSI even if their income would normally disqualify them.[79] Both SSI and Medicaid have asset limits as well as income eligibility restrictions; in 2002 recipients could have total assets no more than $2000 per person or $3000 per couple, excluding primary residences or cars.[80]

3.5 Foundations/charitable grants.

Although all affordable assisted living (indeed all affordable housing) relies heavily on public funding through a variety of sources, it is important to note the significant role played by private not-for-profit organizations. Not only do non-profits serve as project sponsors, property managers and service providers, but they provide a great deal of independent funding. Much of

[79] Social Security Administration, *State Assistance Programs for SSI Recipients*, Washington, DC: U.S. Government Printing Office, 2002.
[80] Social Security Administration, *Desktop Guide to Supplemental Security Income Eligibility Guidelines.*

this funding is provided through direct grants and loans to specific projects; as the profile on Presentation Senior Community in Section 4 shows, several locally based foundations with a commitment to senior services provided key funding to make the project possible. On the national scale, foundations have funded initiatives aimed at improving the availability of assisted living. One such program is the Coming Home initiative, funded by a $6.5 million grant from the Robert Wood Johnson Foundation and administered through the NCB Development Corporation. Coming Home provides grants to state governments to support policy initiatives on assisted living, and offers technical assistance and pre-development loans to local non-profits. The program staff plays a key role in facilitating discussions between the various state agencies (housing, Medicaid, licensing, and elder affairs) and in providing assistance during the feasibility study process.[81] Foundations often play a key role in gathering and disseminating information about best practices or innovative programs to local non-profits.

3.6 State initiatives

One conclusion is clear from the previous sections: although much of the funding used in affordable assisted living comes from the federal government, the states are in the forefront of public involvement. States develop licensing regulations, administer Medicaid funds, tax credits and tax-exempt bonds, and set reimbursement rates and policies. Several states also have funding programs targeted at senior housing and care. The level of familiarity of key state agencies (housing finance and Medicaid, for instance) with assisted living can alter the difficulty of the development process, as well as affect the conversation and coordination between the agencies. Many of the project-level difficulties experienced by providers are the result of complicated interactions between state-specific assisted living regulation, federal housing program guidelines and state Medicaid guidelines. For instance, the ALCP requirement for being licensed may be fairly straightforward for projects in Massachusetts but impossible in Michigan, which does not

[81] Robert Wood Johnson Foundation, *The Coming Home Program: Affordable Assisted Living*, National Program Report 2001, www.rwjf.org.

license assisted living. Projects in Florida face stratospheric insurance costs, limiting their ability to obtain private or public funding. In short, the differences in state regulations, funding programs, coordination between agencies, market conditions, and sponsors' financial and organizational capacity have resulted in highly idiosyncratic projects, often difficult to replicate across state borders or even across sponsors. The National Council of State Legislatures review of legislative activity reveals that most states are in the process of considering a more comprehensive approach to long-term care.[82] Below are profiles of several states that are attempting to implement coordinated, cross-agency initiatives.

3.6.1 Florida

As a state with a high proportion of seniors – nearly 18 percent of the state's population – and relatively high housing costs, Florida has been forced to confront issues of aging sooner and more aggressively than younger states. One of the states receiving assistance from the Robert Wood Johnson Foundation Coming Home program, the Florida Department of Elder Affairs has pioneered several statewide initiatives around affordable assisted living. A distinguishing feature of several initiatives is the use of project-based Medicaid waivers; state budget appropriation allows the Department to set aside Medicaid waivers for demonstration projects. This addresses one of the key difficulties faced by developers of affordable assisted living; waivers are usually allocated to a building after development and licensing are completed, then there is no guarantee of receiving a waiver to cover services, and the process of determining eligibility can take several months, leaving the facility short in the meantime. By working with project sponsors to set aside waivers early in the development process, Florida's program alleviates a major underwriting concern. As the lead agency on many assisted living efforts, the Department of Elder Affairs works closely with other agencies, notably the Florida Housing Finance Corporation and local public housing authorities. The Florida Housing Finance Corporation recently issued a request

[82] Coleman, Fox-Grage and Folkemer 2002.

for proposals announcing the availability of funds for affordable assisted living through a soft-second mortgage[83], which can be used in conjunction with project-based Medicaid waivers. The Department of Elder Affairs is also encouraging and working with public housing authorities to convert existing senior properties; the property profile of Helen Sawyer Plaza describes the first such successful effort. Another joint effort between the Department of Elder Affairs and housing authorities is an attempt to combine project-based allocation of Medicaid waivers with Section 8 vouchers. Housing authorities can issue requests for proposals for vouchers intended for assisted living, and various facilities submit bids to receive the allocation. This combination of housing assistance and service subsidies can bring the cost of existing facilities within an affordable range for lower-income seniors.[84]

Florida is also considering ways to take advantage of its abundance of private-pay facilities. The private market, particularly in large urban areas, is considered somewhat overbuilt, with occupancies around 80 percent and some properties going into default. The Tampa Housing Authority recently purchased a 73-bed high-amenity existing property that had defaulted on its HUD-insured mortgage. The low purchase price, reported by the St. Petersburg Times at $375,000, together with allocations of Section 8 vouchers and Medicaid waivers, allowed the housing authority to offer an attractive assisted living product at very low cost to the residents.[85] However, such opportunities may be limited in the future, as "sweetheart" deals offered to public agencies on HUD repurchase properties come under scrutiny. Nonetheless, Florida's innovative use of project-based Medicaid waivers and high level of cooperation between the Department of Elder Affairs and other agencies, enhanced by participation in the Coming Home program, offers several examples of state-led programs to make assisted living affordable.

[83] "Soft" loans typically do not have required debt service payments. Sometimes, payments are limited to a percentage of positive cash flow. Other soft loans have no payments due until maturity. Others provide for partial cancellation each year over the life of the loan, provided that the borrower remains in compliance with the public purpose of the loan.
[84] Author interview with Margaret Stewart, Florida Department of Elder Affairs.
[85] Wexler, Kathryn, "Authority may buy group home," *St. Petersburg Times*, January 15 2002.

3.6.2 Maine

Since 1993 Maine has been attempting to promote home and community based services and reduce reliance on institutional long-term care. Maine funds Elder and Adult long-term care services through state general revenues and MaineCare, the state Medicaid program. Working through the Department of Human Services' Bureau of Elder and Adult Services, the state has adopted a comprehensive, standardized approach to determine eligibility, arrange and coordinate home care services, and monitor quality of services and expenditures.[86] The Figures below shows the various long-term care programs funded through Medicaid and state general revenues, with fiscal year 2001 expenditures, and the extent of the state's shift away from institutional care.

Figure 3.8: Annual Medicaid and General Fund Expenditures, Fiscal Year 2001

Medicaid Program		General Fund Program	
Nursing facilities	$202,697,747	Home Based Care	$15,559,516
Residential Care	$61,783,716	Adult Day Services	$304,240
Adult Day Health	$787,015	Congregate Housing	$592,156
Private Duty Nursing	$4,292,745	Assisted Living CHSP	$1,812,206
Personal care services	$4,986,955	Alzheimer's respite	$754,609
Waivers: consumer directed, Elder & Adult	$26,358,353	Homemaker	$2,553,194
Consumer directed personal care	$3,765,039		
Home Health	$5,329,567		
Subtotal Medicaid expenditures	$310,001,137	Subtotal General fund	$21,575,926
Number of Clients	24,230	Number of Clients	6,738
Per client cost	$12,794	Per client cost	$3,202

Source: Maine Bureau of Elder and Adult Services, *Maine Home and Community Based Care System*

Figure 3.9: Change in composition of health care expenditures, 1995-2001

	1995		2001	
	Percent clients	Percent Expenditures	Percent clients	Percent expenditures
Nursing facilities	50%	84%	33%	61%
Home care	39	10	49	20
Assisted living	11	6	18	19

Source: Maine Bureau of Elder and Adult Services, *Maine Home and Community Based Care System*

[86] Maine Bureau of Elder and Adult Services, *Maine Home and Community Based Care System*, www.state.me.us/dhs/beas.

3.6.3 Massachusetts

Massachusetts offers an interesting paradox: it is a state with traditionally high housing costs and considerable barriers to development, yet has shown marked success in promoting affordable supportive housing for seniors. For instance, four of the 25 Assisted Living Conversion Program grantees are in Massachusetts, twice as many as in any other state. Several factors appear to explain why such a high-cost area has developed so many models of affordable assisted living. Massachusetts has a well-developed infrastructure around affordable housing in general. State agencies have a high level of familiarity with and support of the relevant federal funding programs and several state sources of funds are available through the Department of Housing and Community Development, the Massachusetts Housing Finance Agency, and the Massachusetts Housing Partnership. The state also has a rich supply of sophisticated, entrepreneurial non-profit organizations with long-term experience in navigating the complex housing finance system. Perhaps because of the high development costs and subsequent need for multi-layered financing, the state also has many consultants with expertise in the various funding programs and the complicated process of assembling multiple subsidies. Maggie Dionne of the Executive Office of Elder Affairs attributes much of the state's success to the emphasis on assisted living as a primarily residential model, which eases some of the licensing burden on providers. In some states, the assisted living licensure is more medically than residentially oriented, for instance requiring 24-hour registered nurse on duty, which can add to costs and deter traditional housing providers from seeking the license.[87] Massachusetts has low levels of nursing requirements and a relatively expeditious licensing process (around 60 days prior to opening). The state targets funds specifically to assisted living for frail elders, both through the housing finance agency's ElderChoice program and through the Group Adult Foster Care program, part of the state's

[87] Author interviews with Colleen Bloom, American Association of Housing and Services for the Aging, Naren Dhamodharan, Gagnier Hicks Associates.

Medicaid plan.[88] Massachusetts also enjoys some financial and technical assistance benefits as a Coming Home state; through this Robert Wood Johnson Foundation/NCB Development Corporation program, sponsors can apply for predevelopment loans and receive technical assistance from the national program office and the state Executive Office of Elder Affairs. The state's main challenges in promoting affordable assisted living are the high costs of development, fierce competition for federal housing funds due to the strong demand for family housing, and the level of Medicaid reimbursement for services, felt by many to be inadequate to fully cover costs.[89]

3.6.4 Michigan

Since 1999, Michigan has been conducting an Affordable Assisted Housing Project pilot program, setting aside Section 8 vouchers for individuals in Oakland County, Michigan, who are receiving services under the Medicaid waiver program. The project is a cooperative effort between the Area Agency on Aging 1-B; an area senior housing provider, American House Senior Living Residences; Macomb Oakland Regional Center; and the Michigan State Housing Development Authority. The home- and community-based services waiver program offers 14 different service options and reimburses up to $32 per day for services; the combination of rental assistance and service coverage made supportive housing affordable to low- and moderate-income seniors. The Affordable Assisted Housing Project was first implemented in Oakland County, Michigan, with 20 Section 8 vouchers allotted to Medicaid home- and community-based service waiver recipients, later expanded to 50 participants. In December 2001, HUD granted permission to expand the project into Macomb County. A project evaluation report published by the Area Agency on Aging in 2001 indicated that the Section 8 program's maximum rents ('payment standard') were problematic due to the high rental costs of residential care facilities. This initially prevented a

[88] MassHousing, *MassHousing's ElderCHOICE Program: Assisted Living for Elders Program Guide*, www.mhfa.com.
[89] Author interview with Maggie Dionne, Massachusetts Executive Office of Elder Affairs.

number of nursing home residents from relocating to residential care facilities, although the average daily cost of residential care is considerably lower than that at nursing homes.[90] The Figure below shows comparisons of average monthly Medicaid and Section expenditures for nursing homes and assisted living.[91]

Figure 3.10: Monthly expenditure comparison

	Nursing home	Assisted living
Medicaid	$2,800	$1220
Section 8 voucher		$320
Total	$2800	$1540

Source: Area Agency on Aging 1-B, *Affordable Assisted Housing Project Evaluation*.

Through advocacy efforts of American House Senior Living Residences, AAA 1-B, and the support of Michigan Congressman Joe Knollenberg, the Housing Choice Voucher program's 40 percent rule was waived for program participants choosing to live in assisted living, thereby allowing participants to pay the portion of rent that exceeded the voucher payment standard. Prior to receiving the Section 8 vouchers, over half of the Medicaid waiver recipients had monthly expenses exceeding their incomes, by an average of $200 per month; the housing vouchers helped lessen a significant financial burden. An alternative solution would be to allow waivers to the normal maximum payment standard, allowing higher Section 8 subsidies in assisted living properties than would be allowable in independent living situations. While the pilot project is a promising means of enabling low-income seniors to afford assisted living, it is a fragile arrangement, dependent on continued funding of Medicaid waivers. Currently the waiver program is closed to new enrollment, with a waiting list of 275 applicants from the community. Moreover, the number of Section 8 vouchers available to be linked with Medicaid waivers is limited, leading to a triage system for assigning vouchers as they become available. The amount

[90] Area Agency on Aging 1-B, *Affordable Assisted Housing Project: A Phase II Evaluation of the 40% Rule Waiver and Utilization of Assisted Living, 2001*, www.aaa1b.com.
[91] The Figure does not represent the total costs to federal and state governments because it does include SSI payments received by residents.

of reimbursement allowed under the waivers has remained fixed for the duration of the program, while the daily Medicaid rate paid to nursing homes increased by 17 percent between 1999 and 2001.[92]

Section 4 Project-Level Financial Profiles

This section contains profiles of five projects representing a range of models for affordable supportive housing that have been developed. Three of the projects are new construction or adaptive reuse that result in new housing units; two involve modification of existing facilities and enhanced service delivery to current residents. The projects are drawn from different regions of the country, from large urban areas and more rural ones. All projects have public agencies or non-profit organizations as sponsors with long-standing relationships to the local community; most are collaborative efforts with several team members. The projects selected are intended to illustrate a variety of different financing structures and service delivery plans through which sponsors can develop affordable supportive for seniors.

Bethany Tower I[93]
Fargo, North Dakota
www.bethanyhomes.org

Model type

An existing Section 202 property, Bethany Tower I received a HUD Assisted Living Conversion Program grant to renovate its current facilities. The project previously had in place extensive services; the Assisted Living Conversion Program grant allows physical renovation for better delivery of services to residents. Bethany Tower I offers a relatively simple model of funding,

[92] Area Agency on Aging 1-B 2001; author interview with Pamela Marron, American Senior Living Residences.
[93] Author interview with Joyce Linnerud, Bethany Homes; HUD, Assisted Living Conversion Program Awardees, www.hud.gov/content/releases/assistedliving.pdf; Bethany Homes Assisted Living, www.bethanyhomes.org/towers/towers.htm.

using neither rental subsidy nor much reliance on Medicaid waivers, and serves a slightly higher income population than many subsidized properties.

Background

Bethany Tower I was built in 1963 as an early Section 202 property. The property currently contracts with a licensed home health agency to provide assistance to residents; North Dakota does not license assisted living but the property is registered with the Department of Human Services. An intermediate care facility and nursing home operated by the same organization are located nearby. The owner applied for and received a Fiscal Year 2000 Assisted Living Conversion Program grant from HUD for $1,448,345. The renovation will take place in two phases with approximately half of the Towers I residents being temporarily relocated to a nearby independent living building owned by Bethany Homes during each phase of the renovation project.

Development team members

- The owner/manager, Bethany Homes, is a not-for-profit organization, and an affiliate of the Evangelical Lutheran Church in America and Lutheran Services in America.

Property overview:

- The property has 55 units: 23 one-bedroom units and 22 efficiencies.
- Due to the initial date of development as an early 202 property, and because Bethany Tower has no Section 8 rental assistance, income eligibility for Bethany Tower is 90 percent of area median income. The monthly rate of a typical unit is $1,028, which includes rent, housekeeping and meals. This is roughly half to two-thirds the cost of private-pay facilities in the area.
- The apartments offer private living quarters and baths, with a common dining room on each floor. The Assisted Living Conversion Program grant will be used to significantly

renovate the building, including remodeling resident bathrooms to comply with ADA standards, window and door replacements, remodeling kitchenettes on each floor, adding a resident call system and updating closet wardrobe space.

- Services currently offered include resident assistants and security personnel, three meals per day are provided and free laundry facilities are available to the residents. Other property amenities include a chapel, coffee shop, gift shop, hair salon, and pharmacy on site. Speech, physical and occupational therapy are provided at the facility, and a home health agency provides assistance to residents, including care plan, scheduled help and wellness checks.

Development timeline:

- Bethany Tower I received a Fiscal Year 2000 ALCP grant; the funds became available in fall 2001; construction began June of 2002 and is expected to last 10-12 months.

Redevelopment/permanent financing:

- A HUD Assisted Living Conversion Program grant for $1,448,345 was received to renovate facility and purchase a new building for temporary relocation.
- Amendment funds of $380,000 were received from HUD to cover rents at the neighboring apartment complex during the Towers renovation, as well as costs associated with the relocation and potential vacancies.

Operating subsidies:

- Bethany Tower I receives no rental subsidy. Prior to renovation, the full monthly costs were paid by residents, many with assistance from families or by spend-down of assets. The Director, Joyce Linnerud, estimates that several of the residents in the renovated building will receive Medicaid waivers.

Other Issues/Problems

There was a considerable delay between the announcement of grants and the actual availability of funds for the FY 2000 ALCP grantees. During the interval, Bethany Homes purchased a nearby independent living building, which it then used to house Tower I residents during the two-phase renovation of the Tower building.

Helen Sawyer Plaza Assisted Living Facility[94]
Miami, Florida

www.co.miami-dade.fl.us/housing/PUBLIC_HOUSING.HTM

Model type

Helen Sawyer Plaza is the first use of licensed assisted living in public housing. The project used HUD funding to renovate and modify existing public housing and received a special state Medicaid waiver allocation to pay for services. A number of housing authorities across the nation are considering developing similar assisted living to make better use of existing stock and enable current residents to age in place.

Background

Part of the existing public housing stock belonging to Miami Dade Housing Agency, in 1998 Helen Sawyer Plaza became the first licensed assisted living facility within public housing in the nation. The idea was presented to Miami Dade Housing Agency as part of a utilization review conducted by MIA Consulting Group, Inc., in 1995. The existing senior housing complex was 30 percent occupied and underused by the public housing clients. It was perceived to be in a "difficult" area. Currently, the rehabilitated development is at full occupancy and has a waiting list of 50 persons. Helen Sawyer has won several awards, including a HUD Best Practices Award,

[94] Author interview with Josie Ramirez, MIA Consulting; Conchy Bretos, "Medicaid waivers and assisted living facilities," *Journal of Housing and Community Development*, May/June 2002; Miami-Dade Housing Authority, *Public Housing Services*, www.co.miami-dade.fl.us/housing/PUBLIC_HOUSING.HTM.

a NAHRO Human Services Award, a National Association of Counties Achievement Award, and a Florida Housing Coalition Success Stories Award.

Development team members

Since the property was part of existing public housing stock, the lead developer was the Miami Dade Housing Agency. MIA Consulting Group, Inc., served as development consultants and is the current management company.

Property overview

- Helen Sawyer is licensed as an assisted living facility for 104 beds (21 one-bedroom units for married residents and 83 efficiencies for single occupancy). It has an Extended Congregate Care license, necessary to access the Medicaid Waiver.
- One hundred percent of the units are affordable to households at 50 percent of area median income. Residents pay rents set at 30 percent of adjusted gross income.
- Eighty percent of residents are women, 70 percent are Hispanic, and 25 percent are African-American. The average age is 85. Forty percent of residents are former nursing home residents.
- All services available under Florida law in an assisted living facility are provided, i.e. assistance with bathing, grooming, incontinence, eating, transferring, ambulation, supervision of medications and transportation. Also provided are housekeeping, laundry, and meal service (three meals and two snacks per day). All rooms are single, private rooms, except for siblings or married couples.
- The building is 8 stories with two elevators to the main ground floor where administrative offices, recreation rooms, computer lab and crafts Figure with televisions are located. Also the kitchen and dining area are located on the main floor. The campus is shady and

the Miami Metrorail stop is adjacent to the property. It is within a quarter mile to the medical center of Miami.

Development timeline:

- This building was a conversion, but occupancy and relocation was achieved within one year, opening in 1999. The state legislature enacted a demonstration project Medicaid Waiver for $1.3 million. This was the first time a Medicaid Waiver and Case Management was allocated to public housing.

Development and permanent financing

- Public housing modernization funds

Operating subsidies:

- HUD subsidizes rent for all apartments, set at 30 percent of residents' monthly income. HUD also provides a utility subsidy for all units.
- 65 residents receive Medicaid waivers that reimburse up to $28 per day for services.

Other Issues/Problems

- The special demonstration program Medicaid waiver avoided the usual Catch 22 situation of developing affordable assisted living. It is impossible to underwrite the Medicaid waiver as a viable source of revenue because waivers cannot be committed before the facility is operational. The necessary license as a Medicaid Waiver eligible facility cannot be obtained until after development is complete, but loans are difficult to secure without a guarantee of Medicaid funding.
- Because Helen Sawyer was an existing public housing building, there were not costs to acquire the building. This meant that the assisted living conversion required funding only for physical changes (e.g., addition of commercial kitchen) and supportive services.

John H. Whitaker Place[95]
Penacook New Hampshire
www.whitakerplace.org

Model Type

John H. Whitaker Place is a new construction project of supportive housing apartments and community health center in a rural setting. The project uses 501(c)3 tax-exempt bonds as the backbone of a streamlined development financing package, which includes a combination of rental assistance and Medicaid waivers to subsidize services and housing operations. 501(c)3 tax-exempt bonds are the most readily available below-market financing source and involve fewer regulatory issues than volume-cap tax-exempt bonds (which are combined with the programmatically complex low-income housing tax credit program).

Background

John H. Whitaker Place is located in rural area near Concord, New Hampshire. A not-for-profit 501(c)3 organization was established to develop the project, drawing from community leaders, healthcare providers, neighbors, residents' family members. In 1998, New Hampshire's Department of Elderly and Adult Services, in conjunction with Housing Finance Authority, issued a request for proposals for pilot projects to implement affordable assisted living using tax-exempt bond financing, rental housing assistance and the state Medicaid waiver, Home and Community-Based Care for Elderly Adults. The facility is shared with Riverbend Elder Services, a community mental health outpatient office. In 2002, John H. Whitaker Place was honored with an NCB Development Corporation /American Association of Homes and Services for the Aging Affordable Assisted Living Award.

Development team members

[95] Author interview with Allen Moses, Riverbend Community Health Center; NCB Development Corporation, *Case Study: John H. Whitaker Place, NCBDC/AAHSA Award for Excellence in Affordable Assisted Living 2001*, www.ncbdc.org; NCD Development Corporation, *Models for Affordable Assisted Living*, presentation at AAHSA Spring Conference, April 10, 2002.

- Riverbend Community Health Center served as lead development partner, manages Elder Services and housing initiatives.
- Concord Regional Visiting Nurse Association provides Wellness Services through a full-time Registered Nurse.
- Covenant Health Systems, Inc., an experienced assisted living provider, was contracted to assist with development and first year of operation.

Property overview:

- The property has 50 units, 6 studios, 42 one-bedrooms, and 2 two-bedrooms. All low-income units are one-bedrooms.
- Eleven units are designated for low-income residents, receive Section 8 rental assistance and Medicaid waiver support. The remaining 39 units are designated for moderate income residents, limited to 175 percent of area median income. The current income range of residents is $6,360 to $64,531, with average income of $23,336. Median income in the Concord, New Hampshire, area is $59,090.
- Rent for low-income units set at $505 (residents pay 30 percent of monthly income). Service costs for low-income residents are $1,500 per month or $50 per day, paid by Medicaid waiver.
- Monthly rent for moderate-income studios set at $2,048, one bedrooms at $2,573, two bedroom units at $2888. These rents are approximately $900 less than market-rate assisted living facilities in Concord
- Currently, the property houses 40 women and 11 men, with an age range between 58 and 96 years, average 81 years.
- Ninety percent of residents receive assistance with ADLs, most need medication management. For the remainder of residents, the spouse needs assistance.

- Services provided include two meals served daily, housekeeping, nursing, recreation, transportation, ADL assistance, and medication management.
- Building facilities include living room, dining room, community room, library, solarium, wellness center, hair salon, and laundry. Building and apartments are designed to be accessible and elder-friendly. Apartments include kitchen facilities for residents' use.

Development timeline

- Spring 1998 Dept of Elderly and Adult Services issues RFP, Riverbend team responded
- Spring 1999 Construction begins
- May 2000 Construction complete; John H. Whitaker Place opens

Development/permanent financing

Development costs			Development sources	
Land & buildings	$4,353,000		Tax-exempt 501(c)3 bonds (7 percent interest, 30 years)	$5,060,000
Soft costs	580,000		HOME loan (30 yr deferred)	650,000
Developer	530,000		Developer loans	348,000
Reserves	595,000			
Total	$6058,000		Total	$6,058,000
Per unit cost	$121,000			

Operating subsidies

Operating costs (monthly)			Operating income (monthly)	
Admin (mgt, van, office)	$46,500		Rental income	
Dietary	16,000		Low Income ($505)	$5,550
Utilities	8,000		Moderate Income (bundled with services)	95,480
Transport & recreation	6,500		Services income (Medicaid)	$16,500
Services	25,600		Misc (includes 6% vacancy)	667
Housekeeping	$10,800			
Total (including $1.25K reserve)	$113,400		Total	$118,197
Per unit monthly	$2,268			

Other Issues/Problems

- John H. Whitaker Place used 501(c)3 tax-exempt bonds, rental assistance and Medicaid waivers to achieve development without tax credits. The development team had initially explored using tax credits, but 501(c)3 bonds proved to be a better way to support development costs and avoided some of the regulatory issues and investor concerns. Together with HOME funds and developer loan, a relatively simple and effective financing package was achieved.
- The project has clearly met local demand; the 11 apartments designated for low-income residents filled prior to opening and have a continuing waiting list. The moderate rate apartments filled to 90 percent occupancy within one year of opening. The Board overseeing the project makes used of strong ties to existing community institutions.
- The dependence on Medicaid requires continuous commitment of state agencies to provide long-term service funding.
- Since opening, staffing costs have escalated, requiring additional funding.
- The initial plan expected to receive 25 Medicaid waivers, half of the state allocation. Eventually the project was allotted only 11 waivers, necessitating a reduction in the number of low-income units.
- Under New Hampshire regulations, the facility is not required to be licensed for assisted living.

Neville Place at Fresh Pond[96]
Cambridge Massachusetts
www.seniorlivingresidences.com/neville.html

Model type

Neville Place is an assisted living facility developed through the rehabilitation of an historic nursing home. The project is typical of the complex financing structure used by many traditional affordable housing development projects, particularly in high development cost areas. Besides multiple subsidies for development funding, Neville Place uses rental assistance and Medicaid funds for the service component, and some cross-subsidy from market-rate units.

Background

In 1996, the Cambridge Public Health Commission issued a Request For Proposals to redevelop a formerly city-owned nursing home in financial difficulties. Residents in Cambridge's elderly-designated public housing were becoming increasingly old and frail. Forty percent of Cambridge Housing Authority's residents in senior properties (approximately 700 households) were between 62 and 74; 30 percent (500 households) were between 75 and 84; 10 percent were 85 or older. Moreover, Cambridge had a declining number of nursing home beds; between 1996 and 2001, the number of beds declined by over 50 percent to 334 beds. To address the needs of its residents in the face of a shortage of affordable supportive housing, the Cambridge Housing Authority assembled a development team to convert the existing nursing home to an assisted living facility that includes some units affordable to low-income seniors, and to build a replacement nursing home nearby, creating an affordable continuum of care. This decision was reached because the existing building was more suited to residential assisted living use than to its existing nursing home use.

[96] Author interview and materials provided by Mike Feloney, Cambridge Housing Authority.

Development team

- Lead developer: Cambridge Housing Authority
- Finance/development consultant: Affirmative Investments, Inc.
- Manager/Service Provider: Senior Living Residences, LLC
- Legal Counsel: Brown Rudnick Berlack and Israels
- Architect: SBA/Steffian Bradley Associates

Property overview

- The property consists of 71 units of assisted living, 34 one-bedroom units, 24 studios, 13 "special-care" units.
- 30 units have project-based Section 8 subsidy plus LIHTC, 9 units are LIHTC (currently occupied by Section 8 voucher holders) and are affordable to households up to 60 percent of area median income, 18 units are affordable to households with incomes up to 80 percent of area median income, and the remaining 14 units are not income restricted.
- The rents (including meals and services) on the low-income units are $2,220 per month for a studio and $2,325 per month for a one-bedroom. The actual cost to most residents is substantially less due to Section 8 and Medicaid subsidies. The non-income-restricted units have rents of roughly $2700 for studios and $3200 for one-bedrooms. Comparable private assisted living facilities have somewhat higher rents.
- Services offered at Neville Place include: three meals daily, 24-hour on-site personal care, assistance with ADLs, medication management assistance, housekeeping and laundry services, individualized wellness care plans, social, educational, and spiritual activities.
- There are extensive building amenities including resident-use kitchen, media room, main dining room and several living areas, resident library and recreation room. The property also has close proximity to scenic Fresh Pond Reservoir with walking trails around the reservoir.

Development timeline

- Development proposal/development agreement: late 1996/1997
- Siting process/home rule petition: 1998/1999
- Comprehensive Permit Zoning approval: December 1999
- Financial closing/construction start: November 2000

- Construction completion/opening: November 2001

Development financing

Amount	Type	Source
$6,280,000	LIHTC Equity	Local Initiatives Support Corporation's National Equity Fund
$3,345,000	Construction loan	East Cambridge Savings Bank
$750,000	Predevelopment loan*	Local Initiatives Support Corporation
$675,000	Loan**	City of Cambridge
$500,000	Loan**	Mass. Dept. of Housing & Community Development
$500,000	Loan**	Community Economic Development Assistance Corporation
$547,000	Loan**	Cambridge Health Alliance
$250,000	Grant	Federal Home Loan Bank
$12,300,000		Total Development Costs
$173,239		Total Development Costs per unit

* To be repaid within one year after construction completion
** No payments due so long as the project maintains affordability

Permanent financing:

- $3,345,000 from the Massachusetts Housing Partnership

Operating subsidies:

- Seven current residents receive service subsidies from Massachusetts' Group Adult Foster Care program, part of the state Medicaid plan. This provides $36.61 per day for non-medical health care services.
- The project has 30 project-based and 9 mobile Section 8 housing vouchers. These provide rental assistance of $1,064 per month for a studio, $1,199 for a one-bedroom unit.
- Eleven current residents participate in the PACE program, a state Medicaid/federal Medicare program.

Other Issues/Problems

- The existing building was acquired from the City under a long-term lease with nominal annual lease payments.

- As with many mixed-finance projects, the complex financing structure causes substantial soft costs in development. In this case, soft costs represent around one-third of total development costs, roughly $57,000 per unit.
- The combination of multiple housing and health care subsidies has made the goal of affordability to a broad range of incomes challenging. Households above Medicaid eligibility (approximately $6,624 per year) but below $22,500 require substantial family contribution or spend down of assets to afford units priced at $2,220 per month. The memory loss/Alzheimer's units have no subsidy beyond Section 8; Group Adult Foster Care does not allow for additional operating costs of these units, which can cost $4000 per month or more.
- Issues with zoning/permitting approvals extended the development period. The site of development is near the Fresh Pond reservoir, Cambridge's main source of drinking water and a prized open-space area. The rehabilitation of the nursing home into assisted living caused few concerns, but the proposed new construction of the nursing home generated some community opposition to new development.

Presentation Senior Community[97]
San Francisco California
www.PresentationSeniorCommunity.com

Model type

Presentation Senior Community provides services equivalent to assisted living through in-home services and an on-site day health center. The complicated financing package combines many subsidies from federal, state, and local public agencies, as well as extensive grants from private foundations. Many sponsors around the nation are exploring innovative ways to provide personal care and health services to low-income residents in a more flexible framework than through official assisted living facilities.

Background

Presentation Senior Community is a newly constructed Section 202 property with an adult day health center on-site. This project, which opened in 2001 after a ten-year community planning process, is a model of extensive service provision combining independent living apartments and an on-site licensed adult day health program. In 1991, Planning for Elders in the Central City, a consortium of nonprofit organizations and senior groups, conducted a comprehensive needs assessment of frail elders in the North of Market Street (Tenderloin) and South of Market Street area in San Francisco. The consortium's eventual recommendation was for a single room occupancy hotel that also housed health and support services, modeled after the On Lok facility also in San Francisco.

Adult Day Health Care[98]

Day health is intended as an alternative to skilled nursing institutionalization for frail elders and younger adults with chronic health conditions and physical disabilities. Day health service

[97] Author interview with Elizabeth Boardman, Presentation Senior Community; Elizabeth Boardman and Kathy Arizon, *Presentation Senior Community: An Innovative Concept Becomes a Reality, 2002*, http://www.presentationseniorcommunity.com/assets/book/pscwebbook.pdf.
[98] *Presentation Senior Community*, ibid.

provides the same kinds of professional and para-professional health care services provided in a skilled nursing facility. The day health staff includes nurses, occupational and physical therapists, social workers, recreational therapists, and personal aides. Personal care includes help with toileting, transferring to and from a wheelchair, and all the adjunct services available in a skilled nursing facility. Services include dietary and speech consultations, podiatry, and psychiatry. Social activities include parties, celebrations, games, arts and crafts, news and English as a Second Language courses. Day health deals with the full array of chronic physical ailments common to the elderly, including Alzheimer's disease, Parkinson's disease, dementia, stroke, hypertension, cancer, diabetes, heart disease, and chronic obstructive pulmonary disease. Unlike a skilled nursing facility, a day health center does not provide beds. Instead, day health service provides door-to-door, wheelchair-accessible transportation between home and the center. With this combination, a person can continue to live in his or her own home, coming to the day health center only during the day to receive services. All day health services in California are very similar because they are regulated by Title 22 of the California Health and Welfare Code. The unit of service is a four-hour day. Clients spend at least four hours, and often five or six hours, per day at the center. This provides a much needed respite for the caregiver at home, who often has serious ailments and challenges of his or her own. California day health programs are inappropriate only for those who are bed-bound and those whose behavior is so disruptive that they cannot be accommodated in a group setting.

Development team members

- Lead efforts for development came from North & South Market Adult Day Health (NMS-ADHC), a small nonprofit service organization providing adult day health

programs in the Tenderloin area of San Francisco. An affiliate of North of Market Senior Services, NSM-ADH is responsible for managing the on-site adult day health center.

- Mercy Housing California, a non-profit affordable housing organization, is the building owner and manages the independent living apartments.
- In-Home Supportive Services Program provides personal care and domestic services to apartment residents, under the auspices of the San Francisco Department of Human Services.
- Project Open Hand (a nonprofit San Francisco organization providing dietary services to seniors, people living with HIV/AIDS, homebound and critically ill people) supplies a daily noontime meal to the day health participants.

Property overview:

- The property contains 92 studio and one-bedroom units that house 139 elders. Sixty units are reserved for frail or disabled elders, the remaining 32 units are regular 202 independent living apartments.
- 100 percent of the units are affordable to seniors at 50 percent of area median income (in 2000 median income for San Francisco was $56,000). Residents pay 30% of adjusted income for rent and utilities, and the PRAC rental assistance subsidy pays the remaining portion of the rent.
- Forty of the building tenants attend Presentation Day Care, 6 attend other day health centers. Forty-five neighborhood residents attend Presentation Day Health program.
- In-Home Supportive Services provides in-home care, including ADL and IADL assistance. 79 of the 139 residents at Presentation Senior Community use In-Home Supportive Services.

- A daily Senior Lunch Program is provided by Project Open Hand and subsidized by the U.S. Department of Education and the San Francisco Commission on Aging. Currently there is no demand for an evening group meal.
- Apartments all have full kitchens, 50 percent have roll-in showers for wheelchair accessibility.

Development timeline:

1991	PECC concept paper recommends day health with SRO residences
1993	Feasibility study concludes that central city day health/senior building OK
1994	MOU between Mercy Housing and NSM-ADHC signed
1995	HUD 202/PRAC funding awarded
	Begin discussions with architect
1998	Lease signed; went into effect April 2001
1999	Groundbreaking ceremony; construction starts in July
2000	Build-out of day health center begins
Jan 2001	Construction of building complete
	Lottery for slots in building (2100 applications for non-frail units; 460 for 60 frail units)
Feb.	Day health center opens
July	Last apartment filled

Development/Permanent financing
Construction funding

$7,938,700	HUD Capital advance (Section 202)	
7,808,000	City and County funds	Local affordable-housing bond issue and hotel tax revenues
200,000	Mercy Housing	
30,112	Interim parking lot income	

418,000	NSM-ADH raised	Build-out of Presentation Day Health
	$10,000	Grant from Anonymous Family trust
	125,000	Mayor's Office of Community Development/CDBG
	150,000	SF Dept of Public Health
	100,000	Richard & Rhoda Goldman Fund (SF-based foundation)
	35,000	Evelyn & Walter Haas, Jr. Fund
16,394,812	Total construction funding	
Non-construction development		
$6,900	Lily Rains Trust	Client Events/Entertainment
$25,000	SF Foundation	Fundraising and Administrative Assist
$15,000	Mt. Zion Health Systems	Furniture and Equipment
$5,000	Bank of America Foundation	Furniture and Equipment
15,000	Bothin Foundation	Furniture and Equipment
10,000	Gerson and Barbara Baker Fund	Furniture and Equipment
2,000	Charles Schwab	Equipment
$25,000	Kaiser Family Foundation	Planning
20,000	Evelyn and Walter Haas, Jr. Fund	Planning
10,000	Catholic Healthcare West	Planning: Pro-bono feasibility study
$1,385	SF Adult Day Services Network	Marketing
$60,000	The CA Endowment	History and Replication Project
$60,000	The CA Endowment	Program Coordination
$55,240	Bank of America Foundation	Program Coordination
$80,000	CA Dept of Aging	Start-Up
$3,000	Fred Gellert Family Foundation	Start-Up
$60,000	Caltrans (Dept of trans)	Van and computer
$30,000	Bernice Hemphill Trust	Three day-health center grant
$483,525	Total non-construction development funds	
$16,880,337	Total development funds	

Operating subsidies:

- 100 percent of units receive HUD Project Rental Assistance Contract; total PRAC of $1,570,000.
- The state Medicaid program, Medi-Cal, reimburses $66.54 per day for adult day health; actual service cost around $85 per day.

- Lunch Program subsidized by U.S. Department of Education and San Francisco Commission on Aging.
- In-Home Supportive Services to apartment residents paid by Medi-Cal, city funds.

Other Issues/Problems

- The project has been aided by strong roots and a good reputation in the city and target neighborhood before starting the project; networks helped in fundraising, in-kind services.
- Operating as day health program and independent living apartments allowed the project to avoid state licensing as assisted living facility while providing roughly the same level of services to residents. However, combining staffs from two different service agencies requires each to learn other's organizational style and become comfortable working together. Also required additional fundraising, since HUD 202 funds could not be used for day health center.
- Presentation Senior Community has no debt; all funding obtained through grants. This allows the property to afford very low rents.
- Development financing shows very low soft costs (about $480,000). The staff costs incurred during the 10-year planning and development phase are essentially not included. This is in sharp contrast to most mixed-finance projects that have extremely high soft costs from finance/development consultants.
- This model works well in a fairly dense urban setting, in which the day health center is easily accessible to neighborhood as well as building residents; such a model would be more difficult to achieve in a suburban or rural environment.

Section 5 Policy options and recommended strategies

Why is providing affordable assisted living such a Herculean task?

Even in the private pay market, assisted living is inherently a complicated, expensive, and high-risk product. The combination of housing, and extensive personal care services is unavoidably costly and operationally demanding. The hybrid nature of the product requires that providers have expertise in real estate development/management and health care/social service delivery. Accurately predicting demand for private-pay assisted living has proven to be quite difficult, since demand is driven by changes in health and marital status, the timing of which are hard to predict. High turnover rates are inevitable, given the changing level of physical need of residents. Failures in the private market in the late 1990s illustrate the difficulty of making assisted living work even when, in theory at least, there should be sufficient demand and high enough fees to cover costs. Lenders and investors correctly perceive assisted living as high risk, reinforced by private market failures, and are wary of further investment in the industry. Yet, affordable assisted living is needed by large numbers of low-income seniors, and it is more cost-effective than serving those seniors in a nursing home.

The affordable market faces some of the same difficulties, together with fragmentation of funding, oversight, and political instability. The market risk from incorrect estimation of demand should be less problematic, since an affordable product has a much larger market that is largely unserved at present. However, fragmentation of funding drives up the already high costs of assisted living by adding more layers of complexity to the development process and requiring ongoing monitoring from various funders. A wide range of government agencies become involved in a single project, exposing projects to potentially conflicting regulations without one agency having clear responsibility. Many of the key regulations are issued at the state level, so that there is infinite variability in the services assisted living facilities can or must provide residents, what costs are eligible for Medicaid reimbursement, and even how states fund their Medicaid coverage

of assisted living. Such wide variation does not make private investors and lenders more comfortable, as investment in a more standardized and established product might. The fragmentation of both funding and oversight results in considerable political instability for the affordable assisted living market; each individual source of government subsidy represents a political risk. As with all ventures, high risk extracts a price from project sponsors. Assisted living has shown itself to be an inherently difficult product; adding the financial and political complexities, and the greater risk they generate, results in a tough market indeed for development of affordable assisted living.

Despite this rather gloomy picture, affordable assisted living is a worthy cause, and for many reasons, one that cannot be ignored. Currently many financial and regulatory barriers inhibit the development of affordable assisted living, and the complex interaction of a variety of regulations make it difficult to suggest a wholesale solution. The Commission on Affordable Housing and Health Facility Needs for Seniors in the 21st Century recently released its final report to Congress, containing some general guiding principles for addressing seniors' housing needs as well as in a number of program-specific reforms, primarily for federal housing and health care programs. The guiding principles are a straightforward assessment of how to approach any changes: preserve existing housing stock; expand successful production, rental assistance, service, and supportive housing models; link shelter and services; reform existing federal financing programs; and create and explore new housing and service programs. In keeping with those general principles, below are some specific policy options for federal and state agencies, as well as program suggestions and initiatives for project sponsors, foundations, research and advocacy organizations.

Federal government

- *Modernize and reposition existing stock*. As Section 3.3 outlined, there is a substantial existing stock of subsidized senior housing, some of it underutilized, much of it in need of modernization. Rehabilitation, reconfiguration, and repositioning within the market of existing stock would improve usability. As the experience of the Assisted Living Conversion Program has shown, in supporting the reconfiguration and conversion of existing properties, HUD could benefit from greater familiarity of state assisted living regulations and should allow flexibility in federal programs to accommodate state variations.

- *Add services to senior housing*. The single greatest problem with most of the existing subsidized housing stock is the lack of supportive services. Programs such as the Service Coordinator are a first step in addressing this; there should be greater effort to encourage and subsidize service provision in federally subsidized senior housing, whether explicitly assisted living or not. These efforts should involve coordination between HUD and HHS on the federal level. Regulatory difficulties to linking housing and services should be identified and reduced.
- *Support production programs*. New development of affordable senior housing through existing programs should continue, with some clarification about the applicability of federal funds for assisted living, particularly for the non-residential property amenities necessary for assisted living. Two of the most prominent development sources, HOPE VI and LIHTC, currently have high levels of uncertainty about the applicability of these funds to assisted living; HUD and the IRS should take steps to address these uncertainties.
- *Reduce financial risks*. Means of reducing private lender and investor uneasiness about assisted living in subsidized facilities should be explored. Possible tools might include the provision of long-term project-based HCBS waivers, expansion of FHA mortgage

insurance for assisted living and initiatives by the Government Sponsored Enterprises to underwrite affordable assisted living.

State governments

- *Coordinated administration of funds*. Since many of the critical funding sources are administered by the states – tax credits, volume-cap tax-exempt bonds, HOME and CDBG funds, and Medicaid – as well as licensing of assisted living facilities, state governments are in the position to offer a one-stop approval process that would streamline the development process. This would also provide a single point of reference to project sponsors, rather than requiring them to negotiate with multiple agencies. As the state initiatives highlighted in Section 3.6 indicate, strong coordination between state agencies can greatly facilitate development of assisted living.
- *Project-basing operating subsidies*. One of the main stumbling blocks for new development is the uncertainty of long-term operating subsidies, particularly Medicaid for services. Project basing these subsidies, as Florida's pilot project, offers a more stable project income and would reassure potential lenders and investors.
- *Spearhead coordinated initiatives*. Combining the previous suggestions, states could develop coordinated statewide initiatives. Such initiatives would assess local and regional needs based on demographic and income data as well as private-pay market conditions, then issue requests for proposals to meet the targeted goals. Project sponsors could submit one application for development funds, housing and service operating subsidies, and facility licensing (similar to the case study of John H. Whitaker Place in New Hampshire). Ideally, states should consider developing reliable and sufficient real estate and service funding streams that address the identified obstacles, rather than continuing to rely on the existing, ill-fitting housing and service programs.

- *Flexible regulation of facilities*. Although state regulations should encourage high quality standards for assisted living, the degree of flexibility in regulation has implications for ease of development. This is particularly important for conversion or redevelopment of existing stock with structural deviations from current regulations, as ALCP grantees have discovered. States should consider how regulations impact costs of new development, conversion, and operation. In particular, states that have adopted a medical model for assisted living regulation should consider creating a more residential model as well.
- *Rethink Medicaid usage*. Perhaps the single largest obstacle to provision of affordable assisted living is the uncertainty of Medicaid availability for supportive services. There is no easy answer to this problem, since states are facing difficult financial situations over the next few years at least. Nonetheless, states need to think about long-term care spending under Medicaid, draw up realistic estimates under different funding scenarios for nursing homes, assisted living, and home health. The political insecurity of receiving Medicaid and continuation of funding remains an intransigent obstacle to the financial feasibility of affordable assisted living.

Foundations, research and professional organizations

- *Facilitate conversations between project sponsors and government funding agencies*. There is a role for foundations and professional organizations to facilitate ongoing discussions between project sponsors and government agencies to monitor project performance, identify regulatory difficulties in the implementation stage, and adjust funding requirements for future grantees. An example of this type of leadership is the continuing conversation between HUD and the developer/sponsors under the Assisted Living Conversion Program, led by the American Association of Homes and Services for the Aging.

- *Provide technical and financial assistance to project sponsors*. Foundations, research and professional organizations are in a position to offer expertise gained from previously funded initiatives, share insights and obstacles overcome, and guide new sponsors away from pitfalls experienced by others. Targeted financial assistance could be made available to facilitate new projects. The current Coming Home initiative of the Robert Wood Johnson Foundation/NCB Development Corporation offers a model of both types of assistance, providing a revolving loan fund for predevelopment expenses, as well as technical assistance to sponsors.
- *Provide technical and financial assistance to state agencies.* Besides working with sponsors, foundations can assist state agencies in developing some of the coordinated policy initiatives described in the state recommendations above. The Coming Home program has also assisted several states in similar efforts, though financial assistance, encouraging coordination between agencies, and sharing information.
- *Collect and disseminate information on ongoing efforts*. Currently there is no readily available source of information on existing efforts to provide affordable assisted living. Due to the geographic distribution of project sponsors, variety of funding sources, and variation in project types, information about projects is not widely dispersed. It would be extremely valuable to collect comparable data on existing projects, including development and operations costs, sources of financing used, sponsor background, partner organizations involved, population served, local market conditions, and regulatory environment. Similar to HUD's development of the Low-Income Housing Tax Credit database, gathering this information and making it available would greatly enhance the ability of project sponsors to design new projects, for funders and researchers to assess the success of projects and identify areas for improvement.

- *Sponsor and conduct additional research*. Relatively little research has been done on affordable assisted living, although several initiatives are underway. Particular areas that could benefit from research are better analysis of the market, including clearer income and asset definitions, the status of low-income elderly homeowners, ethnic and regional differences in product acceptance; cost comparisons of various models of development and service provision; and the impact of licensing requirements, demographic characteristics, and private market conditions on the affordable market.

Sponsors

- *Identify strengths*. Potential project sponsors have a wide variety of existing skills and relationships that will be useful in developing and managing affordable housing. Recognizing and building on existing strengths, such as experience with tax credit development or relationships with referral agencies, will enable sponsors to assemble a development plan that is within their capacity and has fewer surprises.
- *Form strategic partnerships*. Most project sponsors enter the market of affordable assisted living from a primary business of either affordable housing development and management or social service delivery, but not both. Expertise in both areas is necessary for a successful project; many sponsors will find it more efficient to forge partnerships with organizations that complement their base of knowledge than to attempt to develop equally capacity in their weaker area. Many current projects use partnerships consisting of a development team (possibly using finance consultants), a housing manager, and one or more service delivery agents, such as a reduced cost meals program, a home health agency, and a social service deliverer.
- *Become familiar with the regulatory environment*. Regulation of assisted living varies considerably by state. The type of model that works best in a particular place depends greatly on the regulatory requirements, such as staffing

requirements and permitted level of nursing services. Thoroughly investigating the applicable regulations before designing the type of facility or service plan is essential. As the project profiles in Section 4 indicate, some regulatory environments may be more favorable for sponsors that choose to provide supportive housing but not be licensed as assisted living, while licensing may be required to be eligible for certain funding programs.

- *Investigate possible funding sources*. Sponsors should investigate all possible funding sources, and be aware of the program requirements or restrictions involved with each one, before deciding on the appropriate financing structure. In particular, some states or localities offer funds targeted at affordable assisted living, or may provide grants that can be used for services. Developing relationships with funding agencies can also make the application process less opaque.
- *Be aware of private-pay market activity*. Conditions in local private-pay facilities may provide information about potential problems, such as the liability insurance difficulties in Florida. The extent of market penetration and particular income levels served by the private market in an area also impact the possibilities for affordable assisted living.
- *Network with other project sponsors*. In conjunction with some of the foundation activities, project sponsors should communicate with one another to share experiences on obstacles and ways to overcome them. Collective discussions of experience working with particular funding programs can also produce an agenda of regulatory reforms for sponsors to raise with government agencies. The AAHSA working group with ALCP grantees is a good example of such conversation between sponsors. Sponsored by the California Endowment, Presentation Senior Community has produced a detailed report on its development process, including assembling the financing package, obtaining

necessary regulatory approvals, marketing, and the construction process. Less formal communication between sponsors would also be useful.

- *Be prepared for some financing "gaps*." Two keys areas are particularly likely to present financing problems: predevelopment funds and the service component. Predevelopment costs include preparing applications for financing, staff time learning the assisted living regulations, market feasibility studies, and other activities prior to development. These costs require up-front financing that may be require a designated source of funds. The second financial gap comes from the potential shortfall between Medicaid funding and actual service costs. According to sponsors in several states, the amount of Medicaid reimbursement is less than the cost of providing services; sponsors should try to develop a realistic estimate of service costs and look for sources of funds to supplement Medicaid payments.

Appendix A: Definition of Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs)[99]

Activities of Daily Living

The National Health Interview Survey (NHIS) asks questions to identify people who "need the help of other persons with personal care needs such as eating, bathing, dressing or getting around...(inside the) home." (Adams & Marano, 1995). These particular activities are termed activities of daily living. The Survey of Income and Program Participation (SIPP) definition of ADL includes eating, bathing, dressing or getting around inside the home, but also specifies getting into and out of bed or a chair, and toileting. The SIPP asks about whether a person has difficulty with any of these ADLs (one of the criteria for disability) and whether a person needs assistance to do the activity (one of the criteria for severe disability). The National Medical Expenditures Survey (NMES) definition is similar to the SIPP definition. The NMES describes ADLs as basic self-care tasks that include bathing, dressing, toileting, getting in and out of bed or a chair, feeding oneself, and walking across the room. A limitation in an ADL is defined as needing the help of another person or special equipment to perform the activity.

Instrumental Activities of Daily Living

Instrumental activities of daily living (IADLs): The NHIS collects information on people's need for assistance from others in performing instrumental activities of daily living (IADLs). The IADLs include: "doing everyday household chores, necessary business, shopping or getting around for other purposes." People who need assistance in activities of daily living (ADLs) were not asked about IADL. On the SIPP, instrumental activities of daily living include: going outside the home, keeping track of money or bills, preparing meals, doing light housework, and using the telephone.

[99] Source: www.infouse.com

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