National Investment Center for Seniors Housing & Care

NIC Investment Guide

Investing in Seniors Housing & Care Properties

THIRD EDITION

Bella Terra
Jackson, NJ

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Atria on the Hudson
Ossining, NY

Introduction

The *NIC Investment Guide: Investing in Seniors Housing & Care Properties, Third Edition* (*Investment Guide*) provides an overview of the seniors housing and care sector based on current time series data. This third edition, like its predecessors, was prepared by a task force of industry professionals working closely with the staff of the National Investment Center for Seniors Housing & Care (NIC) and was reviewed by an independent panel of industry and financial professionals. This publication helps fulfill the mission of NIC to advance the quality and availability of seniors housing and care options for America's elders through research, education, and increased transparency. This mission facilitates leadership development, quality outcomes, and informed investment decisions with respect to seniors housing and care.

Purpose

The *Investment Guide* is designed as a primer for understanding the seniors housing and care sector for capital providers and others to use to investigate the opportunities and risks of investing in seniors housing to help formulate an investment thesis. The publication serves as an introduction to the industry's investment and performance characteristics and its leading players. Sources used are listed in an appendix to enable readers to follow up on specific issues about which they would like more detail. The *Investment Guide* is intended as a representative overview of the salient features of the industry. Wherever possible, the *Investment Guide* provides information on seniors housing in comparison to other types of commercial real estate.

Data Used

This data-based overview has been made possible by the tremendous progress in data collection by the industry over the past 10 years. The NIC MAP® Data Service (NIC MAP®), covering the nation's top 99 metropolitan markets, has provided reliable time series data for the past eight years including industry performance on occupancy, rent growth, supply, demand and construction. For time series data, aggregates for the nation's top 31 metropolitan markets are used, as data from those markets is available from the fourth quarter of 2005. For point-in-time comparisons, data for all 99 metropolitan markets is used, as it is more representative of the overall seniors housing and care market. See Appendix L for a listing of each metropolitan market tracked by NIC MAP®.

Through NIC's strategic alliance with Real Capital Analytics, NIC MAP® also reports pricing and volume metrics on closed sales transactions of seniors housing and care properties throughout the U.S. over the past six years. The National Council of Real Estate Investment Fiduciaries (NCREIF) has tracked the performance of seniors housing properties since 2003, and the expanded and improved State of Seniors Housing provides yearly snapshots of industry performance in key areas such as expenses and operating margins. Together, these data sources offer essential information on net operating income (NOI) and investment returns. For data consistency reasons, wherever possible, the *Investment Guide* uses data as of the end of the fourth quarter of 2013.

Choices had to be made as to what information to include and what to exclude, either because the data integrity was questionable or because the information was considered beyond the scope of a primer. There were a number of places where the task force recognized that quality data simply is not available and that further work is needed to collect and report such data in the future. NIC is committed to work with others in the industry to fill these data gaps for future editions of this publication and welcomes comments and suggestions to improve future editions of the publication and advance the transparency of the sector.

Organization of Publication

The *Investment Guide* begins with an executive summary providing an overview and roadmap to the entire publication. A new chapter summarizing emerging trends and observations follows the executive summary. This trends and observations chapter relies to a greater degree, on expert opinions, than the balance of the data-driven publication. It is hoped the emerging issues and trends chapter will make the *Investment Guide* more forward looking than past editions.

The technical chapters of the *Investment Guide* begin with a detailed description of each seniors housing and care property type in Sections 3 through 7. For the third edition, we added a separate chapter on majority memory care properties rather than combining memory care properties with assisted living. The property type descriptions include resident profiles, supply data, industry operating structures, operating economics and current trends. In Section 8, we discuss development of new seniors housing and care properties. Section 9 reviews capital sources for both the development and construction of new properties and for the acquisition of existing properties. Finally, Section 10 discusses valuations, returns and loan performance.

We have included a comprehensive set of appendices. These include information of interest to investors in seniors housing and care properties, such as demographics (Appendix B). The appendices also include detailed information on certain topics such as entrance fee CCRCs (community care retirement communities, Appendix D) and lender underwriting standards (Appendix G).

Notes on Data Sources and Footnotes

Appendix M includes a list of all data sources referenced in this *Investment Guide*. Numbered footnotes refer to the data sources in Appendix M. Sources in Appendix M are listed in order of those most frequently referenced in the *Investment Guide*. The numbering of the footnotes is often not sequential. In general, the most timely, accurate and reliable data available has been used.

Acknowledgments

NIC would like to express its sincere appreciation to several groups whose efforts were instrumental in the development and production of this publication. First, NIC would like to thank the Investment Guide Task Force, co-chaired by Kathryn Sweeney and Jerry Doctrow. Members of the task force included:

- Colette Dafoe, Partner, Nixon Peabody
- Jerry Doctrow, Senior Advisor, Stifel Investment Banking, Task Force Co-chair
- Kelly Meissner, Director, Asset Management, Ventas, Inc.
- Carolyn Nazdin, Senior Vice President, KeyBank Real Estate Capital
- Shailini Nehra, Associate Director–Production & Sales, Freddie Mac
- Matthew Pierre, Vice President, Brookdale Senior Living
- Larry Rouvelas, Principal, Senior Housing Analytics
- Kathryn Sweeney, Co-founder, Blue Moon Capital Partners; Task Force Co-chair
- Jeff Theiler, EVP and CFO, Physicians Realty Trust
- Joe Zajdel, Vice President Business Development, Mather LifeWays

NIC would also like to acknowledge and thank outside reviewers, who took the time to provide insightful and constructive comments on the draft version of the publication. Their comments and suggested edits greatly improved the final product, and NIC appreciates their commitment to advance investor understanding of the industry. Finally, we would like to acknowledge the significant contributions of NIC staff members, including Chuck Harry, NIC Director of Research & Analysis, as well as Biba Aidoo, Carisa Chappell, Bill Kauffman, Beth Burnham Mace, and Chris McGraw.


Emeritus
Kingwood, TX

The Bellettini
Bellevue, Washington

In this section

Section 1: Executive Summary

NIC Investment Guide: Investing in Seniors Housing & Care Properties (Investment Guide) serves as a primer for understanding the seniors housing and care property sector. The *Investment Guide* covers the investment characteristics of the sector, as well as its performance and the leading players. Our aim is to provide the most current and reliable industry data for capital providers and others to help them evaluate risks and returns, and to fine-tune their individual investment strategies. The *Investment Guide* reflects the mission of the National Investment Center for Seniors Housing & Care (NIC) to advance the quality and availability of seniors housing and care options for America's elders through research, education, and increased transparency. This mission facilitates leadership development, quality outcomes, and informed investment decisions with respect to seniors housing and care.

1.1 Seniors Housing and Care Properties

The seniors housing and care industry provides both housing and an array of services to seniors, generally to those over the age of 75. Care segments are commonly divided into four categories: independent living (IL), assisted living (AL), memory care (MC) and nursing care (NC). Nursing care has traditionally been provided in an institutional-style setting, though there is a growing movement toward more homelike settings. The other care segments are typically provided in a multifamily setting. Seniors housing and care properties also include continuing care retirement communities (CCRCs), which typically offer all care segments, including independent living, assisted living and nursing care at a single community.

Currently in the U.S. there are approximately 22,700 investment-grade seniors housing and care properties containing 2.9 million units. For the purposes of this publication, we define as "investment grade" those age-restricted properties with at least 25 units/beds that charge market rates for the housing and services offered. These estimates do not include many smaller "board and care" properties, which are not considered for purchase by the typical institutional investor. The total value of this investment-grade seniors housing and care property market is estimated at approximately $330 billion (assuming a $159k price per unit for seniors housing properties and a $71k price per unit for nursing care properties).[1]

The following table shows the number of properties and units offered within the different property types, campus types and care segments:

Exhibit 1.a
Supply of Investment-Grade* Seniors Housing and Care Properties in the U.S.
By Property and Unit Counts across Property Types, Campus Types, and Care Segments | Estimates as of 4Q13**

By Property Type	# of Properties	# of Units***
Majority IL	4,060	883,500
Majority AL	6,305	507,500
Majority MC	1,060	51,000
Majority NC	11,270	1,504,500
Total	**22,695**	**2,946,500**

By Campus Type	# of Properties	# of Units***
CCRCs	1,970	634,000
Combined	5,560	684,500
Freestanding	15,165	1,628,000
Total	**22,695**	**2,946,500**

By Care Segment	# of Units***
Independent Living	716,000
Assisted Living	558,500
Memory Care	145,000
Nursing Care	1,527,000
Total	**2,946,500**

* Current estimates are not comparable to estimates from prior years.
** Estimates are representative of properties with at least 25 units/beds that charge market rates for the housing and services offered.
*** One nursing bed is equivalent to one unit. *Source: NIC Research & Analytics*

Care segments are defined by the type of and level of services offered. Property types are classified by the majority type of care segment offered (e.g., a CCRC with 100 units of independent living, 40 units of assisted living and 80 nursing care beds is classified as majority independent living, as is any combined property with a majority of independent living units or a freestanding independent living property). The one exception is memory care, where a property with a majority of memory care units is classified as majority assisted living because residents receive personal care services similar to those in assisted living, though they usually have memory loss or some form of dementia. The campus type of a property depends on the number and possible combination of care segments offered. Properties are classified as CCRCs when independent living and nursing care are offered at the same property, although assisted living and memory care are generally offered as well. Combined campuses offer at least two different care segments (e.g., independent living and assisted living); however, this does not include properties that offer independent living and nursing care, as these properties are classified as CCRCs. Freestanding campuses offer only one type of care segment (e.g., independent living only).

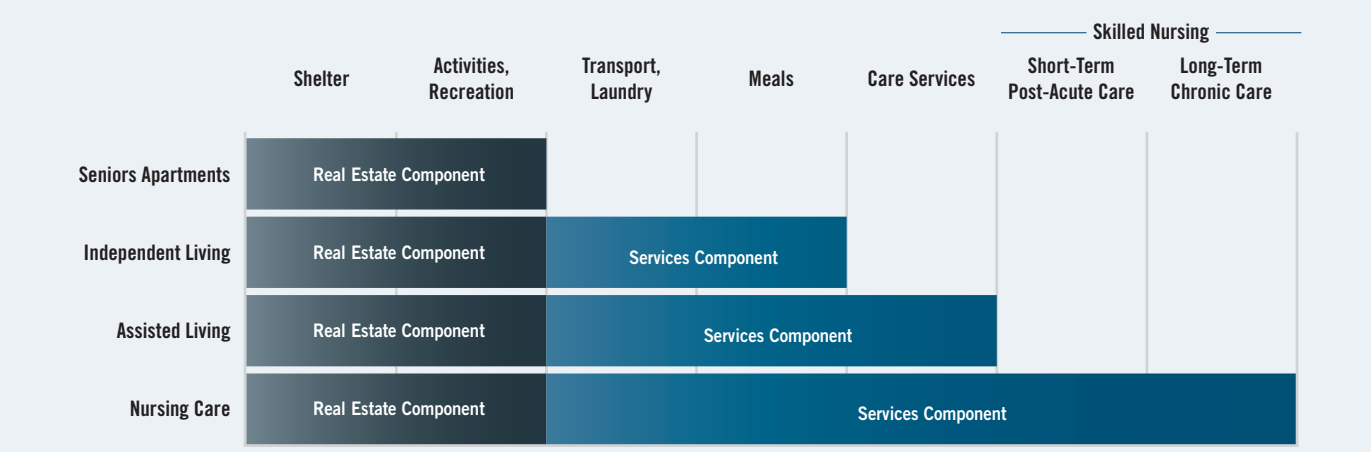
For purposes of this publication, the term "seniors housing" excludes nursing care properties and 55-plus seniors apartments, whereas the term "seniors housing and care properties" includes all of the properties providing the care segments outlined previously but not seniors apartments. The following exhibit highlights the array of services offered across the different property types. (For detailed descriptions of seniors housing and care property types, refer to Appendix A.)

Besides housing, seniors housing and care properties offer hospitality services (meals, transportation, housekeeping, entertainment and concierge services), care services (assistance with bathing, grooming, dressing, eating, medication management and other activities of daily living (ADLs)) and medical services (skilled nursing, rehab therapy and chronic care). The care and medical service mix at the property increases with the residents' needs. Independent living typically serves the most able residents and offers primarily hospitality services. Nursing care, on the other hand, serves the most medically-needy residents and, accordingly, has the most intensive services.

A current trend in seniors housing and care has been the rising acuity levels (i.e. needs) of residents across the care segments. As a result, independent living operators are beginning to see residents who already have some ADL needs. Assisted living operators are, in some instances, serving residents with ADL levels formerly associated with skilled nursing settings. In addition, skilled nursing operators are now serving, with increasing frequency, residents who need short-term rehabilitation services or those with high-acuity medical care

Exhibit 1.b

Property Types by Services Provided



Source: NIC Research & Analytics

needs who were previously served in an acute care hospital, a long-term acute care hospital or an inpatient rehabilitation facility. Some operators of seniors housing now provide home healthcare, therapy and other services to residents in order to better meet the needs of residents in their properties, while others allow residents to engage third-party service providers to meet care needs that could not otherwise be accommodated in their properties.

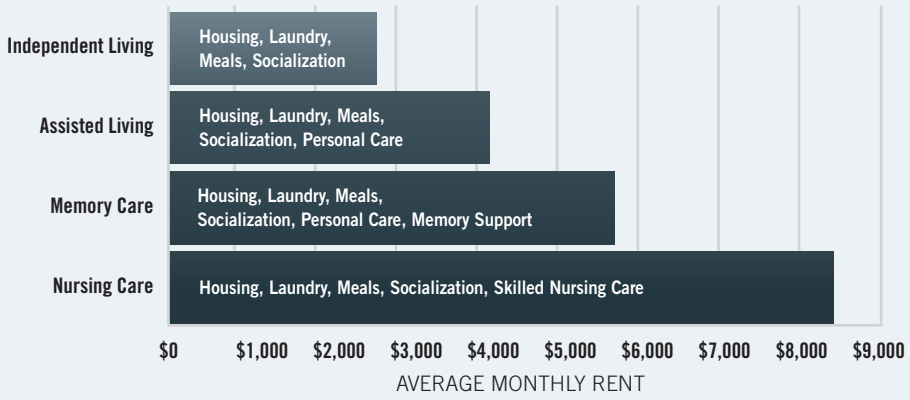
Exhibit 1.c highlights the average asking monthly rents for each care segment, reflecting the needs level and the accompanying service mix. (See Appendix C for more detail regarding needs assessment and pricing.)

In order to further quantify some of the distinctions between the different seniors housing and care property types, Exhibit 1.d provides select metrics.

1.2 Seniors Population

Seniors in need of services and their families drive demand for seniors housing and care properties. For purposes of this publication, seniors are persons of age 75 years and older (75-plus). In the U.S. as of 2012, there were 19.2 million people age 75-plus and 12.3 million households headed by people age 75-plus.[8] Exhibit 1.e on the following page shows the population in the U.S. by age cohort in 2012.

Exhibit 1.c
Average Monthly Rent by Care Segment
As of 4Q13



* The nursing care monthly rent is the average private-pay rate; see Section 4 for the Medicaid and Medicare rates.

Source: NIC MAP® Data Service

Exhibit 1.d
Selected Metrics Across Seniors Housing & Care Continuum
As of 4Q13

	Independent Living Properties	Assisted Living Properties	Memory Care Properties	Nursing Care Properties
Average Monthly Rent	$2,765	$4,159	$5,732	$8,432
Median Number of Units	168	73	46	120
Median Age of Buildings (years)	23	16	14	36
Rolling 4-Quarter Cap Rate/Yield	7.0%	8.3%	**	11.5%

* The nursing care average monthly rent is the average private-pay rate; see Section 4 for the Medicare and Medicaid rates.
** Data not available.

Source: NIC MAP® Data Service

The size of the age 75-plus population is expected to increase during this decade of 2010 to 2019 at a slightly higher rate (2.1 percent annually) than occurred from 1990 to 2009 (1.8 percent annually). Over the next five years, from 2015 to 2020, average annual growth in the 75-84 age cohort is projected to average 3.5 percent, while growth in the 85-plus cohort is expected to average 1.2 percent.[7] The most significant period of growth for the age 75-plus population is expected to occur between 2021 and 2039, when the baby boomers enter this demographic group. During the first five years that baby boomers enter the 75-plus population (2021–2025), the overall 75-plus population is expected to grow cumulatively by 22.6 percent.[6]

Exhibit 1.e
U.S. Population by Age Cohort
Estimates as of 2012

	Population (Millions)		Households (Millions)	
	Number	% of Total	Number	% of Total
45-64	81.9	26.5%	47.0	38.8%
65-74	23.4	7.6%	14.5	12.0%
75+	18.1	5.9%	12.3	10.2%
75-84	13.1	4.2%	8.7	7.2%
85+	5.0	1.6%	3.6	3.0%

Source: U.S. Census Bureau

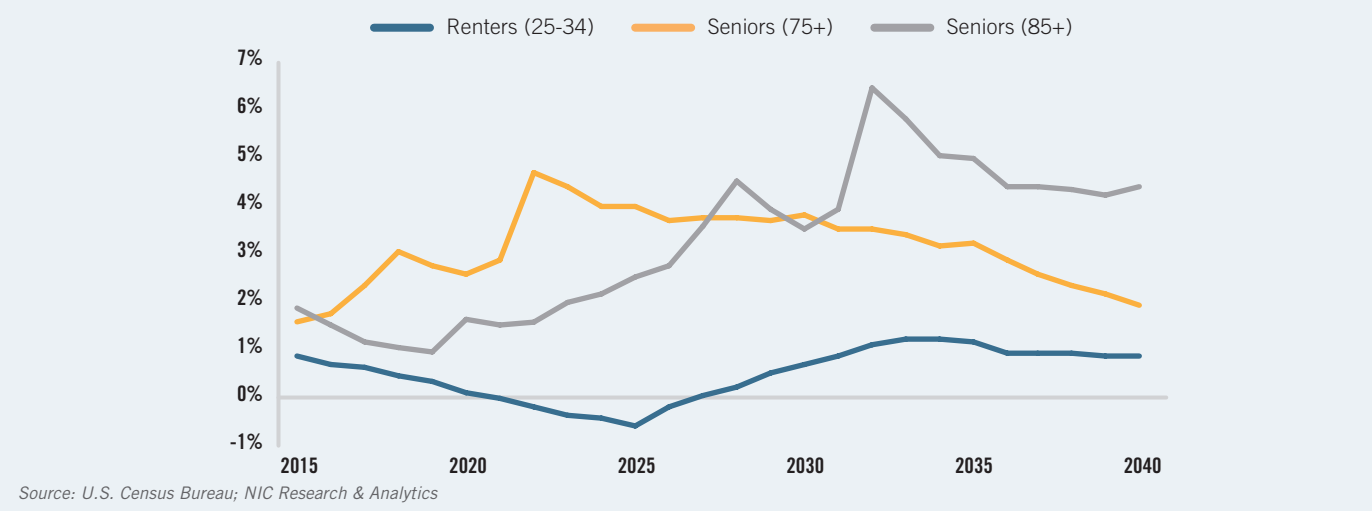
While those living in seniors housing and care properties represent 19.5 percent of seniors' households (9.4 percent when excluding majority nursing care properties), demand is impacted by the fact that many seniors still do not prefer to relocate from their existing homes into a seniors housing and care property.[1] (See Appendix B for more details regarding demand drivers.) Because of the preference of seniors to remain in their existing homes, many businesses provide services within the home to seniors as an alternative to the housing and services offered by seniors housing and care properties. We refer to these services as "alternative services." (Detailed descriptions of alternative housing and services are provided in Appendix E.)

1.3 Performance Comparisons

For many investors, the combined components of real estate, hospitality and needs-driven services give seniors housing and care properties a unique resiliency, offering the benefits of real estate investment along with the strength of the healthcare field. This resiliency was evident during the real estate downturn of 2008–2009, when seniors housing and care properties outperformed other commercial real estate property types in terms of investment returns and rent growth.

The NCREIF Property Index (NPI) is a leading U.S. quarterly time series composite total rate of return measure of investment performance (gross of fees) of a very large pool of individual commercial real estate properties acquired in the private market for investment purposes only. NCREIF is the acronym for the

Exhibit 1.f
Annual Population Growth Rates
2015-2040



Source: U.S. Census Bureau; NIC Research & Analytics

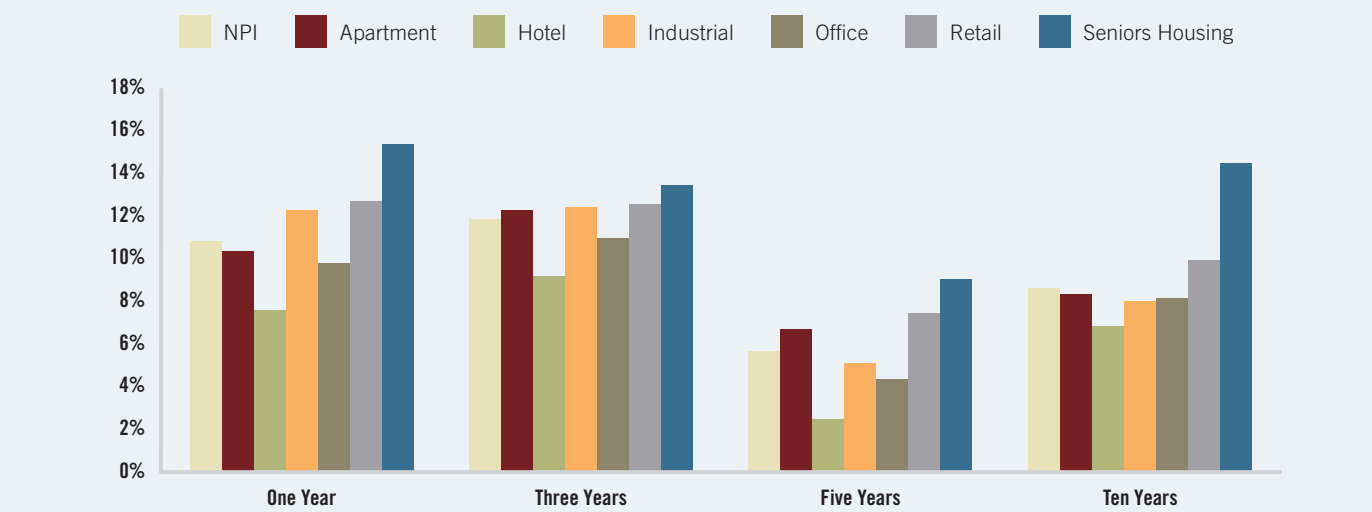
National Council of Real Estate Investment Fiduciaries. All properties in the NPI have been acquired, at least in part, on behalf of tax-exempt institutional investors—the great majority being pension funds. As such, all properties are held in a fiduciary environment. As of the fourth quarter of 2013, the NPI comprised 7,029 properties with a combined market value of $353.9 billion.[10]

The nominal returns on the seniors housing properties within NCREIF's database (not included in the NPI) have outperformed during the last 10 years the nominal performance return measurements for the broad NPI, as well as for the other individual NPI indices. As of the fourth quarter of 2013, seniors housing properties have generated an annualized return of 14.6 percent since the fourth quarter of 2003. This compares to an annualized return of 8.6 percent for the entire NPI. Seniors

Exhibit 1.g

NCREIF Annualized Total Returns

Across Select Property Types in 1-, 3-, 5- and 10-year Periods | As of 12/31/2013

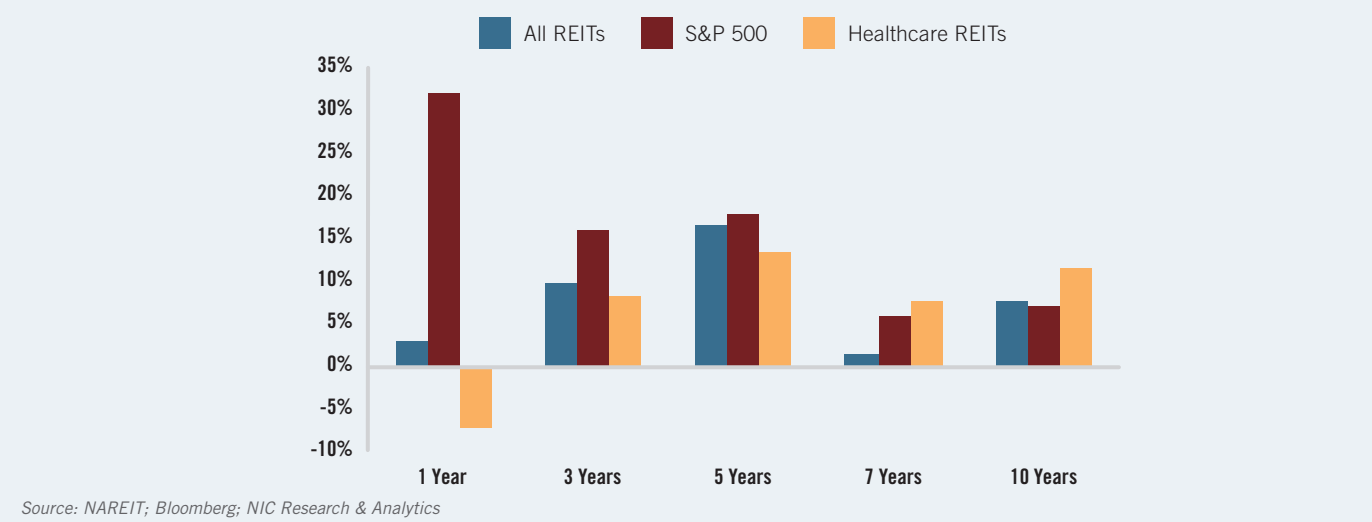


Source: NCREIF; AEW Research

Exhibit 1.h

Annualized Total Equity Returns

Across Select REIT Types and the S&P 500 in 1-, 3-, 5-, 7-, and 10-year Periods | As of 12/31/2013



Source: NAREIT; Bloomberg; NIC Research & Analytics

housing has also outperformed the NPI property types in terms of the appreciation and income components, both of which are discussed in Section 10. As of the fourth quarter of 2013, 11 managers reported data on 70 stabilized seniors housing properties to NCREIF. The value of these assets totaled $2.0 billion.[10]

In the past 10 years, public health care real estate investment trusts (REITs), for which seniors housing and care properties represents a significant share of their investment portfolios, have outperformed the FTSE NAREIT Equity REIT Index and the S&P 500 Index.[36] The health care REIT sector, however, underperformed both in 2013 as investors became more bullish about economic growth and shifted out of dividend stocks including REITs.

Much of the strength in the 10-year investment performance of seniors housing and care properties can be attributed to relatively steady leasing trends when compared to other real estate property types, especially during the recent recessionary period. As compared with the property types within the NPI, seniors housing and care is the only real estate property type that did not experience declining asking rents during the economic recession. Asking rent growth for seniors housing reached a cyclical low of 1.1 percent in the fourth quarter of 2010, which was well above the cyclical lows the core commercial real estate types of apartments and office of -2.3 percent and -4.8 percent, respectively. As of the fourth quarter of 2013, asking rent growth in seniors housing properties was slightly slower than that of apartments, although seniors housing has shown more stability during the current market cycle.

1.4 Property Ownership and Large Operators

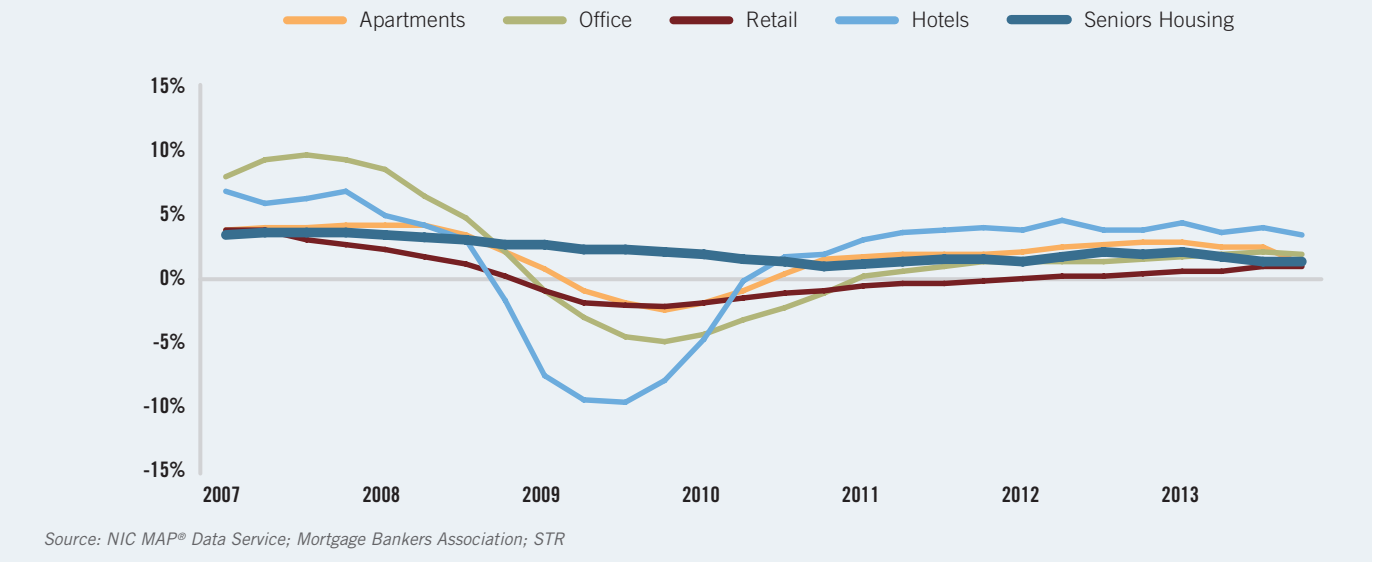
Exhibits 1.j & 1.k outline the property ownership composition within seniors housing and care. The largest owner category of seniors housing and care properties are private for-profit entities, with ownership of 45.4 percent ($104.6 billion) of seniors housing units and 31.1 percent ($60.5 billion) of nursing care beds. Publicly traded REITs own a significant share of the investment grade units, with ownership of 14.7 percent ($33.7 billion) of units in seniors housing properties and 15.5% ($16.6 billion) of beds in nursing care properties.[1]

Exhibits 1.l & 1.m list the largest operators of seniors housing (majority independent living and assisted living properties) and nursing care properties. The 10 seniors housing operators listed control 26.9 percent of units within seniors housing properties in 99 of the nation's largest metropolitan markets.[1] Seniors housing and care properties in many cases are owned by an entity other than the operator. These ownership entities include publicly

Exhibit 1.i

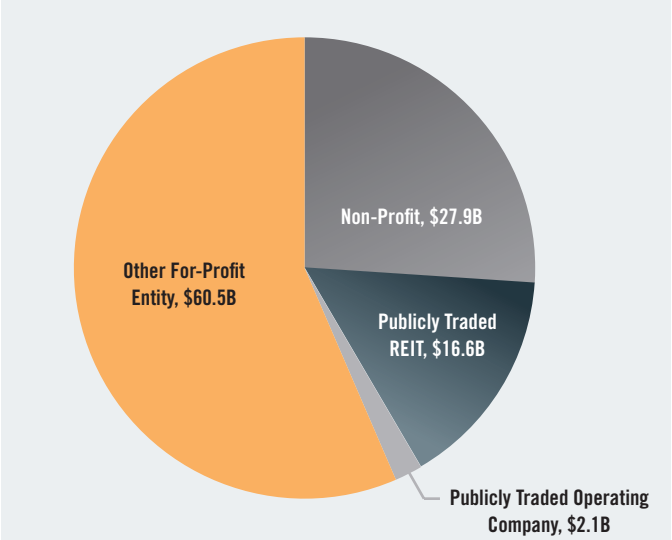
Commercial Real Estate Year-over-Year Asking Rent Growth Trends

1Q07 - 4Q13



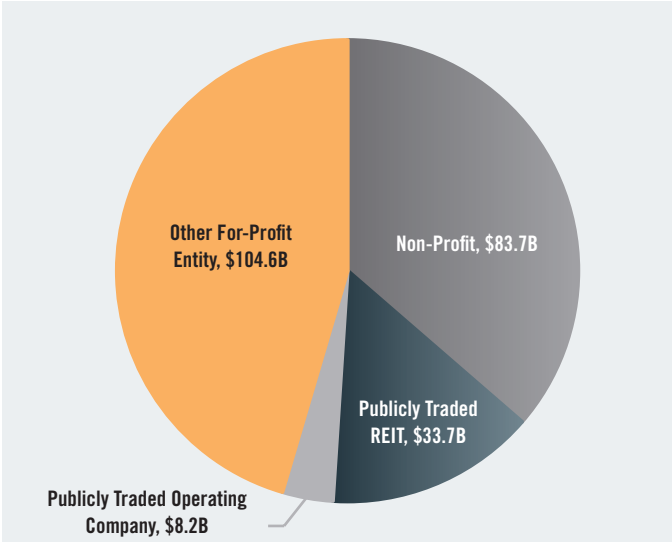
Source: NIC MAP® Data Service; Mortgage Bankers Association; STR

Exhibit 1.j
Implied Market Value of Majority Nursing Care Properties
As of 4Q13



Source: NIC Research & Analytics

Exhibit 1.k
Implied Market Value of Seniors Housing Properties
As of 4Q13



Source: NIC Research & Analytics

traded health care REITs and institutional investors, which often utilize a joint venture ownership structure.

The 10 nursing care operators listed in Exhibit 1.m control 14.5 percent of beds within majority nursing care properties in 99 of the nation's largest metropolitan markets.[1]

Exhibit 1.l
Largest Seniors Housing Operators in the Top 99 Metropolitan Markets
As of 4Q13

	Number of Properties Operated*	Number of Units Operated*
Brookdale Senior Living***	428	51,549
Emeritus Senior Living***	323	30,939
Sunrise Senior Living	239	22,090
Holiday Retirement	179	21,592
Life Care Services LLC	58	20,309
Five Star Senior Living	143	19,607
Erickson Living	16	19,432
Atria Senior Living	126	15,031
Senior Lifestyle	58	8,948
Capital Senior Living Corp	64	7,480
10 Largest Operators' Share of Total Units		**26.9%**

* Includes majority independent living, majority assisted living, and majority memory care properties.

** Includes all units within the property. Majority independent living CCRCs, majority assisted living CCRCs and combined properties may also contain nursing beds.

*** Brookdale announced an agreement to merge with Emeritus on 2/20/2014. It is expected to close during the third quarter of 2014.

Source: NIC MAP® Data Service

Exhibit 1.m
Largest Nursing Care Operators in the Top 99 Metropolitan Markets
As of 4Q13

	Number of Properties Operated*	Number of Beds Operated*
Genesis HealthCare	225	30,194
HCR ManorCare	184	25,428
Golden Living	125	13,751
Kindred Healthcare***	102	12,675
Sava Senior Care	86	10,535
Life Care Centers Of America	80	9,854
Consulate Health Care	68	8,492
Extendicare REIT	56	5,913
Ensign Group	46	5,293
Skilled Healthcare Group	39	5,173
10 Largest Operators' Share of Total Units		**14.5%**

* Includes majority nursing care properties.

** Includes all units within the property. CCRCs and combined nursing care properties may contain some independent living, assisted living, and memory care units.

***Kindred has begun implementing a strategy to reduce its nursing care business by not renewing many of its leases on freestanding nursing care and focus on multiple levels of coordinated post-acute care .

Source: NIC MAP® Data Service

Fountain View Village
Fountain Hills, AZ

In this section

Section 2: Emerging Trends and Observations

Throughout most of this document, the National Investment Center for Seniors Housing & Care (NIC) and the Investment Guide Task Force rely on data driven observations to educate investors on the seniors housing and care industry. This section is different. In order to make this document timelier and forward looking, the Task Force has drawn upon the judgment of its members and other industry participants to make observations and discuss trends for which hard data is not yet available. The observations and trends fall into four broad areas: Demand and Consumer Decision Making, Supply and Development, Design and Service Strategies, and Capital Access and Pricing. The Task Force has included observations and trends for which there was broad consensus among its members and tried to note different points of view where they occur.

2.1 Demand and Consumer Decision Making

- Improving Operating Fundamentals – Occupancy and asking rent levels for private pay seniors housing bottomed in 2010 and have been improving since that time. Economic recovery from the recession and an improving single-family housing market have boosted consumer confidence and contributed to these improvements.

- Adult Children Play a Role – While adult children typically have a limited role in a senior's decision to move to independent living, particularly a CCRC setting, their role grows as the seniors age and frailty increases. Adult children play key roles in the decision for seniors to move into assisted living, memory care and nursing care.

- Residents Average Entry Age Increasing – The recession accelerated a trend toward higher entry ages and higher average ages of residents in all types of private pay seniors housing properties. All categories of seniors housing came to be viewed during the recession as more "needs driven" and less of a lifestyle choice. It is too early to tell if the improving economy may help reverse this trend, but independent living absorption rates are improving, perhaps signaling a return to the perception that seniors housing is both a lifestyle choice as well as a "needs-driven" decision.

- Some Divergence in Demand Trends – The Roaring Twenties generation (born 1918 to 1928) that have fueled demand for seniors housing and care over the last 10 years (reaching age 85 from 2003 through 2013) are giving way to the Depression Era generation, slowing growth in the 85-plus population over the next 15 years. At the same time, growth in the 65-74 age cohort will accelerate. The seniors housing and care industry must attract somewhat younger seniors or increase market share among the older seniors that the industry now primarily serves in order to continue to improve occupancies. It's noteworthy that short-stay post-acute residents in skilled nursing properties tend to be younger than the typical senior moving into a private-pay seniors housing property, providing a potential demand boost to nursing care properties focused on short-stay residents.

2.2 Supply and Development

- Increased Construction – While still at modest levels compared to past peaks, construction levels of private pay seniors housing properties have started to trend up, and there are some markets where construction levels may be high enough to pressure future occupancies and rents. Memory care is the product type that has seen the largest percentage increases in construction.

- Turnover Increases Along with Acuity – Length of stay in seniors housing is greatest in entrance fee CCRCs, shortens in freestanding independent living, and shortens again in assisted living properties and nursing care properties. The shorter length of stay in higher acuity seniors housing means as many as 50 percent of the units in an assisted living property may turn over every year, and the turnover of units in existing properties is a significant source of potentially vacant supply to be filled each year. Memory care, while dealing with higher acuity residents, may have a longer length of stay than stand-alone assisted living because of the progression of Alzheimer's disease.

2.3 Design and Service Strategies

- Affordable Care Act – A summary of health care reform measures contained in the Patient Protection and Affordable Care Act may be found in Appendix I. Health care reform provisions, (particularly hospital readmission penalties), the growing number of seniors using managed care plans and various demonstration programs are starting to drive the integration of acute (i.e., care typically provided in a hospital setting) and post-acute care. As the lines blur across the continuum of care, seniors housing and nursing care operators are identifying ways to team with acute care hospitals and managed care companies. Operators that demonstrate the ability to provide better outcomes for residents coming from an acute care setting and avoid unnecessary readmissions may be able to increase resident flow and occupancy, and command higher managed care rates. Some of the following trends, particularly the addition of ancillary services in some seniors housing and the increased focus on short-stay residents in nursing care are examples of how the evolving impact of health care reform is driving change in the industry.

- Divergent Approaches to Ancillary Services – Some seniors housing and care operators have added rehabilitation therapy, home health care, hospice and other services to better meet the needs of their aging senior population or begun to offer comprehensive post-acute care services to hospitals, managed care companies and physician groups serving as accountable care organizations. Other operators are foregoing ancillary services altogether or instead using third-party service providers. This allows building operators to focus on their core competencies of housing healthier seniors in a non-medical setting and to make their properties more attractive to somewhat younger, healthier seniors. The approach to ancillary services elected may depend on the care segment(s), geographic density within a market, and management execution.

- Convergence of Independent Living and Assisted Living Resident Populations – As many independent living (IL) properties experience a high entry age for residents and offer an array of ancillary services, the differences between services provided in some independent living and assisted living properties have narrowed. Independent living properties still tend to offer larger units but may essentially offer all of the services available in an assisted living property, perhaps using third-party ancillary service providers for a portion of this care.

- Skilled Nursing Increasingly Focused On Post-Acute Care – The skilled nursing industry is bifurcating, with many operators and properties focusing on more intensive therapy for short-stay post-acute care residents rather than serving traditional long-stay custodial-care residents. This has the potential to improve rates and margins at skilled nursing properties able to deliver and document positive outcomes for such residents. It also better positions skilled nursing to capture younger seniors for post-acute care services, even some residents younger than 65 years old.

- Impact of Technology – While not seen as a high-tech industry, technology is having and is likely to continue to have a significant impact on seniors housing and care. Residents moving to seniors housing and care properties today want computer and wireless access, training, and technical support. Increasingly sophisticated

computerized systems are used in marketing, pricing, staffing and billing for seniors housing and care services, and are becoming a differentiator in operator performance. Emerging technology for resident monitoring and improved monitoring and care of persons in their homes have the potential to both positively and negatively impact demand and quality of care in the future.

- Mitigation of Operational Risk – Private pay seniors housing is primarily regulated at the state level, while nursing care, which is primarily reimbursed from public sources, is extensively regulated at the federal level with state administration of these rules. Delivering quality care is essential for seniors housing and care operators to attract residents; avoid adverse media coverage and litigation; and comply with state and federal regulations. As resident acuity and provision of ancillary services increases, the quality of the operator's performance becomes crucial to management success and the industry is still working to develop consistent and widely accepted quality standards. (See Appendix K for discussion of risks.)

2.4 Capital Availability and Pricing

- Increased Transparency – Transparency of seniors housing performance has significantly improved for investors over the last decade through the research and data reporting undertaken by NIC, the American Health Care Association (AHCA), the Assisted Living Federation of America (ALFA), the American Seniors Housing Association (ASHA), the National Council of Real Estate Investment Fiduciaries (NCREIF), National Association of Real Estate Investment Trusts (NAREIT), Real Capital Analytics (RCA) and others.

- Financing Availability Continues to Improve – As of mid-year 2014, agency and other mortgage financing for stabilized seniors housing remains available at reasonably attractive rates. Long-term fixed rate financing from HUD remains available as well. Sale-leaseback and sale-manage-back financing from REITs is also plentiful, with insurance company and CMBS financing availability improving as this publication went to press. The availability of construction financing has also improved, along with the balance sheets of commercial banks and seniors housing performance fundamentals. Private equity capital is committed to the seniors housing sector, with some large transactions in late 2012 and 2013, and private equity interest in post-acute care appears to be growing. (See Section 9 on Capital Sources.)

- Separation of Operations and Real Estate – With publicly traded healthcare REITs outperforming the broader stock market over the last 10 years and low mortgage rates, seniors housing and care real estate has been valued higher than operating companies for a number of years. This leads many operators to separate their real estate from their operations in order to monetize their real estate holdings. Billions of dollars of seniors housing real estate has moved from private and public operator ownership to REITs. As a result, there are now fewer remaining large portfolios to be acquired. A number of REIT acquisitions in recent years were made using a purchase/manage-back agreement rather than a traditional purchase/lease-back structure, bringing REITs more directly into property operations, with some REITs taking ownership interest in operating companies (e.g., Ventas/Atria and Health Care REIT/Sunrise).

- Shift from Public to Private Markets – The largest skilled nursing operators have opted to "go private" over the last decade, and two publicly traded private pay seniors housing operators privatized in 2013. Others have elected to remain privately held while selling their real estate. A reversal of the preference for private over public markets is unlikely in the near term, though some major operators could reenter the public markets as private equity sponsors seek to cash out their investments over the next two to five years.

- Evolving Industry Consolidation – Consolidation of seniors housing and care real estate into publicly traded healthcare REITs has accelerated over the last five years, but fewer large portfolios currently remain available for acquisition. Operator consolidation may be accelerating, with the acquisition of the second largest operator (Emeritus) announced by the largest operator (Brookdale) in 1Q14. Many in the industry believe that the Brookdale/Emeritus transaction coupled with the availability of plentiful capital is likely to spur further consolidation among operators.

Brightview Greentree

Marlton, NY

In this section

Section 3: Independent Living

Independent living properties typically serve the healthiest residents among seniors housing and care properties and offer a lifestyle choice that provides the resident with freedom from daily chores such as cooking, cleaning and home maintenance. Independent living is often a choice for seniors looking to increase social interaction while reducing routine housework. For the purposes of this section, we focus on majority independent living properties, including all those in which the predominant care segment offered across all units is independent living. Continuing care retirement communities (CCRCs) are specifically discussed in Section 6. We begin with a discussion of the resident population.

3.1 Resident Population

Independent living services are generally designed for those over the age of 75. The number of households is a common gauge of potential demand, as one household generally will transition to one unit, even if the household has multiple members (i.e., a married couple). The current penetration rate (i.e., share of 75-plus households living in majority independent living properties) is 5.7 percent.[1]

3.1.1 Resident Profile

The typical new resident of an independent living property is an 82-year-old widowed female. She is relatively healthy and does not require assistance with activities of daily living (ADLs). Prior to moving, she lived in a private home located within 10 miles of the property.[4] More recently, the age of entry for new residents has been rising from the early 80s to the mid-80s, as the economic recession has caused many residents to delay relocating to these properties. This has resulted in residents more frail at move-in which, in some instances, necessitates the use of devices to assist with walking. The improved housing market could reverse this trend in the future, however, by once again capturing younger residents who can readily sell their homes.

The decision to move to independent living is primarily made by the resident, but may involve the resident's adult children as well. Unlike in other care segments, the decision is not necessarily driven by an event or a crisis, but, instead, by the desire to eliminate home maintenance responsibilities and/or for more social interaction. Among the reasons most commonly cited by residents for making a move to independent living are "getting away from the upkeep of their home" and "being closer to family and/or friends."[4]

The primary source of payment for independent living is the income and monetized assets of the resident. The majority of new independent living residents have a net worth in excess of $300,000.[4] Residents' children generally are not as involved in helping to pay for independent living as they are for other seniors housing and care segments. Seniors making the choice to move into independent living generally have the funds to cover the costs. The typical length of stay in independent living is approximately 38 months.[2]

While the current occupied unit penetration rate for majority independent living properties among households age 75-plus is 5.7 percent, research shows that 13 percent of households age 75-plus cite independent living properties as "very desirable," indicating the potential for a higher penetration rate.[5]

(See Appendix B for a detailed discussion of the demographics of prospective residents and their adult children, as well as other factors that influence demand.)

3.1.2 Alternative Housing and Services

As evidenced by the penetration rate, most seniors choose an alternative to independent living. The major alternative to independent living remains seniors that choose to live at home, who may receive help with some duties from family and friends. A number of service providers are available to help seniors remain at home. These services include adult day care programs, in-home caretakers and household help. Other alternative housing options, besides remaining at home, include making a move to an active adult community, or to a seniors-only apartment building. (See Appendix F for a detailed discussion of alternative housing and services.)

3.2 Supply

This section discusses estimates of supply and supply growth over time.

3.3.1 Supply Estimate

There are more than 4,000 investment-grade majority independent living properties across the U.S. Within investment-grade properties, there are over 880,000 units. The median number of units in majority independent living properties is 168.[1]

3.2.2 Supply Growth.

The independent living sector has experienced significant development within the last 28 years. Approximately two-thirds of the current supply of independent living units in the 99 largest metropolitan markets has been developed since 1985. The late 1980s and early 2000s saw strong development activity. Of the independent living units currently open, 17.7 percent were developed between 1985 and 1989, and 15.0 percent were developed from 2000 to 2004. The median age of properties with a majority of independent living units is 23 years.[1]

Exhibit 3.a

Supply of Investment-Grade* Seniors Housing and Care Properties in the U.S.

By Property and Unit Counts across Property Types
Estimates as of 4Q13**

By Property Type	# Properties	# Units***
Majority IL	**4,060**	**883,500**
Majority AL	6,305	507,500
Majority MC	1,060	51,000
Majority NC	11,270	1,504,500
Total	**22,695**	**2,946,500**

* Current estimates are not comparable to estimates from prior years.

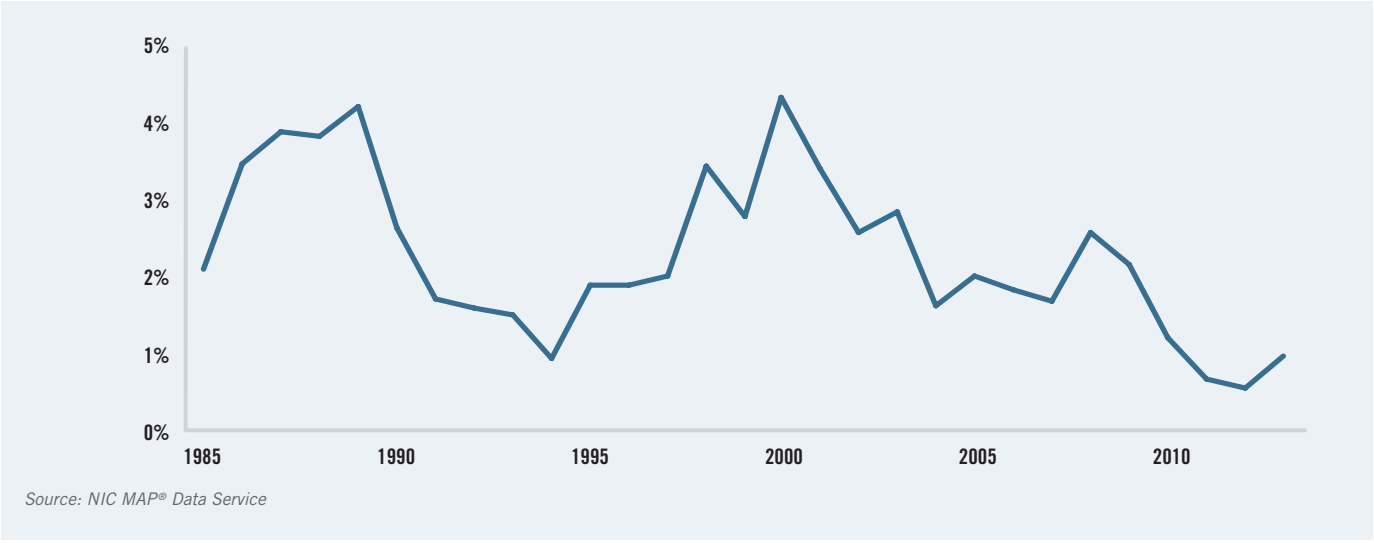
** Estimates are representative of properties with at least 25 units/beds that charge market rates for the housing and services offered.

*** One nursing bed is equivalent to one unit. *Source: NIC Research & Analytics*

Exhibit 3.b

Distribution of Independent Living Units by Year Opened in the Top 99 Metropolitan Markets

1985–2013



Source: NIC MAP® Data Service

Exhibit 3.c

Percentage of Units Operated by Number of Properties Operated in the Top 99 Metropolitan Markets

As of 4Q13

	Majority IL	Majority AL	Majority MC	Majority NC	Grand Total	CCRCs*
Operates Single Property	**29%**	27%	19%	33%	31%	38%
Operated by Chain: 2-9 Properties	**29%**	23%	29%	30%	29%	30%
Operated by Chain: 10+ Properties	**42%**	49%	52%	36%	41%	32%
Operated by Chain: 10-24 Properties	**16%**	12%	8%	14%	14%	15%
Operated by Chain: 25+ Properties	**27%**	38%	44%	22%	27%	17%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

*CCRCs are also included within the majority property types

3.3 Industry Operating Structure

In the seniors housing and care sector, the owner and the operator/manager of a property are often distinct entities, but this is not always the case. This section discusses the predominant operating entities and ownership structures used in the independent living sector.

3.3.1 Ownership Structures

Among properties with a majority of independent living units, 51 percent of the total units are owned by nonprofit organizations. The remaining 49 percent of the units are owned by for-profit entities and include seniors housing operators, real estate investment trusts, and joint-venture arrangements.[1] The for-profit segment includes ownership entities that are publicly traded and those that are privately held.

Majority independent living properties are operated by companies of varying sizes. Approximately 29 percent of properties are operated by entities that operate only a single property in the top 99 metropolitan markets. Properties that are operated by chains represent 71 percent of the market, with larger chains operating 42 percent of the overall market.[1]

3.3.2 Large Operators

Exhibit 3.d lists the largest operators of independent living properties. The 10 operators listed below control 27 percent of the independent living units in the top 99 metropolitan markets.[1]

3.4 Operating Economics

This section discusses the operating economics of independent living properties including operating revenue (occupancy and rental rates), operating expenses and net operating income. Replacement reserves are also discussed. Generally, independent living has lower rental rates and corresponding revenue per unit than other care segments, due to the less intensive care and service components offered to residents. Independent living usually has lower expenses per unit than other care segments as well due to the lack of care required which reduces labor requirements for operators.

Exhibit 3.d

Largest Independent Living Operators by Independent Living Unit Count in the Top 99 Metropolitan Markets

As of 4Q13

	# Units Operated*
Brookdale Senior Living**	24,454
Holiday Retirement	20,602
Erickson Living	16,730
Life Care Services LLC	14,632
Five Star Senior Living	8,248
Atria Senior Living	6,662
Capital Senior Living Corp	4,618
Senior Lifestyle	3,968
ACTS Retirement-Life Communities	3,804
Emeritus Senior Living**	3,690
10 Largest Operators' Share of Total Units	**27.1%**

* Includes only independent living units. These companies may also operate assisted living, memory care, and nursing care.

** Brookdale announced an agreement to merge with Emeritus on 2/20/2014. It is expected to close during the third quarter of 2014.

Source: NIC MAP® Data Service

3.4.1 Operating Revenue

Independent living revenues primarily consist of monthly rental payments for unit occupancy received from private-pay residents.

3.4.1.a Occupancy

Occupancy is the number of occupied units divided by the total number of open units in the top 31 metropolitan markets.

As of the fourth quarter of 2013, occupancy in majority independent living properties was 90.0 percent, down from its previous cyclical peak of 92.4 percent in the first quarter of 2007.[1] Independent living occupancy rates began declining in 2007, as new units continued to come online despite the decline in general economic conditions. Home equity is a primary financial asset of many seniors that allows them to afford independent living. The decline in the housing market consequently adversely affected demand for independent living during the economic recession. An improved housing and stock market have contributed to the increase in occupancy over the past year. Independent living occupancy established a cyclical low in the third quarter of 2010 at 86.8 percent and has been modestly recovering since that time. It should be noted that although occupancy declined from 2007 to 2010, absorption generally remained positive during that time.[1]

Occupancy has been improving since mid-2010, as shown in Exhibit 3.e.

Resident turnover impacts occupancy levels because of the time required to remarket a unit when a resident departs. Median annual resident turnover for independent living properties is 31.6 percent, a lower turnover rate than that of other care segments as well as multifamily apartments.[2] The longer length of stay than other seniors housing care segments can be attributed to the comparably better overall health of independent living residents.

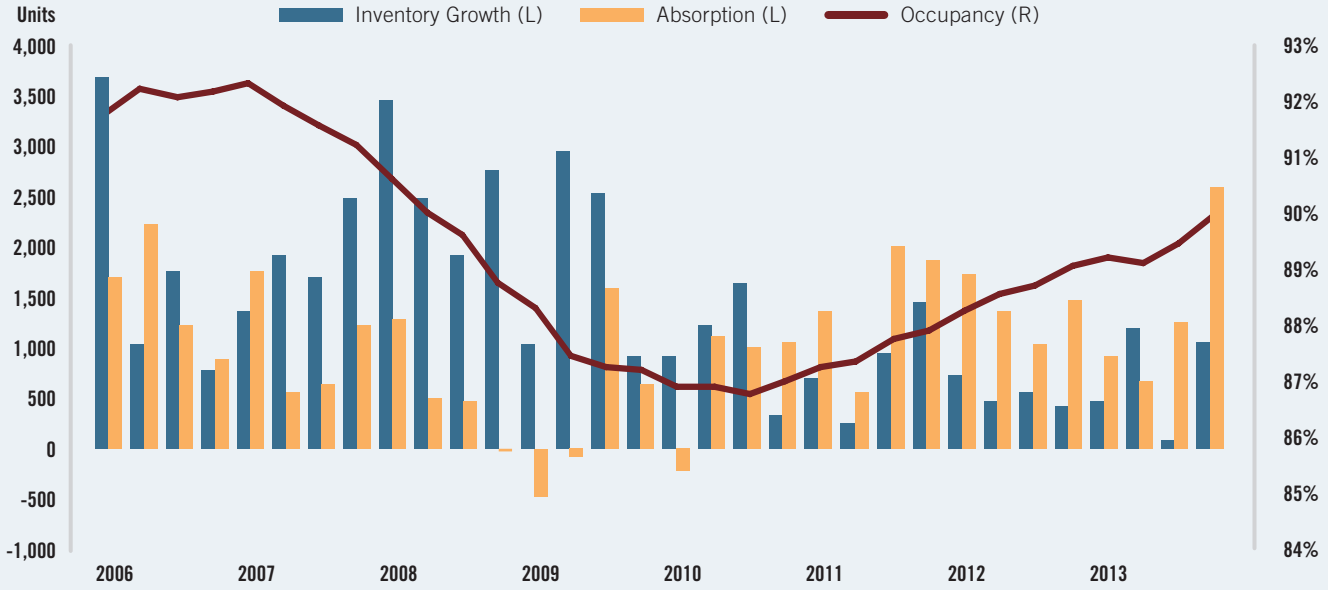
3.4.1.b Rental Rates

The following table shows the distribution of monthly asking rental rates in independent living. Monthly rents typically include the base rent for real estate as well as a base level of services, such as for meals and housekeeping. A number of factors impact rental rates including the community location, amenities, and age.

Exhibit 3.e

Independent Living Supply-Demand in the Top 31 Metropolitan Markets

1Q06–4Q13



Source: NIC MAP® Data Service

Exhibit 3.f
Distribution of Monthly Asking Rent in the Top 99 Metropolitan Markets
As of 4Q13

	Lower Quartile	Median	Mean	Upper Quartile
Independent Living	**2,082**	**2,650**	**2,765**	**3,346**
Assisted Living	3,227	3,980	4,159	4,891
Memory Care	4,678	5,525	5,732	6,568
Nursing Care	6,301	7,731	8,432	9,618

Source: NIC MAP® Data Service

Note the rental rates in Exhibit 3.f include base rents and service fees charged by the operator. As a result of the recession, the deterioration in the overall housing market and additional new units coming online, asking rent growth slowed considerably from 2008 to mid-2010. It remained positive, however, as demonstrated by the following year-over-year asking rent growth chart.

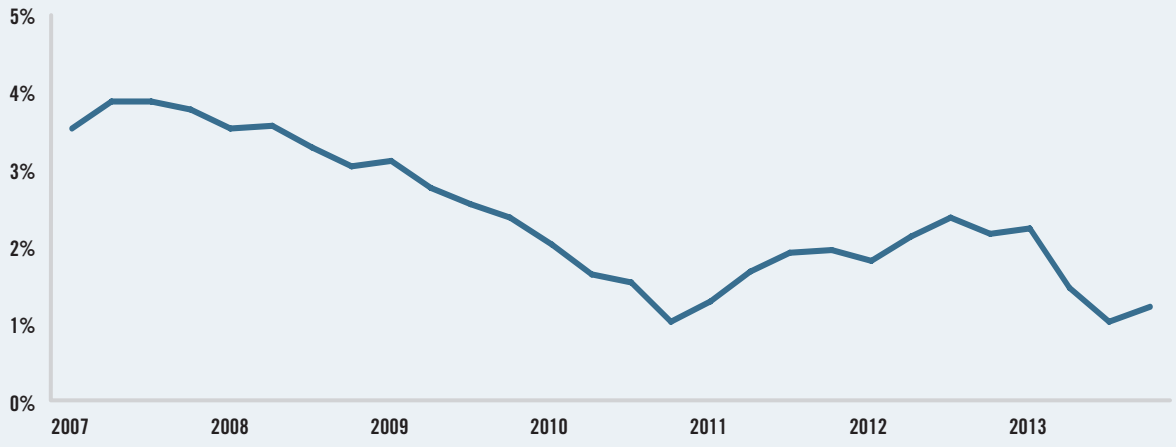
Specifically, average independent living asking rent growth slowed from 4.0 percent in 2007 to 1.1 percent annually as of the fourth quarter of 2010. During 2011, the pace of rent growth improved modestly, ending 2011 at an annual pace of 2.0 percent. In 2013, rent growth remained positive, but slowed back to 1.1 percent by the third quarter of 2013.[1]

Nonetheless, independent living rents, as well as all other property-based seniors housing rents, continued to grow throughout the recent recession, in contrast to rents at many other types of commercial real estate properties. This is discussed further in Section 9.2.1.

3.4.2 Operating Expenses

Exhibit 3.8 contains operating expense data for freestanding independent living properties. Total operating expenses generally range from $1,192 to $2,321 per occupied unit per month. Labor-related expenses are the largest component, generally representing between 36 percent and 42 percent of total operating expenses.[2] Raw food, utilities and property taxes usually represent some of the larger expense items.

Exhibit 3.g
Independent Living Year-over-Year Asking Rent Growth in the Top 31 Metropolitan Markets
1Q07 - 4Q13



Source: NIC MAP® Data Service

Exhibit 3.h
Monthly Operating Expenses in Independent Living Properties Per Occupied Unit
For Fiscal Year Ending 12/31/2012

	Lower Quartile*		Median*		Upper Quartile*	
	Dollars	% of Total Operating Expenses	Dollars	% of Total Operating Expenses	Dollars	% of Total Operating Expenses
Total Operating Expenses	$1,192		$1,447		$2,321	
Labor-related Expense	$501	42%	$515	36%	$943	41%
Property Taxes	$100	8%	$105	7%	$192	8%
Property Insurance	$16	1%	$17	1%	$44	2%
Liability Insurance	$9	1%	$5	0%	$12	1%
Workers Comp	$9	1%	$11	1%	$28	1%
Raw Food	$110	9%	$170	12%	$196	8%
Non-Labor Other Dietary	$22	2%	$16	1%	$22	1%
Utilities	$119	10%	$122	8%	$205	9%
Marketing	$44	4%	$35	2%	$73	3%
Repairs and Maintenance	$62	5%	$58	4%	$105	5%
Housekeeping	$5	0%	$5	0%	$16	1%
Resident Care Supplies	$2	0%	$2	0%	$1	0%
Activities	$9	1%	$11	1%	$26	1%
Total Management Fees	$75	6%	$77	5%	$154	7%
All Other Operating Expenses	$88	7%	$294	20%	$303	13%
All Corporate and/or Other Overhead Expenses	$20	2%	$5	0%	$2	0%
Replacement Reserve	$113		$148		$175	

Note: Expense subcategories may not sum to total expenses due to rounding. State of Seniors Housing defines the lower quartile as the average of the lowest 25% of responses, the median as the average of the 40th through 60th percentile, and the upper quartile as the average of the highest 25% of responses.

Source: State of Seniors Housing 2013 (Table 9.1)

Atria Hacienda
Palm Desert, CA

3.4.3 Net Operating Income

For income-producing asset classes, most industry associations, operators and other industry practitioners report profitability and margins based on net operating income (NOI), which is analogous to earnings before interest, taxes, depreciation, amortization and rent (EBITDAR). NOI is calculated before deductions for operating lease payments, ground lease payments, debt service, depreciation, amortization, income taxes, partnership expenses, capital expenditures, and replacement reserves. Operating margins are calculated as EBITDAR divided by total revenues. The calculations are consistent with standard commercial real estate industry practices.

The table in Exhibit 3.i demonstrates the range of operating margins in freestanding independent living properties.

3.4.4 Replacement Reserves

Reserves for replacement items (ranging from carpeting/flooring and other "wear and tear" items, to major systems such as boilers, roofing and HVAC) vary greatly in independent living properties. The age, physical plant condition, geographic location and overall quality of amenities at the property affect the level of replacement reserves. Properties with deferred maintenance typically warrant a higher capital expenditure allowance for renovations than well-maintained properties. The median replacement reserve for independent living properties was $1,778 per occupied unit in 2012.[2]

3.5 Current Trends

As a result of the recent recession and the associated difficulty of selling a home, as well as heightened concern about finances, some seniors have elected to postpone a move to an independent living community. As a result, when they do move, these new residents tend to be older and are more likely to need assistance with one or more ADLs soon after moving to an independent living property. Although assisted living properties may be appropriate for a portion of these seniors, many look to independent living as a first step.

In response to this trend, some senior housing and care operators have added the capability to provide rehabilitation therapy, home health care, hospice and other services to better meet the needs of an aging seniors housing population. Other operators are using third-party providers to focus on their core mission of housing healthier seniors in a non-medical setting and to make their properties more attractive to somewhat younger, healthier seniors. In addition, some operators have sought to reposition communities by converting some or all of their independent living units to assisted living units in order to serve older residents entering with higher levels of need. Also, some independent living operators have opted to manage their properties with an assisted living license, thereby making it easier to convert units between assisted living and independent living, depending upon demand. However, many independent living buildings are unable to be licensed for assisted living due to safety shortcomings, such as the requirement in many states for non-combustible frames in multi-story assisted living structures. It is too soon to tell whether the trend of new residents being older and frailer as they move into independent living is a temporary phenomenon as a result of the recession or a structural shift. In terms of supply, the pace of new independent living inventory growth has increased slightly over the past two years, a trend that is likely to continue through 2014. Rising occupancy levels and favorable interest rates have spurred new development activities that are anticipated to continue into 2014 and beyond.

Exhibit 3.i

Operating Margins by Property Type

	Lower Quartile	Median	Upper Quartile
Freestanding Independent Living[1]	**20.3%**	**37.3%**	**49.9%**
Freestanding Assisted Living[1]	16.4%	31.2%	43.5%
Freestanding Nursing Care[2]	3.1%	12.9%	22.6%
CCRCs[1]	6.7%	27.5%	37.7%

1. Data for fiscal year ending 12/31/2012
2. Data for fiscal year ending 12/31/2010

Source: State of Seniors Housing 2013; Valuation & Information Group

The Falls at Cordingly Dam

Newton, MA

In this section

Section 4: Assisted Living

Assisted living serves residents with more needs than those in independent living but fewer needs than those typically in nursing care. Assisted living residents cannot have needs that require 24/7 medical attention or supervision. The service mix emphasizes convenience and hands-on care associated with the Activities of Daily Living (ADLs), such as assistance with bathing, grooming, dressing, eating, and medication management. Assisted living properties often include a separate memory care segment, generally in a dedicated wing or floor. Memory care is a specialized service covered in more detail in Section 5. For the purposes of this section, we focus on majority assisted living properties, which include all those in which the predominant care segment offered across all units is assisted living. Continuing care retirement communities (CCRCs) are specifically discussed in Section 7. We begin our review with the assisted living resident population.

4.1 Resident Population

Assisted living focuses on slightly older residents than those in independent living because service needs typically increase with age. The current occupied unit penetration rate (i.e., share of 75-plus households living in majority assisted living properties) is 3.7 percent.[1]

4.1.1 Resident Profile

The typical new resident in assisted living is an 84-year-old widowed female requiring assistance with two ADLs. She moved to assisted living from a private home or apartment located within 10 miles of the property.[3] More recently, the age of entry for new residents has been increasing to the higher range within the mid-80s, as the economic recession caused many residents to delay relocating to these properties.

Residents typically leave their previous home and move into assisted living to obtain assistance with ADLs. The decision to move to assisted living is primarily made by the resident and her or his adult children; this decision is often need-driven and/or event-driven.[3] Events that could trigger a move into an assisted living community include a fall, declining memory, the need for medication assistance and monitoring, or poor diet and eating habits. A significant portion of assisted living residents (somewhere from one-third to one-half) have at least some memory loss. If the resident suffers progressive memory loss or dementia, the resident may need to be moved to a secure memory care wing/floor so they can be provided with specialized services.

Typically, the primary source of payment for assisted living is the income and assets of the resident. Adult children may assist with payment as well. The majority of assisted living residents have a net worth in excess of $200,000.[3] Many assisted living residents pay for their rent and care needs with private funding. (The adult children's contribution is discussed further in Appendix B.) The typical length of stay in assisted living is approximately 22 months.[2]

(See Appendix B for a detailed discussion of the demographics of the prospective residents and adult children, as well as other factors that influence demand.)

4.1.2 Alternative Housing and Services

The alternative services for assisted living include other types of

home- and community-based services (HCBS), especially home health care, outpatient therapy, and informal care provided by a family member or a friend. In addition, nursing care offers some housing and services that overlap with assisted living. (Refer to Appendix E for a detailed discussion on alternative housing and services.)

4.2 Supply

This section discusses supply inventory and supply growth over time.

Exhibit 4.a

Supply of Investment-Grade* Seniors Housing and Care Properties in the U.S.

By Property and Unit Counts across Property Types
Estimates as of 4Q13**

By Property Type	# Properties	# Units***
Majority IL	4,060	883,500
Majority AL	**6,305**	**507,500**
Majority MC	1,060	51,000
Majority NC	11,270	1,504,500
Total	**22,695**	**2,946,500**

* Current estimates are not comparable to estimates from prior years.
** Estimates are representative of properties with at least 25 units/beds that charge market rates for the housing and services offered.
*** One nursing bed is equivalent to one unit. *Source: NIC Research & Analytics*

4.2.1 Supply Estimate

There are approximately 6,300 investment-grade majority assisted living properties across the U.S. This estimate does not include smaller "board and care" properties with fewer than 25 total units. Within investment-grade properties, there are 507,500 units. The median number of units in majority assisted living properties is 73.[1]

4.2.2 Supply Growth

The assisted living sector has experienced a significant amount of development within the last 15 years. More than one-half of the current supply of assisted living units in the 99 largest metropolitan markets has been developed since 1995. The period from 1995 to 2004 saw heightened development activity, with 42.6 percent of units currently in existence built during this time. The late 1990s (1995–1999) experienced the most significant building boom for assisted living, with 24.6 percent of units currently open developed during this time. The median age of properties with a majority of assisted living units is 16 years.[1]

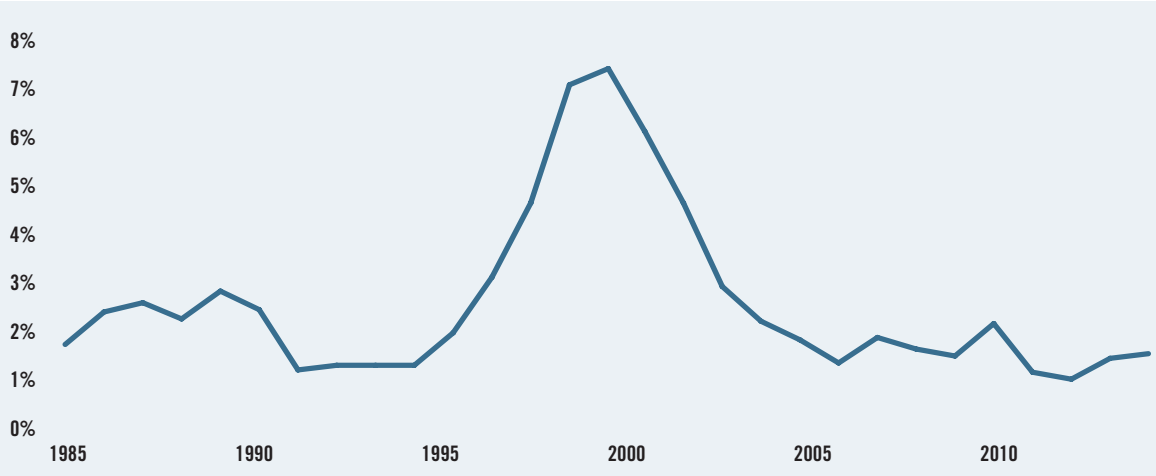
4.3 Industry Operating Structures

The owner and operator/manager of a property are often distinct entities but this is not always the case. This section discusses the predominant operating and ownership structures employed in the assisted living sector.

Exhibit 4.b

Distribution of Assisted Living Units by Year Opened in the Top 99 Metropolitan Markets

1985–2013



Source: NIC MAP® Data Service

Exhibit 4.c

Percentage of Units Operated by Number of Properties Operated in the Top 99 Metropolitan Markets

As of 4Q13

	Majority IL	Majority AL	Majority MC	Majority NC	GRAND TOTAL	CCRCs*
Operates Single Property	29%	**27%**	19%	33%	31%	38%
Operated by Chain: 2-9 Properties	29%	**23%**	29%	30%	29%	30%
Operated by Chain: 10+ Properties	42%	**49%**	52%	36%	41%	32%
Operated by Chain: 10-24 Properties	16%	**12%**	8%	14%	14%	15%
Operated by Chain: 25+ Properties	27%	**38%**	44%	22%	27%	17%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

*CCRCs are also included within the majority property types.

Source: NIC MAP® Data Service

4.3.1 Ownership Structures

Across majority assisted living properties, approximately 14 percent of the total units are owned by non-profit organizations. The remaining 86 percent of the units are owned by for-profit entities, including seniors housing operators, real estate investment trusts and joint-venture arrangements.[1] The properties owned by for-profit entities are either owned by privately held or publicly traded entities.

Majority assisted living properties are operated by companies of varying sizes. Approximately 27 percent of properties are operated by entities that have only a single property in the top 99 metropolitan markets. Properties operated by chains represent 73 percent of the market, with larger chains operating 49 percent of the overall market.[1]

4.3.2 Large Operators

Exhibit 4.d lists the largest operators of assisted living properties. The 10 operators listed control 26.1 percent of the assisted living units in the top 99 metropolitan markets.[1]

Exhibit 4.d

Largest Assisted Living Operators by Assisted Living Unit Count in the Top 99 Metropolitan Markets

As of 4Q13

	# Units Operated*
Emeritus Senior Living**	21,372
Brookdale Senior Living**	19,710
Sunrise Senior Living	12,992
Five Star Senior Living	7,659
Atria Senior Living	6,890
Senior Lifestyle	3,745
Elmcroft Senior Living	3,709
Benchmark Senior Living	2,397
Capital Senior Living Corp	2,395
Assisted Living Concepts, Inc.	2,025
10 Largest Operators' Share of Total Units	**26.1%**

*Includes only assisted living units. These companies may also operate independent living, memory care, and nursing care.
** Brookdale announced an agreement to merge with Emeritus on 2/20/2014. It is expected to close during the third quarter of 2014.

Source: NIC MAP® Data Service

4.4 Operating Economics

As with independent living, operating economics are driven by operating revenue (occupancy, rental rates and care fees) and operating expenses. Replacement reserves are also discussed. Generally, assisted living has higher rental rates and corresponding higher revenue per unit than independent living due to the higher care needs, and lower rental rates and revenue per unit than memory care or nursing care.

4.4.1 Operating Revenue

Assisted living revenues consist primarily of monthly rental payments for unit occupancy and care fees received from generally private-pay residents. A small but growing percentage (less than 10 percent) of assisted living revenues comes from government reimbursement through Medicaid waiver programs. Base fees and care fees, (e.g., primary occupant rental payments for the assisted living property) account for almost all of total unit revenue.

4.4.1.a Occupancy

Occupancy is the number of occupied units divided by the total number of open units in the top 31 metropolitan markets.

As of the fourth quarter of 2013, occupancy in majority assisted living properties was 89.6 percent, down from a high of 90.3 percent in the third quarter of 2006.[1] Assisted living occupancy rates began declining in 2007 coinciding with the decline in general economic conditions. Home equity is a primary financial asset of many seniors that allows them to afford assisted living. The decline in the housing market consequently adversely affected demand for assisted living, despite the fact that assisted living is primarily need-driven rather than lifestyle-driven. The drop in the employment rate also adversely impacted occupancy, as unemployed adult children provide family care-giving. In addition, unemployed adult children have less income to contribute toward the payment of assisted living monthly fees. Assisted living occupancy established a cyclical low in the second quarter of 2009 at 86.6 percent and has been steadily increasing since.[1]

As shown below, assisted living occupancy has been recovering since early 2010.

Resident turnover impacts occupancy, as a unit must be remarketed when a resident departs. Median annual resident turnover for assisted living is 54 percent, which is a higher turnover rate than the other seniors housing and care properties with the exception of nursing care.[2] This turnover is generally a result of the average age and health of assisted living residents.

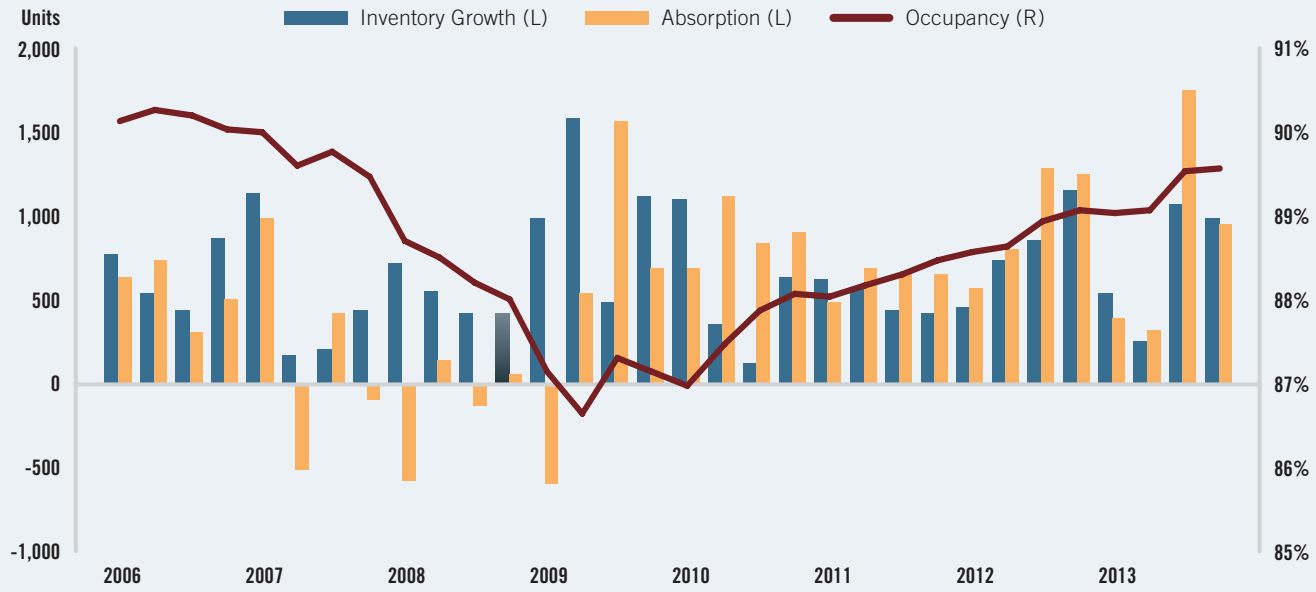
4.4.1.b Rental Rates

The table in Exhibit 4.f shows the distribution of monthly rental rates in assisted living.[1]

Exhibit 4.e

Majority Assisted Living Supply-Demand in the Top 31 Metropolitan Markets

1Q06 - 4Q13



Source: NIC MAP® Data Service

Exhibit 4.f

Distribution of Monthly Asking Rent in the Top 99 Metropolitan Markets ($)

As of 4Q13

	Lower Quartile	Median	Mean	Upper Quartile
Independent Living	2,082	2,650	2,765	3,346
Assisted Living	**3,227**	**3,980**	**4,159**	**4,891**
Memory Care	4,678	5,525	5,732	6,568
Nursing Care	6,301	7,731	8,432	9,618

Source: NIC MAP® Data Service

Note that the rental rates in Exhibit 4.f include base rents and services fees charged by the operator. As a result of the recession, the deterioration in the overall housing and employment markets, as well as additional new units coming online, asking rent growth has slowed considerably but has remained positive with stronger rate growth over the past few years, as demonstrated by the year-over-year asking rent growth chart below.[1]

Specifically, assisted living asking rent growth has slowed from 4 percent in 2006 to 2.1 percent as of the fourth quarter of 2013.[1]

Nonetheless, it is important to note that assisted living asking rents, as well as other seniors housing asking rents, continued to grow throughout the recent recession, in contrast to many other types of commercial real estate sectors. (This is discussed further in Section 10.2.1.)

4.4.2 Operating Expenses

Exhibit 4.h on page 32 reports annual operating expense data for freestanding assisted living properties. Total operating expenses range from $2,042 to $3,472 per occupied unit per month. Labor-related expenses are the largest budget component, generally representing between 51 percent and 55 percent of total operating expenses.[2] Raw food, utilities, property taxes, and replacement reserves are other large expense components.

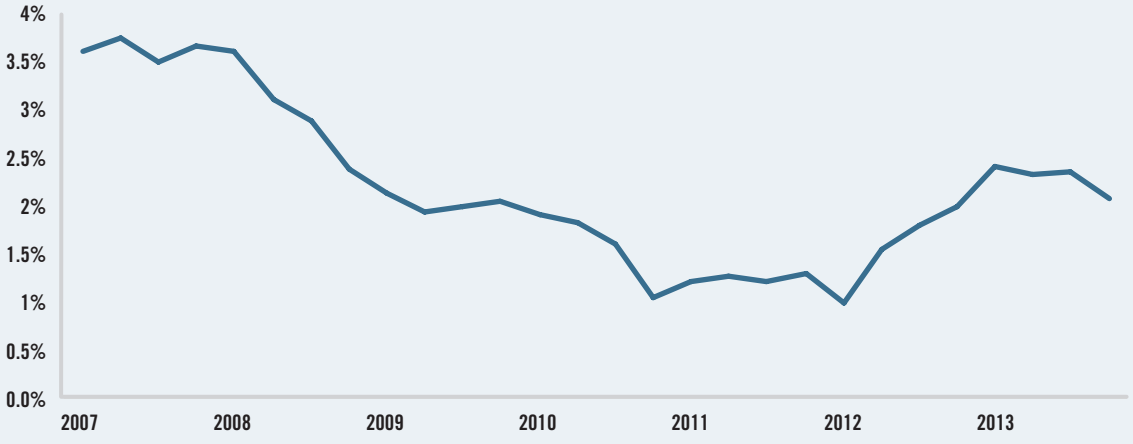
4.4.3 Net Operating Income

For income-producing asset classes, most commercial real estate industry associations, operators and industry practitioners report profitability and margins based on net operating income (NOI), which is analogous to earnings before interest, taxes, depreciation, amortization and rent (EBITDAR). NOI is calculated before deductions for operating lease payments, ground lease

Exhibit 4.g

Assisted Living Year-over-Year Asking Rent Growth in the Top 31 Metropolitan Markets

1Q07 - 4Q13



Source: NIC MAP® Data Service

Exhibit 4.h

Monthly Operating Expenses in Assisted Living Properties Per Occupied Unit

For Fiscal Year Ending 12/31/2012

	Lower Quartile*		Median*		Upper Quartile*	
	Dollars	% of Total Operating Expenses	Dollars	% of Total Operating Expenses	Dollars	% of Total Operating Expenses
Total Operating Expenses	$2,042		$2,735		$3,472	
Labor-related Expense	$1,115	55%	$1,465	54%	$1,782	51%
Property Taxes	$86	4%	$116	4%	$188	5%
Property Insurance	$26	1%	$20	1%	$30	1%
Liability Insurance	$11	1%	$19	1%	$21	1%
Workers Comp	$25	1%	$50	2%	$50	1%
Raw Food	$130	6%	$186	7%	$204	6%
Non-Labor Other Dietary	$58	3%	$14	1%	$37	1%
Utilities	$131	6%	$138	5%	$166	5%
Marketing	$50	2%	$51	2%	$66	2%
Repairs and Maintenance	$88	4%	$75	3%	$100	3%
Housekeeping	$23	1%	$22	1%	$26	1%
Resident Care Supplies	$9	0%	$9	0%	$15	0%
Activities	$17	1%	$16	1%	$28	1%
Total Management Fees	$67	3%	$81	3%	$133	4%
All Other Operating Expenses	$186	9%	$433	16%	$620	18%
All Corporate and/or Other Overhead Expenses	$21	1%	$40	1%	$8	0%
Replacement Reserve	$80		$120		$155	

Note: Expense subcategories may not sum to total expenses due to rounding. State of Seniors Housing defines the lower quartile as the average of the lowest 25% of responses, the median as the average of the 40th through 60th percentile, and the upper quartile as the average of the highest 25% of responses.

Source: State of Seniors Housing 2013 (Table 9.3)

payments, debt service, depreciation, amortization, income taxes, partnership expenses, capital expenditures, and replacement reserves. Operating margins are calculated as EBITDAR divided by total revenues. The calculations are consistent with standard commercial real estate industry practices.
Exhibit 4.i shows the range of operating margins in freestanding assisted living properties.

4.4.4 Replacement Reserves

Reserves for replacement items (ranging from carpeting/flooring and other "wear and tear" items, to major systems such as boilers, roofing and HVAC) vary greatly in assisted living properties. The age, physical condition, geographic location and overall quality of amenities at the property affect the level of replacement reserves. Properties with deferred maintenance typically warrant a higher capital expenditure allowance for renovations than well-maintained properties. The median replacement reserve for assisted living properties was $1,437 per occupied unit in 2012.[2]

4.5 Current Trends

Similar to the trend mentioned for independent living, seniors appear to be postponing their move to assisted living as long as possible as a result of the recession. The consequence is that the average new resident is now older and has higher ADL needs than assisted living residents of the past. This trend may lead to shorter lengths of stay. Some operators are reporting average lengths of less than 24 months, which means more than a 50 percent turnover of residents each year. This trend could result in residents who require more services. Operators who are able to provide these enhanced services (e.g. care, therapy, home health) should be able to capture revenue enhancement opportunities. This also has potential implications for increased staffing which could be offset by the additional revenue generated by the care charges.

Another trend is that of increasing operator and investor interest in dedicated memory care units. This trend may be a result of both the higher need-driven nature of the memory care product, which makes it less susceptible to a down

economy, as well as the increasing prevalence of Alzheimer's disease and other forms of dementia. Another trend that has emerged as a result of the recession is the increased interest in developing affordable assisted living options. These often rely on government funding, including programs from the Federal Housing Administration (FHA) of the U.S. Department of Housing and Urban Development (HUD).

Exhibit 4.i
Operating Margins by Property Type

	Lower Quartile	Median	Upper Quartile
Freestanding Independent Living[1]	20.3%	37.3%	49.9%
Freestanding Assisted Living[1]	**16.4%**	**31.2%**	**43.5%**
Freestanding Nursing Care[2]	3.1%	12.9%	22.6%
CCRCs[1]	6.7%	27.5%	37.7%

1. Data for fiscal year ending 12/31/2012
2. Data for fiscal year ending 12/31/2010

Source: State of Seniors Housing 2013; Valuation & Information Group

Atria Tamalpais Creek
Novato, CA

In this section

Section 5: Memory Care

This section discusses memory care, which serves Alzheimer's and dementia care residents. Topics to be discussed include the target market, supply and operating economics.

Alzheimer's disease is the most common form of dementia, and accounts for 60-80 percent of all dementia cases. However, there are many different forms of dementia, each requiring specialized care.[12]

Alzheimer's and dementia care is most often offered in properties that primarily focus on assisted living services. Generally, the property's main focus is the assisted living care segment, with a dedicated wing or secure floor of Alzheimer's and dementia care. The freestanding dementia care model is becoming more common as operators identify and further understand the complexity of the needs of residents with dementia.

5.1 Resident Population

The current occupied unit penetration rate for majority memory care properties (i.e., share of aged 75-plus households living in majority memory care properties) is 0.3 percent.[1]

5.1.1 Resident Profile

In a typical traditional-model assisted living property, it is estimated that one-third to one-half of the residents live with Alzheimer's disease or another form of dementia. This cognitive impairment and the challenges it brings to everyday life is one of the primary reasons that persons make the move from home to assisted living. Persons living with Mild Cognitive Impairment (MCI), early-stage Alzheimer's disease, or the early stages of other forms of dementia can typically be cared for in the general assisted living population without much risk or specialization to the environment or programming. The challenge presents itself, however, as the level of dementia advances in these residents and they are not moved along the continuum to a more specialized level of dementia care. Persons living with advancing dementia may require a secured (locked) environment, behavioral care and problem-solving, specially trained care staff, specialized dining and menus, more advanced nursing care, and specialized activity programming, all in order to manage the complex symptoms of their dementia. These are typically only services and competencies that are offered in dedicated Alzheimer's and dementia care settings.

A few senior living providers have begun to recognize that specialization in dementia care needs to occur throughout the entire spectrum of the disease process and are now offering earlier stage dedicated dementia care settings and programs as an alternative to "regular" assisted living settings.

(See Appendix B for a detailed discussion of the demographics of the prospective residents and adult children as well as other factors that influence demand.)

5.1.2 Alternative Housing and Services

The alternative housing and services include home health care, private duty care, family care and nursing care. (Refer to Appendix E for a detailed discussion on alternative housing and services.)

5.2 Supply

This section discusses supply inventory and supply growth.

5.2.1 Supply Estimate

There are approximately 1,060 investment-grade majority memory care properties across the U.S. Within these investment-grade properties, there are approximately 51,000 memory care units. Among these properties, the median number of units is 46. In addition, of the 1,060 majority memory care properties, approximately 965 are freestanding memory care market-rate properties, containing 43,500 units. The median number of units in these freestanding memory care properties is also 46.[1]

5.2.2 Supply Growth

The memory care sector has experienced a sizable amount of development within the last 15 years. Greater than two-thirds of the memory care units currently in existence within the 99 largest metropolitan markets have been developed since 1995. The period from 1995 to 2004 experienced heightened development activity, with 49 percent of the units currently in existence having been built during that time span. The late 1990s (1995–1999) in particular saw a building boom for memory care, with 27.7 percent of the units currently open having been developed during this time. The median age of freestanding memory properties is 14 years.[1]

Exhibit 5.a

Supply of Investment-Grade* Seniors Housing and Care Properties in the U.S.

By Property and Unit Counts across Property Types
Estimates as of 4Q13**

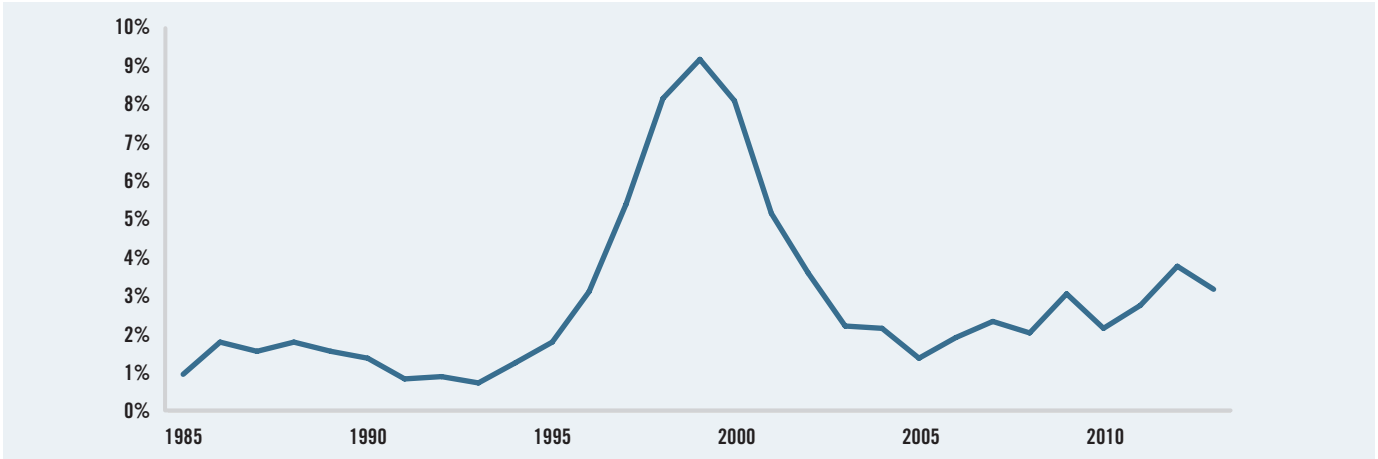
By Property Type	# Properties	# Units***
Majority IL	4,060	883,500
Majority AL	6,305	507,500
Majority MC	**1,060**	**51,000**
Majority NC	11,270	1,504,500
Total	**22,695**	**2,946,500**

* Current estimates are not comparable to estimates from prior years.
** Estimates are representative of properties with at least 25 units/beds that charge market rates for the housing and services offered.
*** One nursing bed is equivalent to one unit. *Source: NIC Research & Analytics*

Exhibit 5.b

Distribution of Memory Care Units by Year Opened in the Top 99 Metropolitan Markets

1985 - 2013



Source: NIC MAP® Data Service

5.3 Industry Operating Structures

The owner and operator/manager of a property are often distinct entities but this is not always the case. This section discusses the predominant operating and ownership structures employed in the memory care sector.

5.3.1 Ownership Structures

Across majority memory care properties, approximately 6 percent of the total units are owned by non-profit organizations. The remaining 94 percent of the units are owned by for-profit entities, including seniors housing operators, real estate investment trusts and joint-venture arrangements.[1] The properties owned by for-profit entities are either owned by privately held or publicly traded entities.

Majority memory care properties are operated by companies of varying sizes. Approximately 19 percent of properties are operated by entities that have only a single property in the top 99 metropolitan markets. Properties that are operated by chains represent 81 percent of the market, with larger chains operating 52 percent of the overall market.[1]

5.3.2 Large Operators

The table in Exhibit 5.d lists the largest operators of memory care units. The 10 operators listed control 33 percent of the memory care units in the top 99 metropolitan markets.[1]

5.4 Operating Economics

This section discusses the operating economics derived from operating revenue (occupancy and rental rates).

5.4.1 Operating Revenue

Memory care properties, like other assisted living properties, generate revenue by providing a combination of services and housing to residents who require some assistance with activities of daily living (ADLs); however, memory care properties focus exclusively on individuals with serious cognitive impairment. Because the major industry associations do not always classify memory care properties as a separate asset subclass from the larger class of assisted living properties, which encompasses memory care, the financial and operational data available is

Exhibit 5.d

Largest Memory Care Operators by Memory Care Unit Count in the Top 99 Metropolitan Markets

As of 4Q13

	# Units Operated*
Brookdale Senior Living**	5,113
Sunrise Senior Living	5,001
Emeritus Senior Living**	4,931
HCR ManorCare	2,925
Five Star Senior Living	2,134
Atria Senior Living	1,479
Silverado Senior Living	1,307
Constant Care Corporation	1,167
Benchmark Senior Living	1,026
Senior Lifestyle	878
10 Largest Operators' Share of Total Units	**32.6%**

* Includes only memory care units. These companies may also operate independent living, assisted living, and nursing care.

** Brookdale announced an agreement to merge with Emeritus on 2/20/2014. It is expected to close during the third quarter of 2014.

Source: NIC MAP® Data Service

Exhibit 5.c

Percentage of Units Operated by Number of Properties Operated in the Top 99 Metropolitan Markets

As of 4Q13

	Majority IL	Majority AL	Majority MC	Majority NC	Grand Total	CCRCs*
Operates Single Property	29%	27%	**19%**	33%	31%	38%
Operated by Chain: 2-9 Properties	29%	23%	**29%**	30%	29%	30%
Operated by Chain: 10+ Properties	42%	49%	**52%**	36%	41%	32%
Operated by Chain: 10-24 Properties	16%	12%	**8%**	14%	14%	15%
Operated by Chain: 25+ Properties	27%	38%	**44%**	22%	27%	17%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

*CCRCs are also included within the majority property types

Source: NIC MAP® Data Service

limited on freestanding memory care properties. Most often, assisted living properties dedicate a secure care segment (usually in a wing or floor of the building) to house and care for residents with memory impairment. Of the 1,060 properties that offer memory care, only 965 of these are freestanding memory care models, and the remaining 95 properties that offer memory care provide it along with other care segments.[1] The freestanding memory care properties are generally newer and smaller than freestanding assisted living properties, but the vast majority of memory care units are located in assisted living properties.

Memory care revenues primarily consist of monthly rental payments for unit occupancy and care fees received from private pay residents.

5.4.1.a Occupancy

Occupancy is the number of occupied units divided by the total number of open units in the top 31 metropolitan markets.

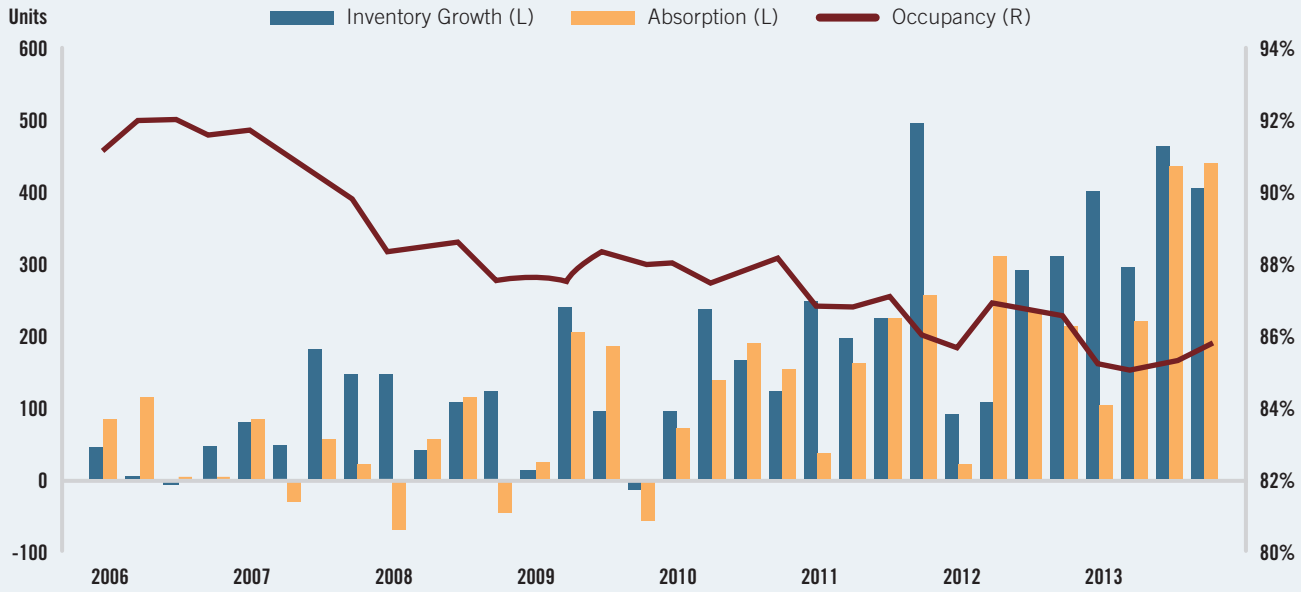
As of the fourth quarter of 2013, occupancy in majority memory care properties was 85.6 percent, down from a high of 92.0 percent in the first quarter of 2006.[1]

Resident turnover has an impact on occupancy as well. Median annual turnover for assisted living/memory care properties was 50.3 percent, which is higher than independent living and comparable to assisted living. This implies a typical length of stay of 23.9 months.[2]

Exhibit 5.e

Majority Memory Care Supply-Demand in the Top 31 Metropolitan Markets

1Q06 - 4Q13



Source: NIC MAP® Data Service

5.4.1.b Rental Rates

The following table shows the distribution of monthly rental rates in memory care.[1] Monthly rents include the base rent for real estate as well as a base level of services, such as for meals and housekeeping, along with the care needs of the residents. A number of factors impact rental rates including the community location, amenities, and age. The care levels are a major factor in the higher rental rates in memory care than the other product segments.

Exhibit 5.f

Distribution of Monthly Asking Rent in the Top 99 Metropolitan Markets

As of 4Q13

	Lower Quartile	Median	Mean	Upper Quartile
Independent Living	2,082	2,650	2,765	3,346
Assisted Living	3,227	3,980	4,159	4,891
Memory Care	**4,678**	**5,525**	**5,732**	**6,568**
Nursing Care	6,301	7,731	8,432	9,618

Source: NIC MAP® Data Service

Autumn Leaves
Woodstock, GA

Genesis Healthcare at Spring Mill
Phoenixville, PA

In this section

Section 6: Nursing Care

Nursing care, sometimes referred to as skilled nursing care, differs from other types of seniors housing and care in a number of important ways:

- Nursing care properties (also called skilled nursing properties or SNFs) rely on government reimbursement (Medicaid and Medicare) for about two thirds of their revenue while other types of seniors housing are predominately private pay.
- Nursing care properties house two types of residents: one for long-stay custodial care and the other for short-stay post-acute care, while most private-pay seniors housing properties house only long-stay residents. Long-stay nursing care residents are generally somewhat older and have more health conditions than residents in other types of seniors housing, but otherwise have many similar characteristics. Short-stay nursing care residents, who stay an average of only 24 days, are somewhat younger, often admitted after a hospital procedure, and receive much more active health care and rehab services than the residents in other types of seniors housing.
- Changes in health care policy, delivery and funding have a much greater impact on nursing care properties and operators than on other types of seniors housing.
- Growth in short-stay post-acute residents and the ability of nursing care operators to provide quality care to these residents and avoid re-hospitalization are key performance drivers for nursing care, but are a much less significant issue in other types of seniors housing.
- Many nursing care properties date from the 1960s and are much older on average than other types of seniors housing properties.
- The supply of nursing care properties is declining while the supply of other types of seniors housing properties is growing.

This section focuses on majority nursing care properties in which the dominate type of care offered is skilled nursing care.

6.1 Resident Population

Majority nursing care properties are the largest component of the seniors housing and care industry, accommodating an estimated 10 percent of the 75-plus population (penetration rate).[1] Over the course of any given year, nursing care properties actually care for a larger portion of this population because of the number of short-stay residents that move through these properties, and nursing care properties also care for some residents below 75 and even below 65 years of age.

6.1.1 Resident Profile

The key to understanding the dynamics of nursing care is to remember these properties care for two distinct types of residents:

1. The traditional long-stay custodial care resident, predominately female, with an average age in the upper 70s with many 85-plus or 90-plus years old.

2. A growing number of somewhat younger, higher acuity short-stay residents coming for post-acute rehab and recovery after a surgical procedure or other hospital stay, or in lieu of an inpatient hospital stay.

Long-stay residents utilize their own funds, Medicaid, VA benefits or long term care insurance to pay for their care and account for about 60% of the occupied beds in a nursing care property at any given point in time. Short-stay residents utilize Medicare or private insurance (including Medicare Advantage programs) to pay for their care and account for 35-40 percent of occupied beds, on average.

Because there are many more short-stay residents in a skilled nursing property, over time it is not unusual today for 80 percent of the residents in a skilled nursing property to be discharged to home or a home-like setting, perhaps with home health care.

Short-stay residents require much higher levels of service, but also provide higher reimbursement and the type of reimbursement that generally offers better margins. A key element in the transformation of the skilled nursing industry is how to attract and care for a growing number of short-stay residents.

6.2 Supply and Demand

This section discusses supply inventory and supply growth.

6.2.1 Supply Estimate

There are approximately 11,270 investment-grade majority nursing care properties across the U.S. Within these investment-grade properties there are approximately 1.5 million beds.[1] The investment-grade majority nursing care properties, as defined by the National Investment Center for Seniors Housing & Care (NIC), include only operating properties that primarily provide nursing care and are not attached to hospitals or characterized as special use facilities. The Centers for Medicare and Medicaid Services (CMS) report a broader universe of certified nursing care properties totaling about 15,650 properties with approximately 1,664,000 licensed beds, which includes beds attached to hospitals and non-operational (licensed) beds.[9] The median number of beds in investment-grade nursing care properties is 120.[1]

6.2.2 Supply Growth

Nursing care properties are older than other types of seniors housing and the total supply is declining. The "Great Society" legislation of the mid-1960s that created the Medicare and Medicaid programs, along with advances in medical science

Transitional/Short-stay/ Post-Acute Care ← **Industry Bifurcation** → **Custodial/Long-stay**

- Average Length of Stay: 24 days
- Average Age: 78.8 years
- Major joint replacement, severe infections, kidney/urinary tract infections
- Most residents discharged home with follow up home health care

Source: Avalere analysis of 2011 Medicare claims data; 2013 AHCA Quality Report

- Average Length of Stay: 1 year+
- Average Age: 79.8 years
- Frail residents with multiple conditions often including dementia and incontinence
- Stay through end of life; many with hospice care in property, at home or in specialized property

Source: AHCA 2013 Congressional Briefing; Valuation & Information Group; 2013 AHCA Quality Report

(e.g., cardiac diagnosis and care), triggered a wave of nursing care property development in the late 1960s and 1970s with supply growth continuing into the 1990s. Fifty-six percent of the supply of investment-grade nursing care properties was built between 1965 and 1989. Many states implemented certificate of need (CON) or other regulations to limit the growth in supply of nursing care properties to help control their Medicaid spending and much of this regulatory framework remains in effect.[1]

Beginning in the 1990s, development of assisted living properties began offering private pay residents a more attractive and, in some cases, more affordable alternative to nursing care properties. More recently, reimbursement changes and increased use of Medicaid, managed care, and home and community-based care alternatives, such as home health care, also began diverting some lower income residents receiving Medicaid from nursing care properties. The combined impact of private pay assisted living and home and community based care has been to gradually reduce demand for nursing care properties and has prompted some nursing care properties to close and others to shift their focus to short-stay post-acute care residents.

When we talk about skilled nursing capacity, three different measures are used: licensed beds — those authorized by the state; operational beds — those actually available for use; and occupied beds — those with a resident in them at a given point in time. As noted above, CMS counts licensed beds while NIC counts operational and occupied beds.

Exhibit 6.a
Supply of Investment-Grade Seniors Housing and Care Properties in the U.S.

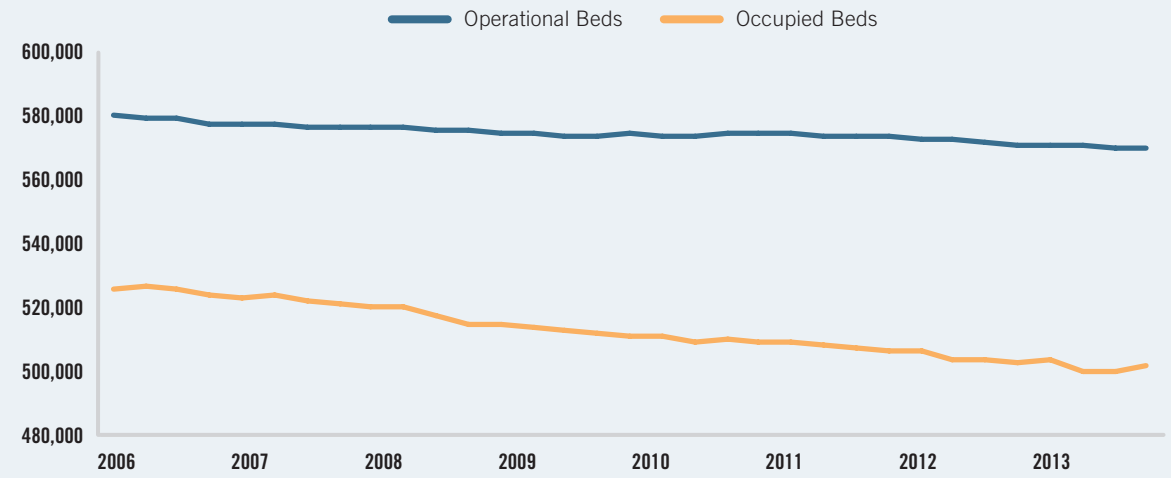
By Property and Unit Counts across Property Types
Estimates as of 4Q13**

By Property Type	# Properties	# Units***
Majority IL	4,060	883,500
Majority AL	6,305	507,500
Majority MC	1,060	51,000
Majority NC	**11,270**	**1,504,500**
Total	**22,695**	**2,946,500**

* Current estimates are not comparable to estimates from prior years.
** Estimates are representative of properties with at least 25 units/beds that charge market rates for the housing and services offered.
*** One nursing bed is equivalent to one unit. *Source: NIC Research & Analytics*

Exhibit 6.b
Majority Nursing Care Operational and Occupied Beds in the Top 31 Metropolitan Markets

4Q05 - 4Q13



Source: NIC MAP® Data Service

6.2.3 Demand

Operational beds have been declining for some time as older, poorly located skilled nursing properties are taken out of service and other properties move from double or higher occupancy rooms to single resident rooms to attract and better care for short-stay residents. As shown in Exhibit 6.b, since the first quarter of 2006 the overall supply of operational nursing care units/beds in the 31 largest metropolitan areas has decreased by 1.6 percent. There are more licensed than operational beds, creating some opportunities for new development but only with State approval to relocate and reuse licensed beds. In the past five years, only 2.1 percent of the operational nursing care beds currently in existence have been developed in the top 99 metro areas.[1]

Occupied beds have also been declining for some time and in recent years declining more rapidly than operational beds. Since the first quarter of 2006, the number of occupied nursing care units/beds in the 31 largest metropolitan areas has decreased by 4.7 percent.[1] Occupancy has declined for the reasons noted above and because the shift to short-stay residents increases turnover and frictional vacancy. There has also been some downward pressure on both hospital and skilled nursing admissions in recent quarters as the recession reduced health care insurance coverage which made some individuals reluctant to undertake elective medical procedures. Length of stay has also been depressed by managed care companies trying to control costs. It is too early to tell what impact the Affordable Care Act may have on improving insurance coverage, and hospital and nursing care admissions.

Occupancy, however, is not the best measure for gauging industry performance as the volume of short-stay residents increases. When evaluating the performance of skilled nursing properties with large volumes of short–stay post-acute residents, the important measure becomes the number of residents cared for over a given period or "patient throughput," not occupancy.

6.3 Market Size, Ownership, and Operation of Nursing Care Properties

NIC estimates that the total value of investment-grade nursing care properties in the U.S. is $107 billion. This assumes an average per unit/bed value of $71,000, which was the average purchase price in 2013.[1]

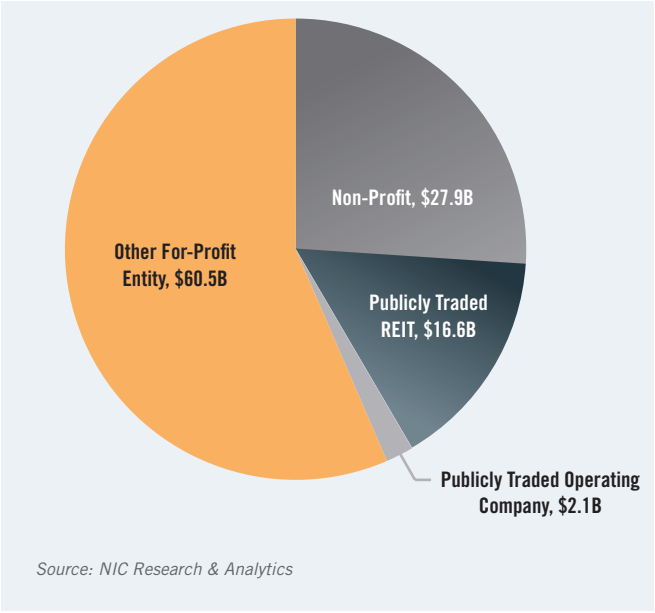
6.3.1 Property Ownership

The entities owning and operating nursing care and other types of seniors housing properties are often separate. The graph below shows publicly traded Real Estate Investment Trusts (REITs) own approximately 16 percent of the total supply of investment-grade nursing care properties and other private entities owning approximately 84 percent.[1] In mid-2014 at the time this publication was being written, The Ensign Group, a publicly traded skilled nursing operator, was in the process of spinning off most of its properties into a newly created health care REIT, CareTrust REIT. This transaction will reduce the number of nursing care properties owned by publicly-traded operators and increase those owned by REITs.

Exhibit 6.c

Implied Market Value of Majority Nursing Care Properties

As of 4Q13



Source: NIC Research & Analytics

Exhibit 6.d

Percentage of Units Operated by Number of Properties Operated in the Top 99 Metropolitan Markets

As of 4Q13

	Majority IL	Majority AL	Majority MC	Majority NC	GRAND TOTAL	CCRCs*
Operates Single Property	29%	27%	19%	**33%**	31%	38%
Operated by Chain: 2-9 Properties	29%	23%	29%	**30%**	29%	30%
Operated by Chain: 10+ Properties	42%	49%	52%	**36%**	41%	32%
Operated by Chain: 10-24 Properties	16%	12%	8%	**14%**	14%	15%
Operated by Chain: 25+ Properties	27%	38%	44%	**22%**	27%	17%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

*CCRCs are also included within majority property types.

Source: NIC MAP® Data Service

6.3.2 Operating Entities

Approximately 74 percent of the investment-grade nursing care beds in the U.S. are operated by for-profit entities, with the remaining 26 percent operated by non-profit companies. Operations are fragmented with 33 percent of properties operated by single property operators and another 30 percent run by operators with fewer than 10 properties.[1]

The 10 largest operators are listed on Exhibit 6.e. These operators in total control 14 percent of all investment-grade nursing care units in the top 99 metropolitan markets.[1] Only four are publicly traded companies: Ensign Group, Skilled Healthcare Group, Extendicare REIT, and Kindred Healthcare. It should be noted that Kindred has begun implementing a strategy to reduce its nursing care business by not renewing many of its leases on freestanding nursing care buildings and to focus on multiple levels of coordinated post-acute care (including long-term acute care hospitals, rehabilitation hospitals, skilled nursing care, outpatient rehabilitation therapy, home health and hospice care) in targeted markets.

6.4 Reimbursement

Unlike other types of seniors housing and care properties that are primarily private pay, nursing care properties on average receive 67 percent of their revenue from public sources. As of 2010, 42 percent came from Medicaid, a joint federal/state program that will pay for nursing home care for the indigent, with another 25 percent coming from Medicare, a federal program for persons 65 years and older that pays for post-acute care in a nursing care property after a three-day hospital visit.[14]

Exhibit 6.e

Largest Nursing Care Operators by Nursing Care Bed Count in the Top 99 Metropolitan Markets

As of 4Q13

	# Beds Operated*
Genesis HealthCare	29,302
HCR ManorCare	24,825
Golden Living	13,661
Kindred Healthcare**	12,569
Sava Senior Care	10,416
Life Care Centers of America	9,737
Consulate Health Care	8,509
Extendicare REIT	5,844
Ensign Group	5,114
Skilled Healthcare Group	5,070
10 Largest Operators' Share of Total Units	**14.0%**

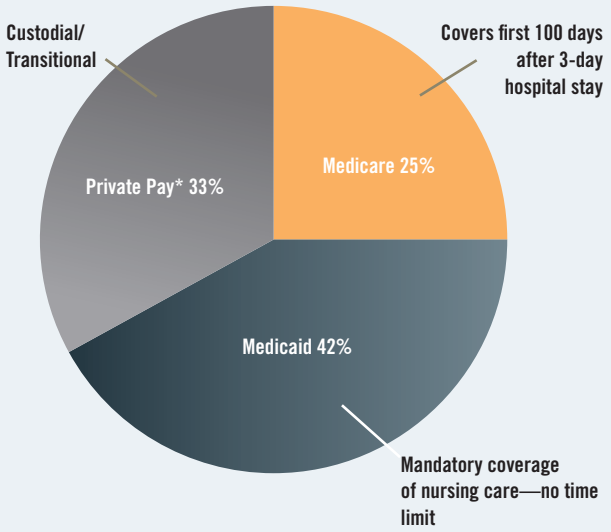
* Includes only nursing beds. These companies may also operate independent living, assisted living, and memory care.

** Kindred has begun implementing a strategy to reduce its nursing care business by not renewing many of its leases on freestanding nursing care buildings and to focus on multiple levels of coordinated post-acute care.

Source: NIC MAP® Data Service

Exhibit 6.f

Breakdown of Payment Sources for Skilled Nursing Property Care, 2010



*Private pay can include payments from private insurance or out-of-pocket spending.
Source: Avalere analysis of Medicare Healthcare Cost Report Information System (HCRIS) and Eiken et al. Medicaid Expenditures for Long-Term Services and Supports: 2011 Update. Thomson Reuters: October 31, 2011.

Most investors see considerable risk in nursing care properties and operators because of their reliance on government reimbursement. Contentious budget battles on Capitol Hill, a 2 percent reduction in Medicare reimbursement for nursing care operators, a 1 percent reduction in their cost of living, increases adopted in recent years, and uncertainty about the so called "Doc-Fix" (revisions to the sustainable growth rate (SGR) formula) at the time this publication was being written, all provide investors with reason for concern. However, a longer-term view of nursing care reimbursement is useful in separating political rhetoric from actual policy issues and reimbursement challenges. As indicated in Exhibit 6.g, since 1999 Medicare reimbursement has increased at an average compound annual rate of 4.42 percent and Medicaid reimbursement has increased at an annual compound rate of 3.95 percent.[16,19]

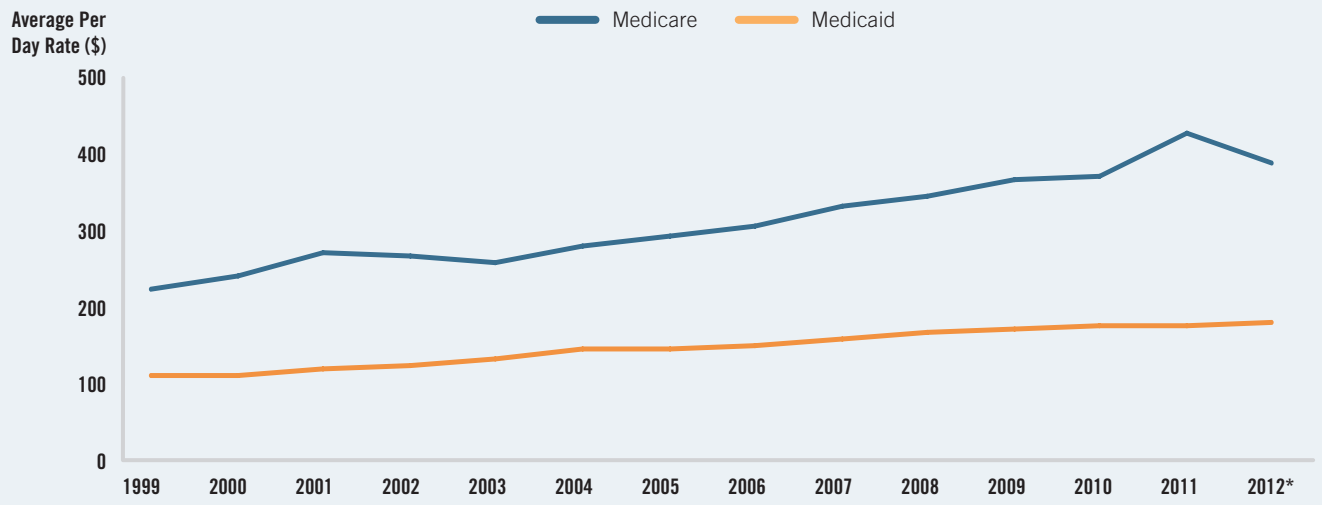
There have been a number of reimbursement challenges for operators, particularly from swings in Medicare reimbursement (See Appendix on Medicaid and Medicare). But overall, the rate of growth in both Medicare and Medicaid reimbursement has generally kept track with increases in cost and resident acuity, which has been gradually rising over time. Medicare reimbursement for nursing care properties was cut significantly in the 1997 Balanced Budget Act, with reductions implemented in 1999/2000 causing a significant disruption that prompted a number of operator bankruptcies. The 1999/2000 cuts were, however, a one-time event in the 50-year history of the Medicare program and were promptly corrected by Congress. On a long-term basis, there is considerable evidence of an implicit social contract at both the state and federal levels to provide post-acute and custodial care for seniors and history demonstrates more stability in skilled nursing reimbursement than believed by most investors.

As shown in Exhibit 6.h, Medicaid rates for long-term custodial care are about $179 per day/$5,439 per month, about 35 percent below private pay rates that include both long-term custodial and short-stay post-acute care. Medicare rates, which cover only short-stay post-acute care, average $388 per day/$11,810 per month—117 percent higher than Medicaid rates and 41 percent higher than private pay rates. But, it should be noted, Medicare is paying for more intense levels of treatment and therapy for residents following a minimum three-day hospital visit.[16] The rules and rate levels for Medicaid reimbursement vary from state to state. The timing of Medicaid reimbursement is also often subject to budgetary and political realities that vary by state with some states, notably Illinois, being chronic late payers. It is also important to understand that revenue from both Medicaid and Medicare are subject to audits as well as clinical and regulatory compliance reviews with the potential for retroactive rate adjustments. Precision in documentation and claims processing is essential to defend billing and reimbursement disagreements.

6.5 Rental Rates

Exhibit 6.i shows the distribution of monthly rental rates from private pay residents, who make up about 33 percent of the total payer mix in nursing care properties. The median monthly asking rent for nursing care was $7,731 during the fourth quarter of 2013, 40 percent more than memory care, 94 percent more than assisted living and 190 percent more than independent living.[1] These rates reflect both the greater need for health care among long-term custodial care nursing care residents and the fact that private pay rates for nursing care also cover some short-stay post-acute care where residents are being provided with a significant amount of nursing and rehabilitation care.

Exhibit 6.g
Average Per Day Payments for Nursing Property Services for Medicare and Medicaid, 1999-2012



**2012 Medicare payment rate is projected, not actual.*

Source: Avalere analysis of Medicare Healthcare Cost Report Information System (HCRIS) and Eiken et al. Medicaid Expenditures for Long-Term Services and Supports: 2011 Update. Thomson Reuters: October 31, 2011. Private pay can include payments from private insurance or out-of-pocket spending.

Exhibit 6.h
Average Rates by Payor Source

Payor Source	Monthly Rate	Per Diem
Medicaid[1]	$5,439	$179
Medicare[1]	$11,810	$388
Private Pay[2]	$8,434	$277

1. Data as of 2012
2. Data as of 4Q13

Source: Elijay LLC; American Healthcare Association; NIC MAP® Data Service

Exhibit 6.i
Distribution of Monthly Asking Rent in the Top 99 Metropolitan Markets ($)
As of 4Q13

	Lower Quartile	Median	Mean	Upper Quartile
Independent Living	2,077	2,650	2,761	3,346
Assisted Living	3,225	3,977	4,161	4,893
Memory Care	4,683	5,536	5,729	6,570
Nursing Care	**6,301**	**7,731**	**8,434**	**9,618**

Source: NIC MAP® Data Service

Private pay rents for nursing care have shown less cyclical movement than other property types, likely because the supply of nursing home beds has not experienced large swings. Annual asking rent growth for majority nursing care properties has oscillated around 3 percent for the last three years.[1]

6.6 Net Operating Income

For income-producing asset classes, most commercial real estate industry associations, operators and practitioners report profitability and margins based on net operating income (NOI), which is analogous to earnings before interest, taxes, depreciation, amortization and rent (EBITDAR). NOI is calculated before deductions for operating lease payments, ground lease payments, debt service, depreciation, amortization, income taxes, partnership expenses, capital expenditures, and replacement reserves. Operating margins are calculated as EBITDAR divided by total revenues. The calculations are consistent with standard commercial real estate industry practices.

Exhibit 6.j shows median, upper quartile and lower quartile operating expenses for nursing care. For a typical property, labor costs account for 44 percent of total expenses.[20] This compares to 54 percent for assisted living and 36 percent for independent living.[2]

Exhibit 6.k shows EBITDAR operating margins for various types of seniors housing and care properties. It is notable that nursing care margins (13 percent median) are well below the level of other types of predominately private-pay seniors housing properties that have median margins in excess of 30 percent.[2] It is also notable that the range of operating margins from the upper to lower quartile of nursing care properties is much wider than the range for other types of seniors housing properties. The reliance of nursing care on government reimbursement, where rates are set to limit profitability, reduces overall margins for nursing care properties. The wide range of margins suggests that nursing home profitability is significantly impacted by whether or not the operator focuses on higher margin short-stay, post-acute residents and the overall quality of the operator, which can vary greatly.

6.7 Replacement Reserves/Capital Expenditure Requirements

Reserves for replacement items (ranging from carpeting/flooring and other "wear and tear" items, to major systems such as boilers, roofing and HVAC) vary greatly in nursing care properties. The age, physical condition, geographic location and overall quality of amenities at the property affect the level of replacement reserves. Properties with deferred maintenance typically warrant a higher capital expenditure allowance for renovations than well-maintained properties. The U.S. Department of Housing and Urban Development (HUD) generally requires replacement reserves for nursing care properties of between $450 and $500 per bed.

In addition to replacement reserves to keep nursing care properties in good condition, the changing nature of nursing care services, particularly the desire to attract and properly care for a larger number of short-stay post-acute care residents may require significant capital expenditures to upgrade a traditional nursing care property. Key improvements needed to adapt a property to accommodate short-stay residents may include: converting from double to single room occupancy, adding larger rehabilitation gyms, upgrading fits and finishes to include quartz or similar synthetic counter tops, laminated wood flooring, wallpaper, flat screen televisions, and upgraded beds and furniture; as well as enhanced care capabilities such as piped oxygen, resident monitoring equipment and larger nursing stations. Attracting short-stay residents may also require a separate or upgraded entrance for such residents, cosmetic exterior improvement and larger parking lots to accommodate an increased number of visitors, third-party service providers and staff. Not all nursing care properties can successfully make this transition because short-stay residents typically have more discretion over care locations and prefer properties convenient to family and often near hospitals where residents received their acute care services.

6.8 Capital Availability

HUD financing is a key source of long-term financing for nursing care properties with some REITs (particularly Aviv, Omega

Exhibit 6.j
Monthly Operating Expenses in Nursing Care Properties Per Occupied Bed

For Fiscal Year Ending 12/31/2010

	Lower Quartile	Median	Upper Quartile
Total Operating Expenses	$4,626	$5,758	$7,133
Labor-related Expense	$2,009	$2,560	$3,225
Liability Insurance	$23	$44	$76
Workers Comp	$316	$446	$669
Raw Food	$168	$203	$256
Repairs and Maintenance	$221	$316	$435
Housekeeping	$19	$28	$62
Total Management Fees	$517	$742	$1,034
Replacement Reserve	$228	$412	$637

Note: Each line item is derived from separately sorted rows, and, therefore, the indented categories will not sum to the total operating expenses.

Source: Valuation Information Group

Exhibit 6.k
Operating Margins by Property Type

	Lower Quartile	Median	Upper Quartile
Freestanding Independent Living[1]	20.3%	37.3%	49.9%
Freestanding Assisted Living[1]	16.4%	31.2%	43.5%
Freestanding Nursing Care[2]	**3.1%**	**12.9%**	**22.6%**
CCRCs[1]	6.7%	27.5%	37.7%

1. Data for fiscal year ending 12/31/2012
2. Data for fiscal year ending 12/31/2010

Source: State of Seniors Housing 2013; Valuation & Information Group

Healthcare Investor, LTC Properties and the newly formed CareTrust REIT) also active. CMBS financing was a major capital source for skilled nursing transactions but is less available today. Development financing from commercial banks, select REIT and private equity investors is available at higher rates than for private pay seniors housing, but the overall level of skilled nursing development is limited by CON and similar regulations (See Section 9 – Capital Sources for additional information.)

6.9 Investment Trends

Most large nursing care operators went private in the early to mid-2000 time frame and others have separated their real estate from operations. Several operators are large enough, even without their real estate holdings, to reenter public markets once the impact of the Affordable Care Act and other reimbursement issues are clarified. Valuations for nursing care operators are currently low due to reimbursement uncertainty and the lack of significant players in the public markets. The shift to short-stay care is increasing clinical care demands on operators and increasing capital expenditure needs. This may spur further operator and property consolidation. (See Section 2 – Emerging Trends and Observations for additional information.)


Eagle Lake Nursing & Rehabilitation
Eagle Lake, TX

Valencia Terrace
Corona, CA

In this section

Section 7: Continuing Care Retirement Communities

Continuing Care Retirement Communities (CCRCs) provide older adults with independent living, assisted living and skilled nursing options (frequently with specialized memory support options) typically from one sponsor in a single location. This arrangement allows older adults to remain in the same community with the same provider even if their future care needs change. Modern CCRCs tend to target an independent living customer seeking hospitality-style amenities and services with the security of knowing that future care needs will be met.

There are currently two primary revenue models for CCRCs: a rental-based product and an entrance fee-based product. Entrance fee refers to a sum paid by the resident upon entering into a continuing care contract, generally more than $200,000 to over $2 million, depending on the market, apartment size and features. In nearly all cases, a monthly service fee, which may include a long-term care insurance premium, is charged in addition to the upfront fee. Continuing care contracts convey the right to occupy a unit within the community until the contract is terminated either by the death or by the departure of the resident. Entrance fee-based CCRCs are generally larger than their rental counterparts and represent 49 percent of CCRC properties, while pure rental CCRCs comprise 51 percent of all CCRCs. The median size of CCRCs is 286 units. CCRCs have a median age of 31 years.[2]

Entrance fee CCRCs offer different types of contracts for the services associated with residents' future care needs as well as different levels of repayment. These contract types are discussed in Appendix D.

7.1 Resident Population

This section focuses on the overall CCRC market. We begin our discussion with the resident profile. The current occupied unit penetration rate for CCRCs (i.e., the share of 75-plus households living in CCRCs) is 4.2 percent.[1]

7.1.1 Resident Profile

The majority of new CCRC residents live in an independent living unit. The typical CCRC resident is between 80 and 84 years of age and does not require assistance with any activities of daily living (ADLs). While CCRCs serve a predominately single female population, entrance fee CCRCs have a significantly higher percentage (41 percent) of married couples compared to only 22 percent at rental CCRCs.[22] Prior to moving into a CCRC, the typical resident lived in a private home located less than 20 miles from the property. The typical CCRC resident has a higher level of education than that of residents of other seniors housing and care properties (this is especially true of the entrance fee resident) and has the financial wherewithal to pay the upfront entrance fee.

The decision to move to a CCRC is usually made by the resident rather than a family member (as is often the case with other types of seniors housing) and is largely choice/lifestyle-driven, even though a health condition or recent health event can often trigger interest. New residents of CCRCs tend to be planners, with the thought that, if their health deteriorates, a continuum of care is available without the need to move again. Specifically, people moving to CCRCs tend to be risk-averse and focused on planning for the future to ensure care for life.

Because a CCRC move-in is usually the last move an individual wants to make, and because new residents are generally healthier than residents in other types of seniors housing, resident turnover in CCRCs is significantly lower. In the independent living portion of CCRCs, median annual turnover is 12.2 percent within entrance fee CCRCs, compared to 16.8 percent for all CCRCs—both lower than all other types of seniors housing and care properties (independent living, assisted living and nursing care).[2]

The primary source of payment for CCRCs is similar to that for independent living – the resident's income and assets. Often, the value and liquidity of one's house are particularly important factors in one's ability to afford an entrance fee CCRC. Ninety-five percent of entrance fee CCRC residents moved directly from a single-family home. By comparison, only 75 percent of rental CCRC residents moved directly from a single-family home. Eighty-three percent of entrance fee CCRC residents have a net worth in excess of $300,000, compared to 36 percent of rental CCRC residents. The resident's children are typically not a source of payment for CCRCs.[22]

The median length of stay in a CCRC (excluding the nursing care section) is 71.5 months.[2]

(See Appendix B for a detailed discussion of the demographics of prospective residents and their adult children, as well as other factors that influence demand.)

7.1.2 Alternative Housing and Services

The alternative housing services for those considering a move to a CCRC include remaining in their current homes, moving to active adult communities, age-restricted apartments, cohousing and village communities. (Refer to Appendix F for a detailed discussion of alternative housing and services.)

7.2 Supply

This section discusses supply inventory and growth over time.

7.2.1 Supply Estimate

There are approximately 2,000 investment-grade CCRCs across the U.S. This number includes properties that offer, at a minimum, both dedicated independent living and nursing care on the same campus, though 80 percent of CCRCs also offer assisted living or memory care. Within these investment-grade properties, there are approximately 630,000 units, which span the spectrum of seniors housing care segments. The median size of all CCRCs is 286 units; however, this differs significantly by payment model. The median size of entrance fee CCRCs is 329 units, compared to 238 units for rental CCRCs.[1]

Exhibit 7.a

Supply of Investment-Grade* Seniors Housing and Care Properties in the U.S.

By Property and Unit Counts across Campus Types
Estimates as of 4Q13**

By Campus Type	# Properties	# Units***
CCRCs	1,970	634,000
Combined	5,560	684,500
Freestanding	15,165	1,628,000
Total	**22,695**	**2,946,500**

* Current estimates are not comparable to estimates from prior years.

** Estimates are representative of properties with at least 25 units/beds that charge market rates for the housing and services offered.

*** One nursing bed is equivalent to one unit. *Source: NIC Research & Analytics*

7.2.2 Supply Growth

Approximately half of existing CCRC units were developed in the last 30 years. About four in seven of the CCRC units in the 99 largest metropolitan markets have been developed since 1980. The 1980s saw the highest level of development, with 24 percent of existing units in CCRCs delivered during that decade. Since CCRCs generally contain a large portion of independent living units, the heightened development period of the late 1980s for independent living is reflected within CCRCs. The median age of CCRCs is 31 years.[1]

7.3 Industry Operating Structures

The owner and operator/manager often are distinct entities. This section discusses the predominant operating and ownership structures employed in CCRCs.

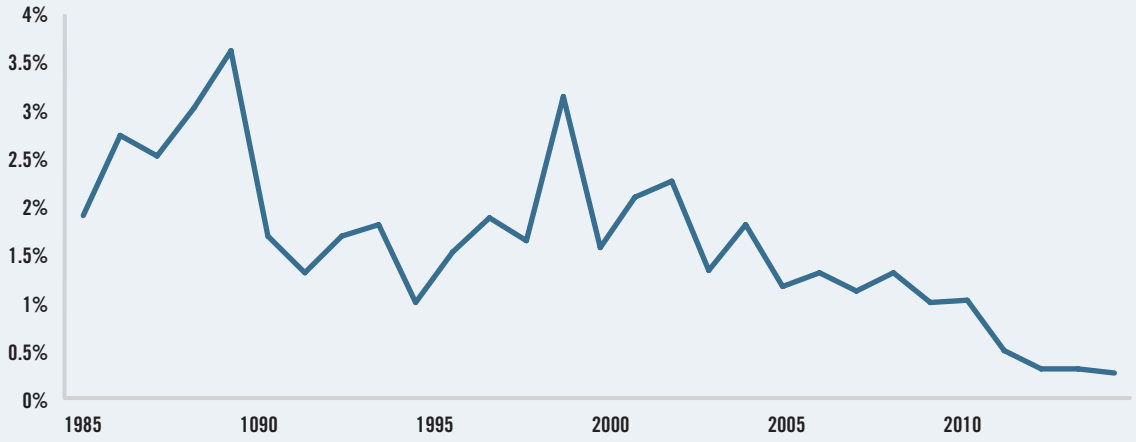
7.3.1 Ownership Structures

The majority (74 percent) of units within CCRCs are owned by not-for-profit organizations, which have access to tax-exempt bond financing. The remaining 26 percent of the units are in properties owned by for-profit entities and include REITs and joint-venture arrangements.[1] The properties owned by for-profit entities can be privately owned or owned by publicly traded entities. It should be noted that two of the largest CCRC operators, Brookdale and Five Star, are publicly traded.

Exhibit 7.b

Distribution of Units in CCRCs by Year Opened in the Top 99 Metropolitan Markets

1985 - 2013



Source: NIC MAP® Data Service

Exhibit 7.c

Percentage of Units Operated by Number of Properties Operated in the Top 99 Metropolitan Markets

As of 4Q13

	Majority IL	Majority AL	Majority MC	Majority NC	Grand Total	CCRCs*
Operates Single Property	29%	27%	19%	33%	31%	**38%**
Operated by Chain: 2-9 Properties	29%	23%	29%	30%	29%	**30%**
Operated by Chain: 10+ Properties	42%	49%	52%	36%	41%	**32%**
Operated by Chain: 10-24 Properties	16%	12%	8%	14%	14%	**15%**
Operated by Chain: 25+ Properties	27%	38%	44%	22%	27%	**17%**
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

* CCRCs are also included within the majority property types

Source: NIC MAP® Data Service

7.3.2 Large Operators

Exhibit 7.d lists the largest operators of CCRCs. The 10 companies listed control 22.3 percent of the units within CCRCs in the top 99 metropolitan markets.[1]

7.4 Operating Economics

This section discusses the operating economics derived from operating revenue (occupancy and rental rates), operating expenses and net operating income (NOI). Replacement reserves are also discussed.

7.4.1 Operating Revenue

For rental CCRCs, operating revenues depend upon occupancy and rental rates. In the case of entrance fee CCRCs, revenues are realized through the collection of entrance fees less repayments of entry fees for terminated contracts and monthly service fees. CCRC revenues primarily consist of payments received from private pay residents, though communities with a high percentage of nursing care beds may collect a meaningful percentage of revenues through government reimbursement and insurance.

Exhibit 7.d

Largest Operators by CCRC Unit Count in the Top 99 Metropolitan Markets

As of 4Q13

	# Units Operated*
Life Care Services LLC	19,616
Erickson Living	19,432
Brookdale Senior Living	11,100
Five Star Senior Living	7,495
ACTS Retirement-Life Communities	5,168
Covenant Retirement Communities	4,412
Lifespace Communities	3,593
Vi Senior Living	3,043
Sunrise Senior Living	2,985
Delmar Gardens Enterprises Inc	2,667
10 Largest Operators' Share of Total Units	**22.3%**

* Includes independent living, assisted living, and memory care units, and nursing care beds.

Source: NIC MAP® Data Service

7.4.1.a Occupancy

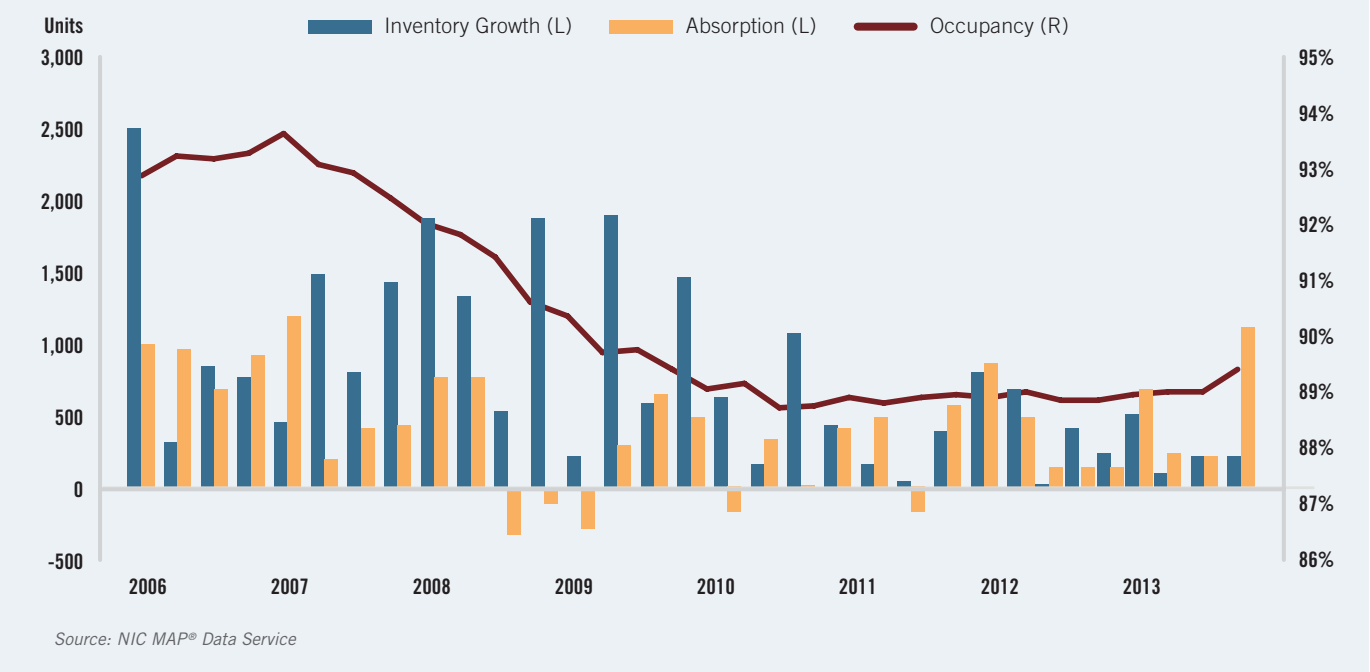
The discussion of occupancy will focus on all CCRCs, both rental and entrance fee models. Occupancy is the number of occupied units divided by the total number of open units in the top 31 metropolitan markets.

As of the fourth quarter of 2013, occupancy in CCRCs was 89.4 percent. Prior to the 40 basis point increase in occupancy during the fourth quarter of 2013, CCRC occupancy had remained essentially flat since the second quarter of 2009. From the second quarter of 2009 through the third quarter of 2013, CCRC occupancy oscillated between 88.7 and 89.7 percent. During that four-year period, absorption and inventory growth were rather anemic, with absorption only strong enough to essentially offset new inventory growth. The 40 basis point increase in occupancy during the fourth quarter of 2013 was the first material increase in CCRC occupancy in the current economic cycle.[1] The median annual resident turnover within

Exhibit 7.e

CCRC Supply-Demand in the Top 31 Metropolitan Markets

1Q06 - 4Q13



Source: NIC MAP® Data Service

CCRCs, outside of nursing care beds, is low at 16.3 percent. This implies a length of stay of 71.5 months.[2]

7.4.1.b Rental Rates

Exhibit 7.f shows the average monthly rental rates in CCRCs by care segment. While entrance fees are typically used to reduce the average monthly rental rates for residents of entrance fee CCRCs, the average rental rates shown below for entrance fee CCRCs are higher than those shown for rental properties. This is the result of the fact that many entrance fee CCRCs are very high-end properties.

The rental rates in Exhibit 7.f include base rents and service fees charged by the operator in rental and entrance fee CCRCs. As a result of the recession, the deterioration in the overall housing market, and the addition of new units coming online, rent growth has slowed considerably as demonstrated by the year-over-year asking rent growth chart below, though it has remained positive.

Exhibit 7.f

CCRCs Average Monthly Asking Rent by Care Segment and Payment Type

As of 4Q13

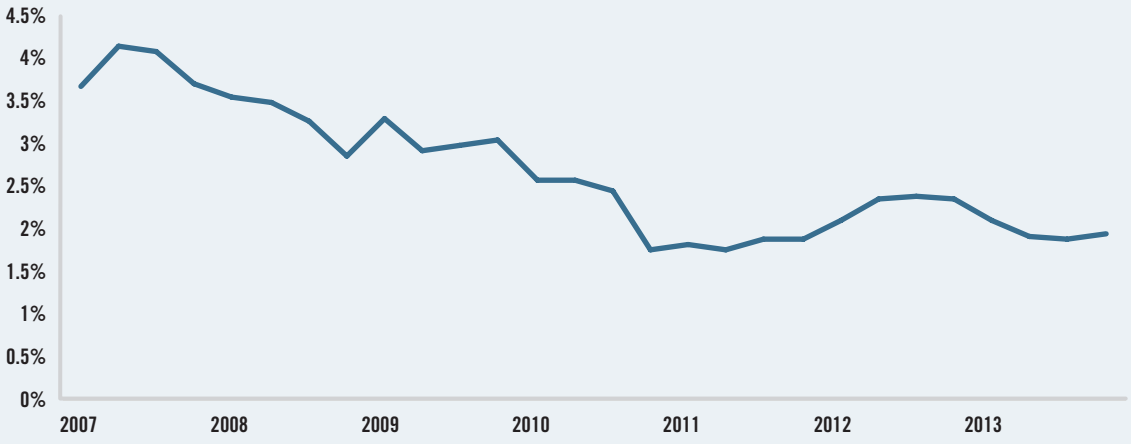
	Rental	Entrance Fee	All CCRCs
Independent Living	$2,557	$2,892	$2,784
Assisted Living	$4,176	$5,009	$4,601
Memory Care	$5,809	$6,438	$6,167
Nursing Care	$8,487	$9,448	$8,882

Source: NIC MAP® Data Service

Exhibit 7.g

CCRC Year-over-Year Asking Rent Growth in the Top 31 Metropolitan Markets

1Q07 - 4Q13



Source: NIC MAP® Data Service

Exhibit 7.h
Monthly Operating Expenses in CCRCs Per Occupied Unit
For Fiscal Year Ending 12/31/2012

	Lower Quartile*		Median*		Upper Quartile*	
	Dollars	% of Total Operating Expenses	Dollars	% of Total Operating Expenses	Dollars	% of Total Operating Expenses
Total Operating Expenses	$2,870		$3,442		$4,904	
Labor-related Expense	$1,558	54%	$1,888	55%	$2,439	50%
Property Taxes	$123	4%	$105	3%	$248	5%
Property Insurance	$26	1%	$27	1%	$64	1%
Liability Insurance	$26	1%	$18	1%	$25	1%
Workers Comp	$34	1%	$37	1%	$45	1%
Raw Food	$202	7%	$222	6%	$246	5%
Non-Labor Other Dietary	$24	1%	$23	1%	$102	2%
Utilities	$165	6%	$185	5%	$275	6%
Marketing	$55	2%	$96	3%	$86	2%
Repairs and Maintenance	$82	3%	$85	2%	$142	3%
Housekeeping	$14	0%	$13	0%	$31	1%
Resident Care Supplies	$27	1%	$44	1%	$119	2%
Activities	$6	0%	$11	0%	$31	1%
Total Management Fees	$112	4%	$141	4%	$199	4%
All Other Operating Expenses	$345	12%	$424	12%	$837	17%
All Corporate and/or Other Overhead Expenses	$70	2%	$125	4%	$16	0%
Replacement Reserve	$258		$304		$421	

Notes: Expense subcategories may not sum to total expenses due to rounding. State of Seniors Housing defines the lower quartile as the average of the lowest 25% of responses, the median as the average of the 40th through 60th percentile, and the upper quartile as the average of the highest 25% of responses.
Source: State of Seniors Housing 2013 (Table 9.5)

Total operating expenses generally range from $2,870 to $4,904 per occupied unit per month. Labor-related expenses are the largest component, generally representing between 50 percent and 55 percent of total operating expenses.[2]

7.4.3 Net Operating Income

Most industry associations and operators report profitability and margins based on NOI, which is analogous to earnings before interest, taxes, depreciation, amortization and rent (EBITDAR). NOI is calculated before deductions for operating lease payments, ground lease payments, debt service, depreciation, amortization, income taxes, partnership expenses, capital expenditures, and replacement reserves. Operating margins are calculated as EBITDAR divided by total revenues. The calculations are consistent with standard commercial real estate industry practices.

The table in Exhibit 7.i shows the range of operating margins in CCRCs.

Exhibit 7.i
Operating Margins by Property Type
For Fiscal Year Ending 12/31/2012

	Lower Quartile	Median	Upper Quartile
Freestanding Independent Living[1]	20.3%	37.3%	49.9%
Freestanding Assisted Living[1]	16.4%	31.2%	43.5%
Freestanding Nursing Care[2]	3.1%	12.9%	22.6%
CCRCs[1]	**6.7%**	**27.5%**	**37.7%**

1. Data for fiscal year ending 12/31/2012
2. Data for fiscal year ending 12/31/2010

Source: State of Seniors Housing 2013; Valuation & Information Group

7.4.4 Replacement Reserves

Reserves for replacement items (ranging from carpeting/flooring and other "wear and tear" items, to major systems such as boilers, roofing and HVAC) vary greatly in CCRCs. The age, physical condition, geographic location and overall quality of amenities at the property affect the level of replacement reserves. Properties with deferred maintenance typically warrant a higher capital expenditure allowance for renovations than well-maintained properties. The median replacement

reserve for CCRCs was $3,647 per occupied unit in 2013, reflecting the older median age of these properties.[2]

7.5 Current Trends

Home Values and CCRCs Occupancy – In 2001, proceeds from the sale of a home were the primary source of funds for entrance fees, cited by 58 percent of new CCRC residents. In 2012, only 38 percent of new CCRC residents indicated that home sales proceeds were the primary source of funds.[22] In 2012, the use of savings and investments to augment home proceeds was more common.

Home values, which peaked in 2006-2007, declined precipitously in 2008 and 2009. In 2010 and 2011, home values bounced along the bottom. As a consequence of the housing market collapse, demand for units at entrance fee CCRCs declined, particularly among the more price-sensitive segments of the market, and CCRC occupancy declined to a level slightly below 89 percent and stayed there for most of the past three years.

In many markets, the lowest level of the bust was not reached until the spring of 2012 when home values started to gain some upward momentum. After a seasonal decline the following winter, home values continued to show signs of recovery throughout 2013. Buoyed by the home market, absorption of CCRC units increased in the fourth quarter of 2013 and CCRC occupancy finally climbed above 89 percent to 89.4 percent.[1]

Acquisitions of Distressed CCRCs – Many CCRC developments financed before mid-2007 ran into difficulty filling new inventory delivered during the housing downturn and struggled to meet occupancy covenants. For communities financed with highly leveraged tax-exempt structures, sometimes 100 percent of development costs (including borrowed reserves), debt service payments became unsustainable. Sponsors that were unable to provide additional capital lost their new communities to receivership. A number of these communities have been sold to new investors at a lower cost basis or were refinanced at lower interest rates. This has permitted distressed CCRCs to reset their fee structures in light of current market realities and for occupancy to begin to climb.

Continuing Care at Home – In response to the housing downturn, some CCRC providers began offering services to seniors in the surrounding community, either by delivering services to them or by inviting them to use services on the CCRC campus. Operators are seeking to serve these non-resident seniors both to introduce them to their community as a marketing tool, as well as to develop ancillary revenue opportunities. While this is a viable economic option for older adult homeowners still feeling the effects of the housing downturn, the social engagement and wellness amenities of a CCRC generally cannot be replaced.

Aging in Place within Independent Living Units – In order to reduce capital investment, speed delivery of new CCRCs and respond to resident concerns about an eventual stay in an assisted living or nursing environment, some providers have begun offering to deliver increased levels of health care service within independent living units to the extent permitted by statutes. Due to the regulatory climate in California, many providers have eliminated nursing from their campuses and provide higher acuity care in assisted living environments. It remains to be seen if these communities can maintain their marketability to new prospects upon turnover and existing populations exhibiting higher acuity.

Future Indicators – Adult children of current CCRC residents indicate that those who understand CCRCs are their biggest proponents.

Exhibit 7.j
Adult Children's Perspectives Comparing CCRCs to a Single-family Home

Percentage of Respondents that Indicate CCRCs Affords Greater Opportunities

Personal Safety and Security	88%
Social Activities	84%
Aging in Place	79%
Convenience	78%
Staying Fit	73%
Lifelong Learning	73%
Choice and Options in Life	69%
Eating Well	67%

Source: ASHA, Senior Living for the Next Generation Volume I

The Commons in Lincoln
Lincoln, MA

In this section

Section 8: Development

Compared to the other major real estate classes, seniors housing and care development is most closely related to multifamily properties, although with certain key differences. This section gives an overview of key considerations in the development of seniors housing and care and compares many aspects to multifamily.

As in all real estate, various factors affect viability of seniors housing and care development: what revenue can a project generate; what Net Operating Income (NOI) margins can be earned; what financing and cap rates (or discount rates) are achievable; and how expensive are development costs. The first three factors above are primarily addressed elsewhere in this publication; this section will deal with the fourth factor, development costs.

Development costs for seniors housing and care fall into four categories: land, building costs, professional fees and other soft costs, and lease-up reserves.

- Land costs are driven by project footprint and per-acre prices. Footprint, in turn, depends on several factors: zoning unit count, building height and area, and grounds.
- Building costs are functions of project square footage and construction type; construction pricing; furniture, fixtures and equipment (FFE); and municipal fees.
- Professional fees may include market research and analysis, architects, lawyers, engineers, designers, bankers, environmental consultants and developers. Other soft costs include sales and marketing and project overhead incurred during the development period.
- Lease-up reserves cover operating losses and debt service payments during lease-up.

The following discussion focuses mostly on aspects of these costs unique to seniors housing and care properties and less on aspects common to real estate development.

8.1 Land

The amount of land required for developing seniors housing and care properties can vary greatly depending on several factors.

8.1.1 Footprint

The footprint of a typical suburban seniors housing and care development is 2-to-10 acres depending upon unit count, building heights, building setbacks, parking, and other factors. Continuing care retirement community (CCRC) developments generally have a substantially larger footprint than other seniors housing properties. Urban projects typically have a smaller footprint with greater height and unit density.

8.1.1.a Unit Count

Unlike the multifamily sector, which builds projects that can range from a mere dozen units up to thousands of units, the seniors housing and care industry has found a narrow range of property sizes to be most successful. If projects are too small, they lack economies of scale for needed services to seniors; if too large, they become difficult to lease up and then keep full in the niche market they serve.

The median size of a freestanding independent living property is 115 units, with half of such properties between 86 and 134 units (see Exhibit 8.a).[1] However, many independent living properties are developed with accompanying assisted living, memory care and/or nursing care components. The median size of an independent living property that includes assisted living or memory care (but not nursing care)—called a "combined" property—is 163 total units; larger ones commonly exceed 200 units. CCRCs (which include nursing care and often assisted living and memory care) average approximately twice the size of combined properties.[1]

Exhibit 8.a

Distribution of Unit Counts by Property Type

As of 4Q13

	Majority Independent Living			Majority Assisted Living			Majority Nursing Care		
	Freestanding	Combined	CCRC	Freestanding	Combined	CCRC	Freestanding	Combined	CCRC
Lower Quartile	86	120	244	34	65	118	91	106	144
Median	115	163	320	48	85	176	120	148	212
Upper Quartile	134	210	420	68	112	231	150	190	298

Source: NIC MAP® Data Service

Ranges for other types of properties, by their respective majority care segment, are provided in Exhibit 8.a.

8.1.1.b Building Height and Grounds

The impact of building height and grounds (including structured or surface parking) in sizing a property's footprint are specific to an individual project, driven primarily by local zoning and regulatory requirements. Independent living properties tend to have greater parking requirements than assisted living or nursing care properties because residents are more likely to drive. Most suburban assisted living, memory care, and skilled nursing are three stories or less, while independent living communities will often be as tall as zoned density and construction type will allow.

8.1.2 Land Cost

Independent living, assisted living and memory care usually will be developed in residentially-attractive areas near population centers, often paying a premium to be along arterials for adult child ease of access and for marketing reasons. Many CCRC developers are looking for walkable areas with proximity to neighborhood retail and services. Nursing care is typically developed in proximity to hospitals because its census tends to be filled by referrals rather than by drive-bys.

8.2 Building Costs

Building costs are driven by project type, project square footage, construction type, construction pricing, state licensing requirements, local zoning requirements, building code requirements, FFE and municipal fees.

8.2.1 Project Square Footage

Project square footage stems from many considerations including unit mix, unit size, unit features and common areas. Aspects of these decisions unique to seniors housing and care are outlined below.

8.2.1.a Unit Size

Average unit size is a function of both (1) unit mix (i.e., how many one-bedroom units to build) and (2) unit design (i.e., how many square feet in a one-bedroom unit).

Unit Mix

Since independent living is more of a lifestyle choice than need-driven, the projects tend to offer one- and two-bedroom units. Assisted living projects tend to feature studio and one-bedroom units with small kitchenettes. Nursing care offers many two-bed shared units to serve low-paying Medicaid residents; however, Medicare-reimbursed nursing care is shifting toward more private rooms. The unit mix of a property depends on how large it sizes each payor segment and partly on how richly it builds out the units within each care segment.

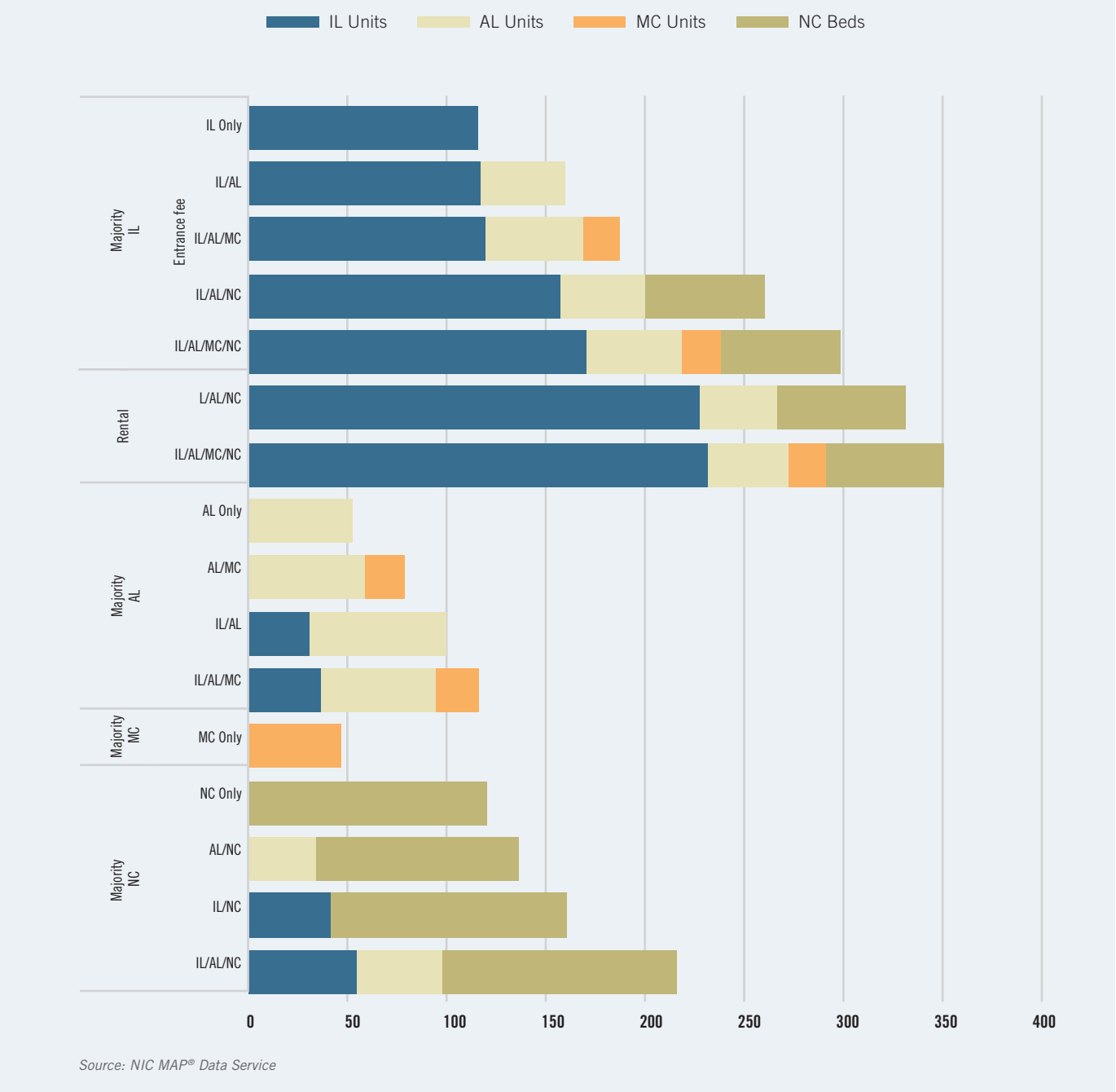
Exhibit 8.b illustrates typical project sizes for various configurations. For example, when a community with a majority of independent living units chooses to offer assisted living, it typically builds 40-to-50 assisted living units; when it offers memory care, it usually develops around 20 memory care units; and when it offers nursing care beds, it is typically in a 60-bed nursing center. Entrance fee communities usually offer more independent living units but keep the health care center (as the area with assisted living, memory care, and nursing care is often called) at roughly the same size as at its rental counterparts.[1]

When a majority assisted living community offers memory care, it is typically in a 20-unit memory care neighborhood; when it offers independent living, it is typically only 30 to 36 units of independent living.[1]

Exhibit 8.b

Median Unit Count by Property Type and Segment in the Top 99 Metropolitan Markets

As of 4Q13



Source: NIC MAP® Data Service

Exhibit 8.c shows the unit mixes among different care segments within properties. Independent living has the most diverse mix: 48 percent of the units in independent living properties are one-bedroom units, 29 percent are two-bedroom units and 15 percent are studios, with an occasional three-bedroom unit or cottage. By contrast, in a typical development, 60 percent of assisted living units and 79 percent of memory care units are studios.[1]

To attract higher-reimbursing Medicare and private-pay residents, many new nursing care developments have 30-50 percent of beds in private rooms. In addition, the culture change movement within nursing care has promoted a higher mix of private rooms for residents.

Exhibit 8.d shows the size of a unit has increased over time for assisted living and independent living properties (in the chart, a studio has one room, a 1-bedroom has two rooms: a living room and bedroom). Before 1985, a typical assisted living property consisted almost entirely of studios. Since 2000, however, newly built assisted living properties generally incorporate a smaller share of studios.

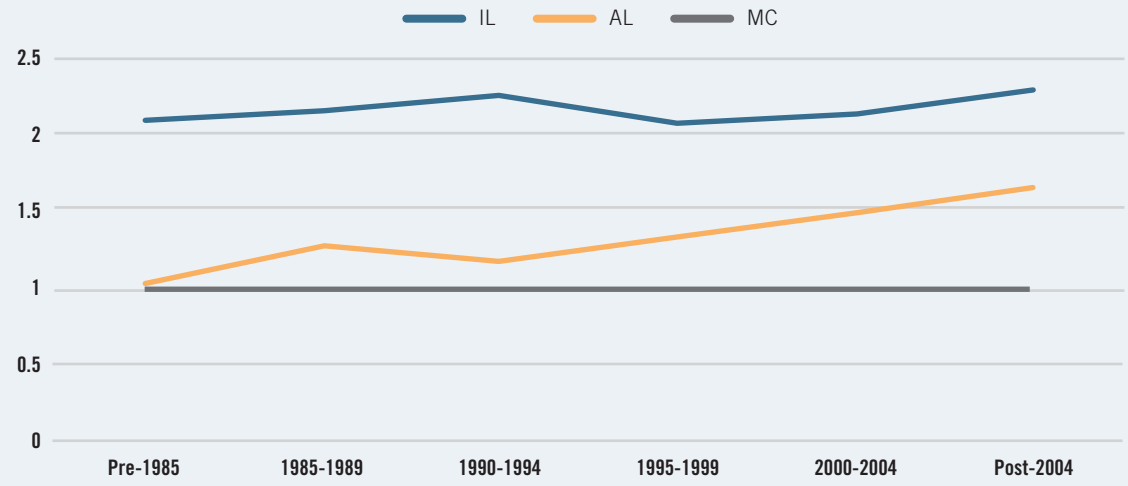
Exhibit 8.c
Average Number of Rooms and Room Unit Type Distribution by Care Segment
As of 4Q13

	# OF ROOMS:	1	2	3	4	
	Average # of Rooms	% Studios	% 1 BRs	% 2 BRs	% 3+ BRs	Total
Independent Living	2.3	15.0%	48.3%	29.0%	7.8%	100.0%
Assisted Living	1.4	59.8%	35.8%	4.4%	0.0%	100.0%
Memory Care	1.2	79.3%	16.8%	3.9%	0.0%	100.0%

Note: A 1 bedroom contains two rooms: a living room and a bedroom. For NC, unit type is not defined since all data is bed-based.

Source: NIC MAP® Data Service

Exhibit 8.d
Median Number of Rooms Per Unit by Care Segment and Property Year of Operating



Source: NIC® MAP Data Service

In independent living, unit bedroom count has been variable, but the trend has been toward mixing in more two- and three-bedroom units and a few studio units. For memory care, the typical property has consistently been developed primarily with studios throughout the years; however, some developers build larger rooms intended for two residents.

Compared to multifamily residential properties, seniors housing and care properties tend to have more studios and fewer two-bedroom units because a higher proportion of seniors live alone in their units than does the broader apartment-dwelling population. In addition, many seniors trade off the size of their units to achieve more affordable pricing, which also includes the cost of services.

8.2.1.a.ii Unit Design

For unit design, square feet per type of unit is the other basic factor driving unit size and is comparable to that of standard multifamily housing. Studios range from 250–500 square feet; one-bedroom units from 500–1,000 square feet; two-bedroom units from 900–2,000 square feet; and three-bedroom units/cottages are 1,500-plus square feet. Nursing care beds average 150–250 square feet per bed depending on the mix of companion vs. private rooms. (All figures here are rentable space not including common areas and circulation space.)

8.2.1.b Common Areas

Beyond revenue-generating apartment units, a key development decision is how much space (and cost) will go into non-revenue generating common areas and circulation spaces. At the lower end of common areas allocation is the value tier of independent living developments with few amenities. These properties may add less than 25 percent of additional square footage beyond their revenue-generating unit space for corridors, lobbies, stairwells and wall thickness. At the other end are high-end independent living properties competing as a lifestyle option. These properties may have 35 percent or more square footage beyond the apartment units for multiple dining options; space for programmed and resident-driven activities; and amenities such as theaters and fitness centers that may include locker rooms, cardiovascular and strength training equipment, group exercise rooms, spas, salons and multi-pool aquatic components.

At assisted living and memory care properties, a higher proportion of common area will be provided due to smaller average unit sizes and more space dedicated to care and services. Operationally, memory care also requires more common area because unit count within care segments ideally should not be too large (due to resident dynamics) and because daytime oversight of residents is more effective in common areas than in their rooms. Nursing care building design is affected heavily by regulatory requirements: nursing stations, corridor width, door width, storage requirements and space for toileting assistance, among others. Non-rentable areas totaling 40-55 percent are common in assisted living, memory care, and nursing care.

Compared to standard multifamily properties, seniors housing and care communities typically have proportionately more common area due to group dining areas, shorter hallway runs, operational and regulatory needs, more staff requiring their own space and room for programmed activities.

8.2.2 Construction Costs

Seniors housing construction costs are illustrated in Exhibit 8.e. Certain seniors housing requirements—such as central kitchens, more common areas and more staff space—drive building costs higher than for multifamily residential properties. In other ways, seniors housing—with less of a need for showcase kitchens and bathrooms—costs less to build than multifamily developments. However, high-end CCRCs can approach condominiums in their development costs.

Assisted living usually costs more than independent living due to stronger building code requirements in most states, shorter hallway runs and more common area.

8.2.3 Furniture, Fixtures and Equipment

Furniture, fixtures and equipment (FFE) includes furniture, wall coverings, carpet, and kitchen and laundry equipment. It may also include smaller items, such as flatware and linens.

8.2.4 Municipal Fees

Municipal fees encompass the costs of extending municipal infrastructure, development permits and, for nursing care, the costs of obtaining certificates of need (CONs). Such fees are specific to an individual project.

Exhibit 8.e
Construction Costs per Gross Square Foot
2013

	Mid-Level		High-Level		Raleigh, NC Mid-Level/City Index 79.7	
	Low	High	Low	High	Low	High
Independent Living	$115	$133	$140	$188	$92	$106
Cottages	$99	$113	$139	$159	$79	$90
Assisted Living	$138	$172	$198	$242	$110	$137
Skilled Nursing	$162	$191	$202	$251	$129	$153
Commons	$183	$232	$254	$329	$146	$185
Underground Parking	$67	$93	$105	$131	$54	$74

Notes/Definitions:

Component costs include full burden of general condition, insurance, tax, performance bond & fee, but do not include site costs.

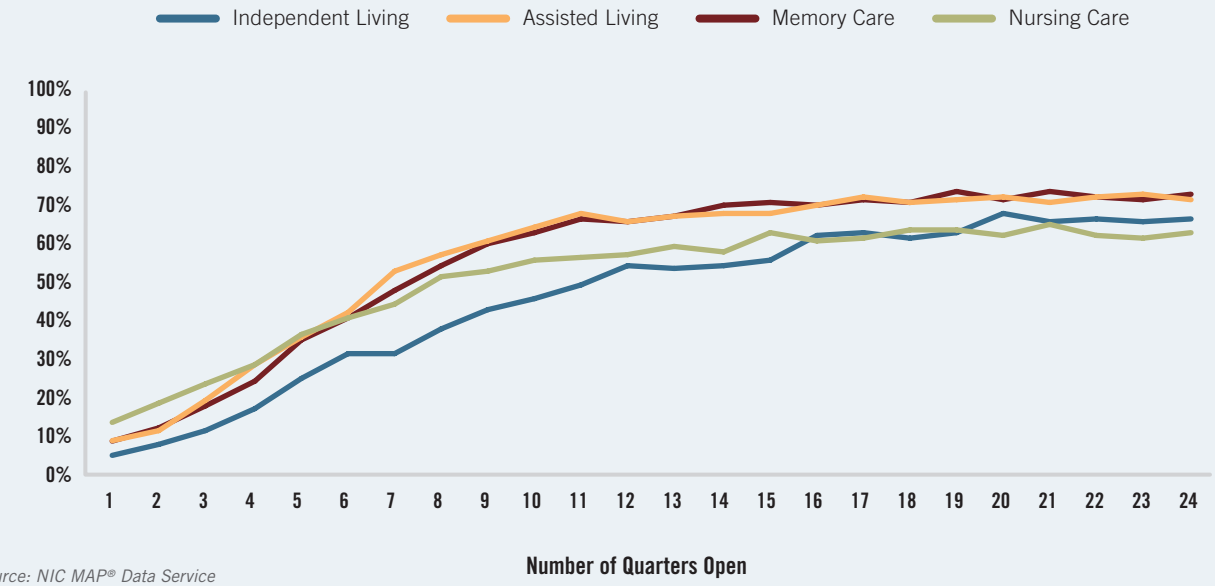
Costs based on a national average with city index of 100; the means index for a specific city should be used to adjust the data to that particular city. Raleigh, NC, for example, has an index of 79.7, which translates to a cost range of $92-$106 per SF for independent living. Chicago, IL has an index of 116.5, which translates to a cost range of $134-$155 per SF for independent living.

Mid-level projects: generally are of wood-framed construction with standard amenities and finishes, and typically target the more moderate income senior.

High-level projects: generally are of steel or concrete construction with high-end luxury amenities and finishes, and typically target the higher income senior.

Source: ASHA Special Issue Brief; The Weitz Company

Exhibit 8.f
Percentage of Care Segments with 90% Occupancy or Greater by Number of Quarters Open



Source: NIC MAP® Data Service

8.3 Professional Fees

Professional fees include those paid to architects, lawyers, engineers, interior designers, bankers, market research analysts and developers. As in other real estate development, the level of fees depends on project scope and market conditions. The required billable hours tend to amount to more than those for a similar multifamily development, while the billable rates may be higher due to specific expertise in this market niche. These are discussed more thoroughly in Appendix F.

8.4 Lease-up Reserves

Lease-up reserves cover operating losses and debt service. Both reserves are affected by the pace of lease-up. Fixed expenses prior to opening for independent living, assisted living and memory care properties generally include a general manager and/or sales staff hired to promote the property before it opens. This is generally three to nine months before opening for assisted living and memory care; and generally nine to 18 months before opening for independent living. After a property opens, fixed expenses include the typical multifamily costs, plus additional staffing for health care and hospitality services.

Accel at Hermann Park
Houston, TX

Atria on the Hudson
Ossining, NY

In this section

Section 9: Capital Sources

The purpose of this section is to provide an overview of debt and equity sources of capital for the seniors housing and care industry. Capital sources and terms vary by property type, transaction type (acquisition, refinancing or development) and financing type (debt, equity and sale-leaseback). The sections included discuss sources of debt capital, equity and health care real estate investment trusts (REITs).

9.1 Debt Capital

Traditional sources of debt capital include Fannie Mae, Freddie Mac, the U.S. Department of Housing and Urban Development (HUD)/Federal Housing Administration (FHA), commercial banks, commercial finance companies and tax-exempt bonds.

9.1.1 Fannie Mae and Freddie Mac

Serving the secondary mortgage market, Fannie Mae and Freddie Mac utilize similar underwriting standards and financing terms. They do not source transactions directly with owners; rather, they use a network of specially approved lenders who source the loans for them in accordance with the agencies' eligibility criteria. The select lenders also underwrite the loans, sell them to Fannie Mae and Freddie Mac, and then service them after closing. Both Fannie Mae and Freddie Mac finance properties that provide independent living, assisted living and memory care services. Neither agency finances stand-alone nursing care properties, but a small component of nursing care is acceptable as a continuum of care in a large combined property. The future of Fannie Mae and Freddie Mac may be uncertain as both agencies have been under conservatorship by the U.S. Treasury since September 2008. Nevertheless, their continuous presence in the market as a relatively agile source of long-term debt and their stature as the largest holders of seniors housing mortgage debt in the country give them a critical role in the industry.

Mortgage rates from Fannie Mae and Freddie Mac remain attractive. Fixed-rate terms are the most popular with investors who have long-term horizons or for those who seek to diversify the cost of capital in their portfolios. Variable-rate options are also available and provide more flexibility for early repayment than fixed-rate financing over the term of the loan. Rates in early 2014 for 10-year loan maturities on assisted living and memory care properties ranged from 5.5 percent to 5.6 percent, while independent living properties had slightly lower rates.

Fannie Mae's and Freddie Mac's nonrecourse financing terms remain competitive with loan-to-value (LTV) requirements of up to 75 percent for market-rate, conventional financing (up to 80 percent for tax-exempt financing) and minimum debt service coverage ratios from 1.30x for independent living properties to 1.40x for assisted living properties and 1.45x for memory care properties on stabilized projects in strong major metropolitan markets. If eligible, properties with a nursing care component may require higher debt service coverage. For cash-out financing, maximum LTV ratios are typically lower by at least five percentage points and/or debt service coverage ratios may be higher by five percentage points. Since rates have remained relatively low for some time, many loans continue to be constrained by their appraised value.

The 2013 Top Five Fannie Mae and Freddie Mac seniors housing lenders by volume are presented below, in alphabetical order.

Exhibit 9.a
Top Five 2013 Fannie Mae & Freddie Mac Seniors Housing Lenders & Lending Territory

Berkadia Commercial Mortgage *	Nationwide
CBRE Multifamily Capital *	Nationwide
Greystone Financial Group	Nationwide
KeyBank Real Estate Capital *	Nationwide
Oak Grove Capital	Nationwide
PNC Real Estate	Nationwide
Red Mortgage Capital	Nationwide

*Denotes Top 5 for Fannie Mae and Freddie Mac.

Source: Fannie Mae and Freddie Mac

A complete list of Fannie Mae- and Freddie Mac-approved seniors housing lenders is located on their respective websites:

https://www.efanniemae.com/mf/refmaterials/lenderinfo/seniorhousinglen.jsp
http://www.freddiemac.com/multifamily/sellerservicers/seniors.html

9.1.2 HUD

HUD finances assisted living, memory care and nursing care properties, and properties with no more than 25 percent of the total units dedicated to independent living. HUD continues to be a consistent source of long-term, nonrecourse financing, particularly for nursing care properties, which are not eligible for Fannie Mae or Freddie Mac financing. Like Fannie Mae and Freddie Mac, HUD is a secondary market maker, financing properties that have been originated and underwritten by approved lenders who will service the loans when they are closed.

HUD's production volume accelerated greatly in 2009 responding to the contraction of credit markets and the rollout of HUD's LEAN Program, which streamlined the financing process for health care assets. Unfortunately, the boost in HUD's pipelines forced borrowers to wait as long as 12 months from underwriting to closing. And, although the processing problem was largely resolved in 2012, Congressional discord on fiscal and budgetary matters early in 2013 again slowed HUD's processing time to a crawl. Borrowers again were in the unenviable position of having to wait up to 12 months for FHA commitments. Despite a long delay, borrowers waited because of HUD's low rates.

During the past several years, HUD's fully amortizing rates have compared very favorably against other long-term debt options. For example, late in 2012 for-profit borrowers could fix an 80 percent LTV, 35-year HUD mortgage below three percent plus 65 basis points mortgage insurance. While in early 2014 rates are 150 basis points higher, they are still at historically low levels. From time to time, HUD will mitigate concerns over the sustainability of small assets, older assets that have not been upgraded or rehabilitated, or property locations in weaker markets by requiring a reduction in the maximum leverage allowed. For many owners, HUD financing became the only viable option for new construction financing from 2009 until 2011, the year when commercial banks stabilized and began to open up their balance sheets. Like Fannie Mae and Freddie Mac, HUD is a key provider of debt to the seniors housing and care industry.

Exhibit 9.b
HUD Portfolio

Current Active Loans as of 12/31/2013 ($Millions)

	Number of Loans	Unpaid Principal Balance
Assisted Living	860	$6,051
Board and Care	48	$194
Nursing Properties	1,992	$14,808
Total	**2,900**	**$21,053**

Source: HUD

Exhibit 9.c
Top Ten FY2013 HUD Healthcare Lenders and Lending Territory

Beech Street	Nationwide
Berkadia Commercial Mortgage	Nationwide
Cambridge RC	Nationwide
Capital Funding	Nationwide
Greystone	Nationwide
Housing & Healthcare Finance	Nationwide
Lancaster Pollard	Nationwide
Love Funding	Nationwide
Red Mortgage Capital	Nationwide
Wells Fargo	Nationwide

Source: HUD

9.1.3 Commercial Banks

Bank financing for seniors housing and care covers a wide range of institutions and financing options. Commercial banks typically lend for new construction, acquisitions, lines of credit, corporate credit lines and shorter-term property financing, (i.e., bridge or

mini-perm loans). Historically, commercial banks have been the largest source of new construction financing to the seniors housing and care industry. However, during the nationwide financial crisis from 2008-2011, most banks were not lending on new construction projects due to a lack of capital for these projects. In fact, even acquisition and refinance debt for stabilized projects was minimal through the early part of 2011 as commercial banks reduced their exposure to all asset classes, including seniors housing and care. Letters of credit (LOCs) for tax-exempt construction financing became less available and more expensive (where they were available) with terms requiring more conservative (lower) LTV ratios.

As the end of the first quarter of 2012 approached, many banks were lending again to grow commercial loan portfolios that had been reduced in the post-2008 period. As of the end of 2013, new construction projects were growing in number in response to pent-up demand for new product in many markets. Credit standards (going-in LTVs and property occupancy) have generally loosened for acquisition/refinance transactions because the competition among lenders for good opportunities has increased. Other lending terms remain the same as in the post-2008 era, which reflects lenders' cautiousness about taking on undue amounts of portfolio risk. Sponsor/operator quality (financial strength and experience), debt service coverage (annual net operating income divided by annual principal and interest payments) and debt yield ratios have not decreased significantly but can be loosened on a case-by-case basis.

Exhibit 9.d
Select Commercial Banks & Head Office

BB&T	Winston-Salem, NC
Bank of the West	San Francisco, CA
CapitalSource	Los Angeles, CA
First Niagara	Buffalo, NY
KeyBank	Cleveland, OH
M&T Bank	Buffalo, NY
PNC	Pittsburgh, PA
Regions Bank	Birmingham, AL
Synovus Bank	Columbus, GA
Wells Fargo	San Francisco, CA

9.1.4 Commercial Finance Companies

Commercial finance companies, like the aforementioned commercial banks, saw a material change to their cost of and access to capital after the credit market disruptions in the second half of 2008. This was very dynamic and most apparent with real estate debt products. With these changes to their funding mechanisms, commercial finance companies' real estate products were used more selectively throughout 2009 until capital markets and funding mechanisms began to show improvement in the latter part of 2009 and into 2010. However, throughout 2009, the underlying funding mechanisms for asset-based lending products secured by accounts receivable were less disjointed and commercial finance companies continued to remain active in this product area.

Exhibit 9.e
Select Finance Companies & Head Office

Contemporary Healthcare	Shrewsbury, NJ
GE Healthcare	Bethesda, MD
MidCap Financial	Bethesda, MD

9.1.5 Life Companies and CMBS

Some life insurance companies were consistently lending to the seniors housing and care industry until 2008 when they pulled back from the sector, similar to many other finance companies. Since 2011, life companies have re-emerged as active providers of debt to experienced seniors housing owner-operators, competing strongly with the agencies, commercial banks, and finance companies for larger, high quality financing opportunities. The relatively strong performance of the seniors housing and care sector from 2008-2011 has encouraged some new entrant life companies to consider debt opportunities in the sector primarily for majority independent living assets with few or no licensed beds. Not to be overlooked are the commercial mortgage–backed securities (CMBS) lenders. While CMBS has historically been a source of debt financing for nursing care assets, recent financing activity suggests expanded interest in the seniors housing sector. In the first quarter of 2014, no less than $150 million of CMBS debt was issued for majority independent living assets. As the long-term performance of seniors housing and care becomes better understood, lenders and investors will continue to be attracted to the sector.

9.1.5 Tax-Exempt Financing (or Bonds)

In 2013, senior living organizations borrowed $2.8 billion in tax-exempt fixed-rated debt spread out over roughly 100 issues. Just under half of that amount was issued for new money purposes, primarily for renovations and expansions, with few issues for major repositioning or new campus projects. This number is down from the $3.7 billion issued in 2012 (112 issues), due to a spike in borrowing rates in the second half of the year that limited fixed-rate refinancing volume in 2013.

So far in 2014, a steady decline in long-term tax-exempt interest rates has reignited fixed-rate volume. Four new campus financings closed in the first half of the year, and two to three more are expected before year-end 2014. Currently, long-term interest rates for refinancing issues range from 4 to 6 percent depending on credit. Borrowing costs for most credit categories are again at or below pre-crisis levels (with many hitting all-time lows in 2012). Long-term rates for new campus projects hover around 7.50 percent and remain above historical averages.

As has been the trend since 2009, borrowing through bank direct purchase lending increased in 2013 to a Ziegler-estimated $1.8 billion. Regional banks in particular are active lenders. Term lengths have extended from an average of three years post-crisis to 10 years in 2014, with some out longer. Deals can be structured on a variable-rate basis, variable with a swap to fixed, or on a purely fixed-rate basis. Bank credit fees have also come down in recent years and now are typically just 1 to 2 percent. Bank direct purchase lending continues to be active in 2014.

A small number of senior living organizations experienced financial challenges in 2013, primarily legacies of the housing bust and occupancy struggles stemming from the recession. Overall, the larger trend is of improving credit. Fitch Ratings assigned a stable outlook to the sector in the fall of 2012. Standard & Poor's assigned a stable outlook to the sector in 2013. Overall in 2013, bond ratings' upgrades surpassed downgrades by a ratio of 5:3, which is the best year since 1998. Ratings upgrades continue to outpace downgrades in 2014.

Despite the credit improvement in the sector, financing covenants remain somewhat more restrictive in 2014 than they were prior to the crisis. In addition, new campus and off-balance sheet major repositioning financings require additional sponsor monetary support, in the form of either contingent or trustee-held liquidity support agreements, should projects need more capital prior to stabilization.

9.2 Equity

Typical equity sources in seniors housing and care include both private and public equity. Traditional sources of equity capital have included high-net-worth individuals, pension funds and institutional firms.

9.2.1 Private Equity

Historically, equity for seniors housing and care property investments has been raised through networks of high-net-worth individuals. This form has been used by many smaller operating and development companies in the sector and remains a common practice. More organized networks can take on the form of tenants in common (TIC) investments or other limited liability company (LLC) structures. The late 1990s saw the entry of more institutional forms of private equity into the industry. Today, seniors housing and care properties are a growing investment target for pension funds, insurance companies, universities and endowments. These firms invest in the industry through private equity firms via separate accounts, commingled funds or dedicated seniors housing funds. A representative list of private equity firms appears in the table below.

Exhibit 9.f
Select Private Equity Firms with Seniors Housing and Care Assets

Firm	Headquarters
AEW Capital Management	Boston, MA
Artemis Capital Partners	Boston, MA
Blackstone Group	New York, NY
Blue Moon Capital Parners LLC	Aliso Viejo, CA
Capital Health Group	Media, PA
Capitol Seniors Housing	Washington, D.C.
Fillmore Capital Partners	San Francisco, CA
Focus Healthcare Partners	Chicago, IL
Formation Capital	Alpharetta, GA
Fortress Investment Group	New York, NY
Kayne Anderson Capital Advisors	Los Angeles, CA
KKR	New York, NY
Harrison Street Real Estate Capital	Chicago, IL
Heitman	Chicago, IL
JER Partners	McLean, VA
Lowe Enterprises	Los Angeles, CA
Och Ziff	New York, NY
Prudential Real Estate Investors	Madison, NJ
ROC Seniors Housing Fund	Salt Lake City, UT
Redwood Capital	New York, NY
Walton Street Capital	Chicago, IL
Westport Capital Partners	Wilton, CT
Wexford Equities	Greenwich, CT
Wolff Real Estate	Scottsdale, AZ

9.2.2 Public Operating Companies

Public operating companies raise equity and debt through the public markets and are an important source of capital for the industry. The industry has seen continued consolidation of local and regional operators driven by the major public operators. In February 2014, the two largest public operators, Brookdale Senior Living and Emeritus Corporation, announced a merger to

form the largest seniors housing owner-operator in the United States. The merger is anticipated to close in the third quarter of 2014 and the Brookdale name will be retained. The following tables show the public operating companies as of December 31, 2013.

Exhibit 9.g
Seniors Housing Public Operating Companies
As of 12/31/2013

Company	Ticker	Market Capitalization ($Millions)
Brookdale Senior Living (1)	BKD	$3,378
Emeritus Corporation (1)	ESC	$1,033
Capital Senior Living	CSU	$691
Five Star Quality Care	FVE	$265

(1) Brookdale announced an agreement to merge with Emeritus on 2/20/2014. It is expected to close during the third quarter of 2014.

Source: Bloomberg

Exhibit 9.h
Nursing Care Public Operating Companies
As of 12/31/2013

Company	Ticker	Market Capitalization ($Millions)
Kindred Healthcare	KND	$1,070
Ensign Group	ENSG	$974
National HealthCare	NHC	$758
Skilled Healthcare Group	SKH	$189
Diversicare Healthcare Services	DVCR	$28

Source: Bloomberg

9.3 REITs

Public and private health care REITs have been one of the largest sources of financing for the seniors housing and care industry over the past several years. The following table shows the size of the public health care REITs with seniors housing and care assets as of December 31, 2013. In addition to the companies listed, in April 2014, American Realty Capital Healthcare Trust (HCT) became a publicly traded health care REIT, which has subsequently been agreed to be purchased by Ventas for $2.6 billion in stock and cash.

Typical health care REIT financing for seniors housing—not inclusive of nursing care—at this writing in mid-2014 remains a 10- to 15-year triple–net lease with an initial cash yield in the 6 to 9 percent range with fixed annual escalators or escalators tied to the Consumer Price Index (CPI), possibly with floors or caps,

Exhibit 9.i
Public Health Care REITs with Seniors Housing and Care Assets
As of 12/31/2013

Company	Ticker	Market Capitalization ($Millions)
Ventas	VTR	$16,845
HCP, Inc.	HCP	$16,572
Health Care REIT	HCN	$15,464
Senior Housing Property Trust	SNH	$4,183
Omega Healthcare Investors	OHI	$3,662
Healthcare Trust of America	HTA	$2,331
Healthcare Realty Trust	HR	$2,043
National Health Investors	NHI	$1,854
LTC Properties	LTC	$1,230
Sabra Health Care REIT	SBRA	$990
Aviv REIT, Inc.	AVIV	$891
Universal Health Realty	UHT	$509

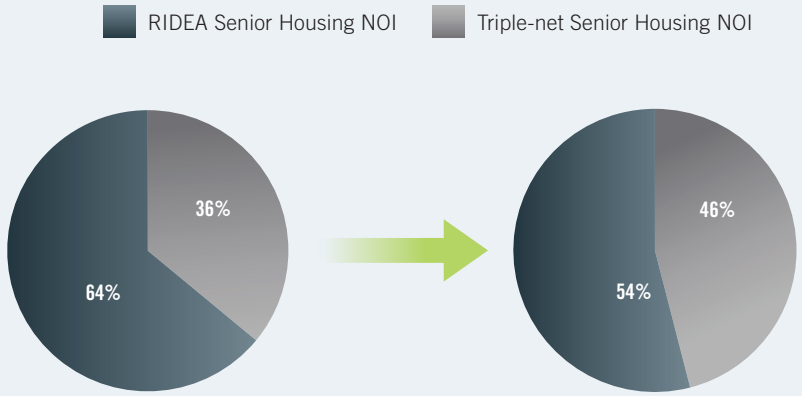
Source: Bloomberg

and earnings before interest, taxes, depreciation, amortization and rent (EBITDAR)—after management fee—to rent coverage requirement of 1.0x to 1.3x.

Health care REITs have enjoyed strong access to capital over the past several years given the market's interest in defensive asset class investments. Health care REITs entered 2014 with relatively low debt levels and large untapped credit lines. Although some health care REITs fund limited seniors housing construction, the majority of health care REIT investments are acquisitions of stabilized properties, a trend that is likely to continue throughout 2014 and into the foreseeable future. In addition, given the age and condition of properties within their portfolios, REITs have continually invested dollars in the renovation of existing properties.

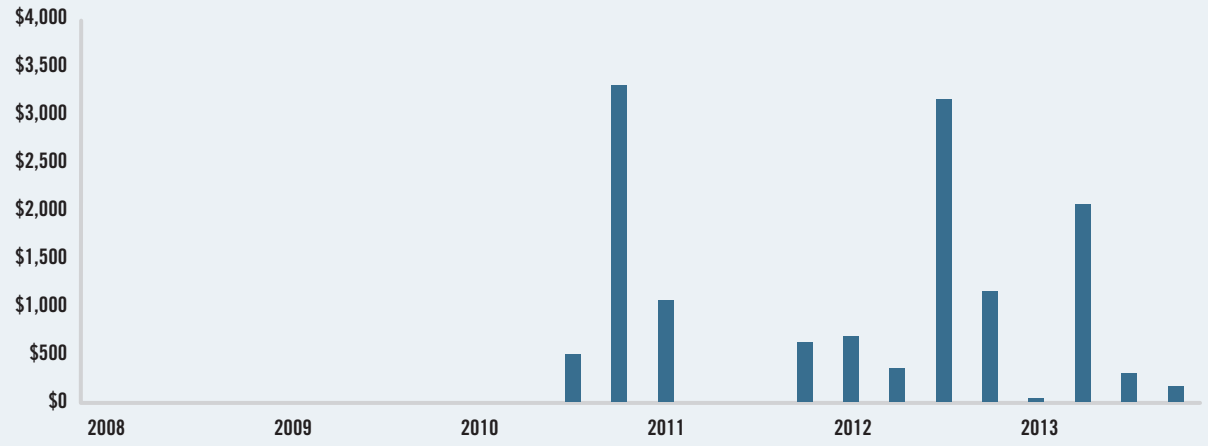
The RIDEA structure, named from the REIT Investment Diversification and Empowerment ACT of 2007, which had important changes effective February 1, 2009, allows REITs to lease seniors housing properties to taxable REIT subsidiaries (TRSs), provided they engage a third-party manager to operate the business. This allows health care REITs to capture the entire operating profit or loss from a seniors housing or health care business after a management fee, as opposed to the typical fixed rent payment from a triple-net lease. Health care REITs, particularly the three largest diversified health care REITs, have increasingly utilized this structure over the past several years, enabling them to participate in the strong performance seen in the sector. As of December 31, 2013, approximately 46 percent of Health Care REIT, HCN, and Ventas's collective seniors

Exhibit 9.j
"Big 3" REIT (HCN, HCP, VTR) Senior Housing NOI



Source: Green Street Advisors

Exhibit 9.k
"Big 3" REIT (HCN, HCP, VTR) RIDEA ($Millions)
1Q08 - 4Q13



Source: Green Street Advisors

housing net operating income (NOI) came from properties in a RIDEA structure.[24] As of December 31, 2013, REITs had not utilized the RIDEA structure for nursing care deals.

Public, non-traded REITs have played an increasing role in providing capital within the industry as well. These REITs raise money from individual investors, but their shares do not trade freely on a public exchange. The non-traded REIT industry continues to grow and now raises roughly $10 billion per year for real estate investments. A list of non-traded REITs with a significant focus on seniors housing properties is presented in Exhibit 9.I.

9.4 Investment Strategies

There are numerous ways to integrate seniors housing into an investment portfolio in both the public and private markets. These strategies are available to incorporate with certain varieties depending on the investor's return objectives, overall risk tolerance and portfolio constraints.

Exhibit 9.I
Non-traded REITs with a Significant Seniors Housing Property Focus

REIT	Headquarters
CNL Lifestyle Trust	Orlando, FL
Griffen American Healthcare REIT II	Irvine, CA
American Realty Capital Healthcare Trust	Boston, MA
NorthStar Healthcare Income	Greenwood Village, CO
Sentio Healthcare Properties	Orlando, FL

Exhibit 9.m
Implementation Strategies

	Equity	Debt
Public	**Public Equity Investments** • Public Operating Company • Public REIT	**Public Debt Investments** • Public REIT Senior Debt • CMBS Debt • Public High Yield Debt (Nursing Care Only) • Preferred Investment — REITs
Private	**Private Equity Investments** • Private Operating Company • Private REIT • Joint Venture with Operators or REITs • Direct Ownership in Properties Leased to or Managed by Operators	**Private Debt Investments** • Secured and Unsecured Credit Facility Participation • First Mortgage Loans Secured by Seniors Housing Properties • Mezzanine Debt/Second Mortgage

Belmont Village
Thousand Oaks, CA

In this section

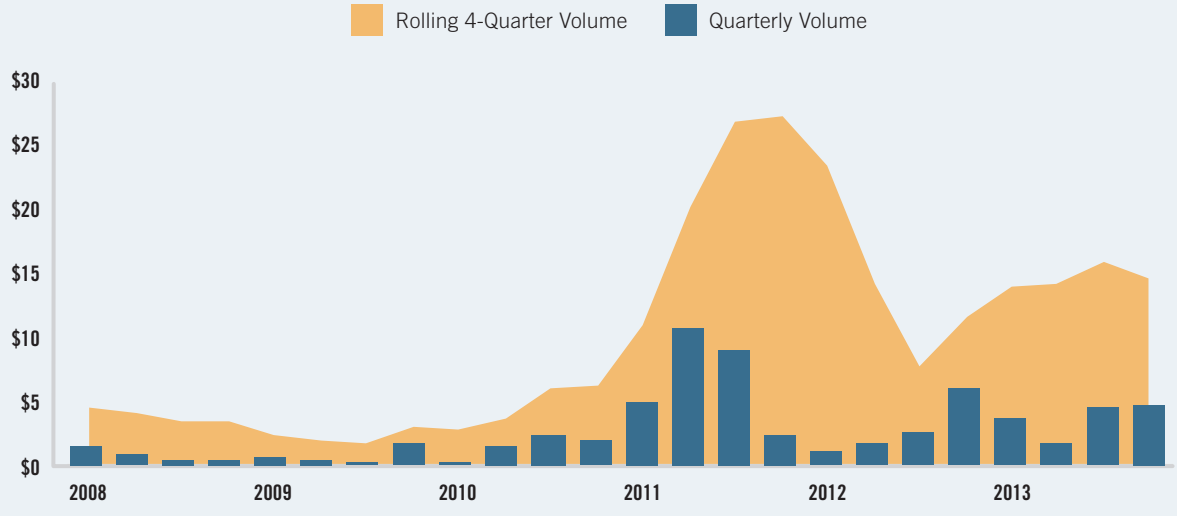
Section 10: Valuations, Returns and Loan Performance

This section discusses the valuation metrics commonly used in the seniors housing and care industry and provides the returns for seniors housing and care compared to that of other real estate asset classes.

10.1 Asset Valuations

The total market capitalization of the investment-grade seniors housing and care property market in the U.S., which comprises approximately 22,700 investment-grade seniors housing and care properties containing 2.9 million units, is estimated to be $330 billion. During 2013, transaction volume was plentiful. Total volume for 2013 came to $14.7 billion, which was the second highest volume in three years; the largest annual volume occurred in 2011 when more than $27 billion worth of deals closed due in part to several large real estate investment trust (REIT) transactions. The volume in 2011 partly reflected the low cost of capital available to REITs, which provided them a competitive advantage. However, more recently, the smaller listed REITs have become more active in 2013.[1]

Exhibit 10.a
Seniors Housing & Care Transaction Volume ($Billions)
1Q08 - 4Q13

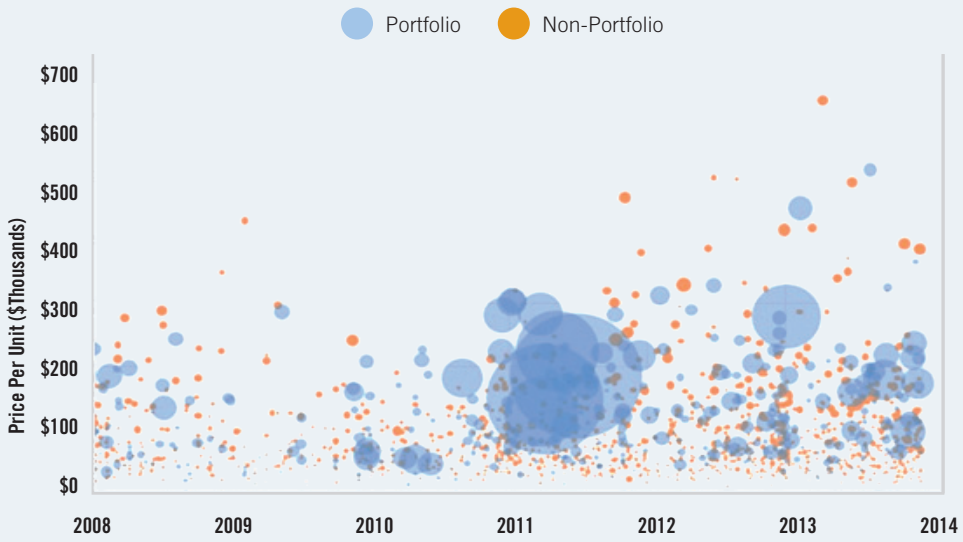


Source: NIC MAP® Data Service

Exhibit 10.b

Seniors Housing & Care Transaction Summary

01/2008 - 12/2013



Note: Bubble size proportional to price of the deal.

Source: NIC MAP® Data Service

10.1.1 Average Price per Unit

The chart in Exhibit 10.c shows, across the closed sales transactions, the distribution of price per unit by property type in 2013.[8]

Exhibit 10.c

Price Per Unit by Property Type

2013

	Independent Living	Assisted Living	Nursing Care (per bed)
Lower Quartile	$89,607	$67,371	$36,842
Median	$132,090	$99,601	$62,500
Average	$143,095	$125,266	$71,167
Upper Quartile	$185,808	$158,797	$103,333

Source: NIC MAP® Data Service

10.1.2 Capitalization Rate

Exhibit 10.d shows capitalization (cap) rates by property type for the 2008–2013 period.[9]

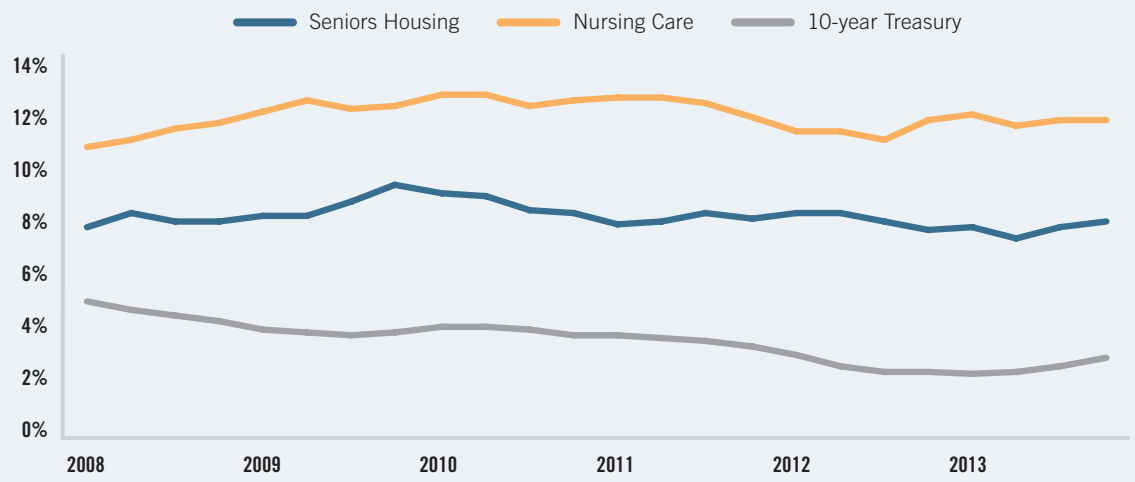
As Exhibit 10.d shows, cap rates for nursing care properties are generally higher than those for other seniors housing and care property types. Nursing care properties, which typically receive 50 percent or more of their revenue from Medicaid and perhaps another 25 percent or more from Medicare, have a greater amount of government reimbursement, which is seen as slower growing and more at risk from federal government budgetary pressures than is private revenue. Nursing care properties also provide the highest degree of services and tend to be older properties, some dating from the early days of Medicare/Medicaid in the mid-1960s. However, along with the health care industry in general, nursing care is going through a transformation period and there has been an increase in replacement properties in order to capitalize on the changing environment. Many also may be in less desirable locations from a marketing perspective because a high degree of government regulation has made it difficult to relocate properties even as neighborhood conditions have changed.

Moving down the acuity level scale from nursing care to assisted living and to independent living, the amount of regulation declines, while the revenue attributable to real estate rather than services increases, which tends to boost per-unit pricing and reduce cap rates, all else being equal.

10.1.3 Initial Lease Yields

A third measure of value is the initial cash yield on a triple-net

Exhibit 10.d
Rolling 4-quarter Capitalization Rates/Yield
1Q08 - 4Q13



Source: NIC MAP® Data Service

REIT lease. Most health care REITs are publicly traded and disclose investment activity on a quarterly basis, including initial lease yield. The disclosure also includes the lease payment coverage ratios (net operating income [NOI] divided by lease payment). Cap rates can be derived by multiplying the initial lease yield by the lease payment coverage ratio. REIT investment yield is a contractual amount and therefore is more reliable than quoted cap rates. Lease coverage is almost always quoted on a trailing 12-month basis with a one-quarter lag to the prior quarter's reported result. Investors may also need to adjust reported lease coverage for management fees, as some REITs report coverage ratios before management fees and some after management fees.

10.1.4 Valuations Among Seniors Housing Sectors

When comparing valuation among the different seniors housing sectors, the use of cap rates and price per unit (PPU) are common measures. Development cap rates have historically been 250–500 basis points higher than those of existing properties, although recently, those spreads have narrowed.

Exhibit 10.e displays price per unit and cap rates for majority independent living, assisted living and nursing care properties. These metrics are on a rolling four-quarter basis and both measures—cap rates and price per unit—are as of the fourth quarter of 2013. It should be noted that there is wide disparity in cap rates among properties, however; and preferred properties in preferred locations often command much lower cap rates than those seen in the table below, while those properties and locations less preferred will have higher cap rates.

Exhibit 10.e
Transaction Valuation by Property Type
2013

	Price Per Unit	Cap Rate
Independent Living	$143,095	7.0%
Assisted Living	$125,266	8.3%
Nursing Care	$71,167	11.5%

Source: NIC MAP® Data Service

10.2 Comparative Performance

This section examines the comparative performance of seniors housing and care and other real estate property types. We use not only occupancy and rent growth performance, but also National Council of Real Estate Investment Fiduciaries (NCREIF) returns and an index of publicly traded health care REITs.

10.2.1 Occupancy and Rent Growth

Seniors housing has proven to be a more stable asset class, in terms of operating fundamentals, than other traditional forms of commercial real estate, especially regarding asking rent growth. Seniors housing is the only recognized real estate class that did not experience declining asking rents during the recent economic recession. Asking rent growth for seniors housing reached a cyclical low of 1.1 percent in the fourth quarter of 2010, which was well above the cyclical lows of the core commercial real estate types of apartments and office, of -2.3 percent and -4.8 percent, respectively. As of the fourth quarter of 2013, asking rent growth in seniors housing properties was slightly slower than that of apartments, although seniors housing has shown more stability during the current market cycle.[1,18]

Seniors housing has performed in line with core commercial real estate in terms of occupancy during the current market cycle. Seniors housing occupancy declined 470 basis points from its cyclical high in 2006 to its cyclical low in 2010, which is comparable to the declines that were seen in office and retail. The apartment sector performed the best among the core commercial real estate property types, with vacancy rates declining only 350 basis points from its cyclical high to its cyclical low. The apartment sector has also fully recovered to its prior peak occupancy levels of 95 percent (5 percent vacancy). Seniors housing occupancy has risen 280 basis points through the fourth quarter of 2013 and remains 190 basis points below its prior peak. However, since establishing its cyclical low in the first quarter of 2010, seniors housing occupancy has outpaced the recoveries of office and retail.[1,18]

10.2.2 NCREIF Returns

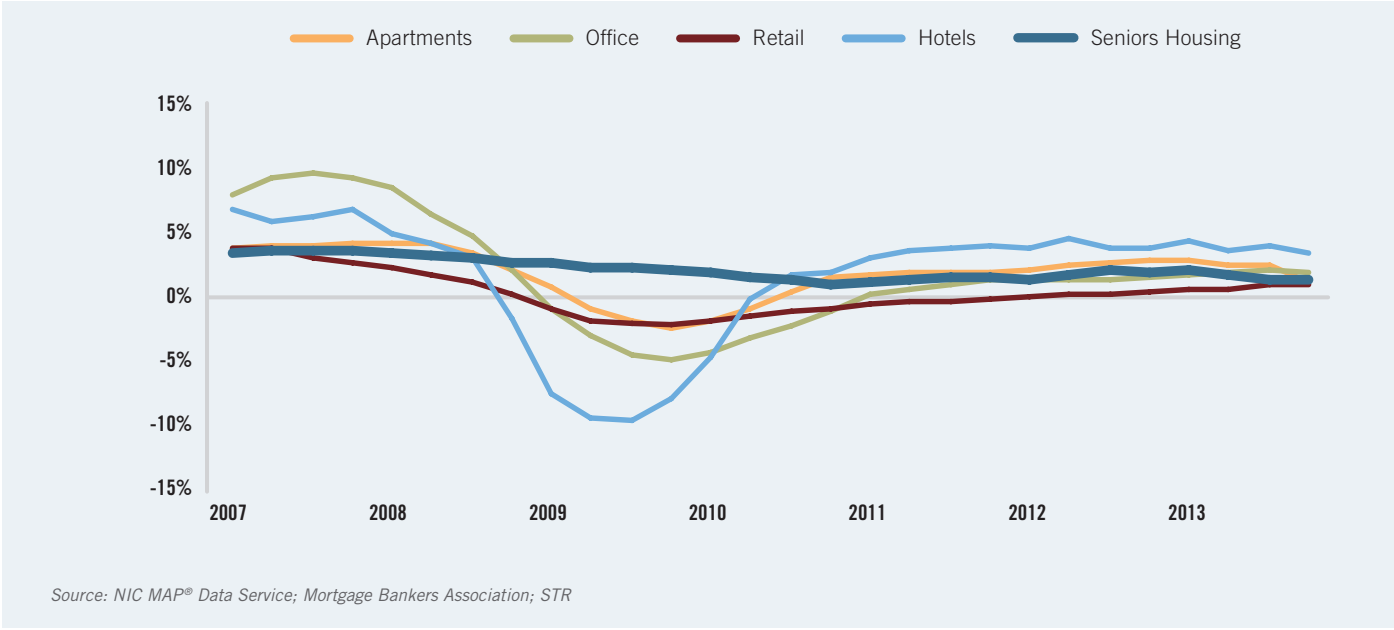
The NCREIF Property Index (NPI) is a leading U.S. quarterly time series composite total rate of return measure of investment performance of a very large pool of individual commercial real estate properties acquired in the private market for investment purposes only. All properties in the NPI have been acquired, at least in part, on behalf of tax-exempt institutional investors—the great majority being pension funds. As such, all properties are held in a fiduciary environment. As of the fourth quarter of 2013, the NPI comprised 7,029 properties with a combined market value of $353.9 billion.[10]

The nominal returns, which are completely unlevered, on the seniors housing properties within NCREIF's database (but which are not included in the NPI) have outperformed during the last 10 years the nominal performance return measurements for the broad NPI as well as for the other individual NPI indices as shown in Exhibits 10.h and 10.i. As of the fourth quarter of 2013, the seniors housing sector had generated an annualized return of 14.6 percent since the fourth quarter of 2003. This compares to an annualized return of 8.4 percent for the apartment index and

Exhibit 10.f

Commercial Real Estate Year-over-Year Asking Rent Growth Trends

1Q07 - 4Q13



Source: NIC MAP® Data Service; Mortgage Bankers Association; STR

8.6 percent for the entire NPI. This outperformance stems from greater gains in both the appreciation component (6.7 percent for seniors housing vs. 2.9 percent for apartments and 2.4 percent for the total index, respectively) and the income component (7.5 percent vs. 5.4 percent and 6.2 percent, respectively). It is important to note that NCREIF requires that properties included in the NPI, as well as seniors housing properties, be valued at least quarterly, either internally or externally, using standard commercial real estate appraisal methodology. Each property must be independently appraised a minimum of once every three years.[10]

More recently, during the fourth quarter of 2013, the seniors housing properties within NCREIF's database registered a positive 4.9 percent total return, which is above the positive returns of 2.5 percent for the broad NPI, and of 2.5 percent for apartments. This total return for seniors housing consisted of a 1.6 percent income return (better than the NPI income return of 1.3 percent) and a 3.3 percent capital return (again, better than the NPI's capital return of 1.2 percent). For the 12 months ending December 2013, the total return index for seniors housing was 15.5 percent, more than the NPI's return of 11 percent and the apartment sector's return of 10.4 percent.[10]

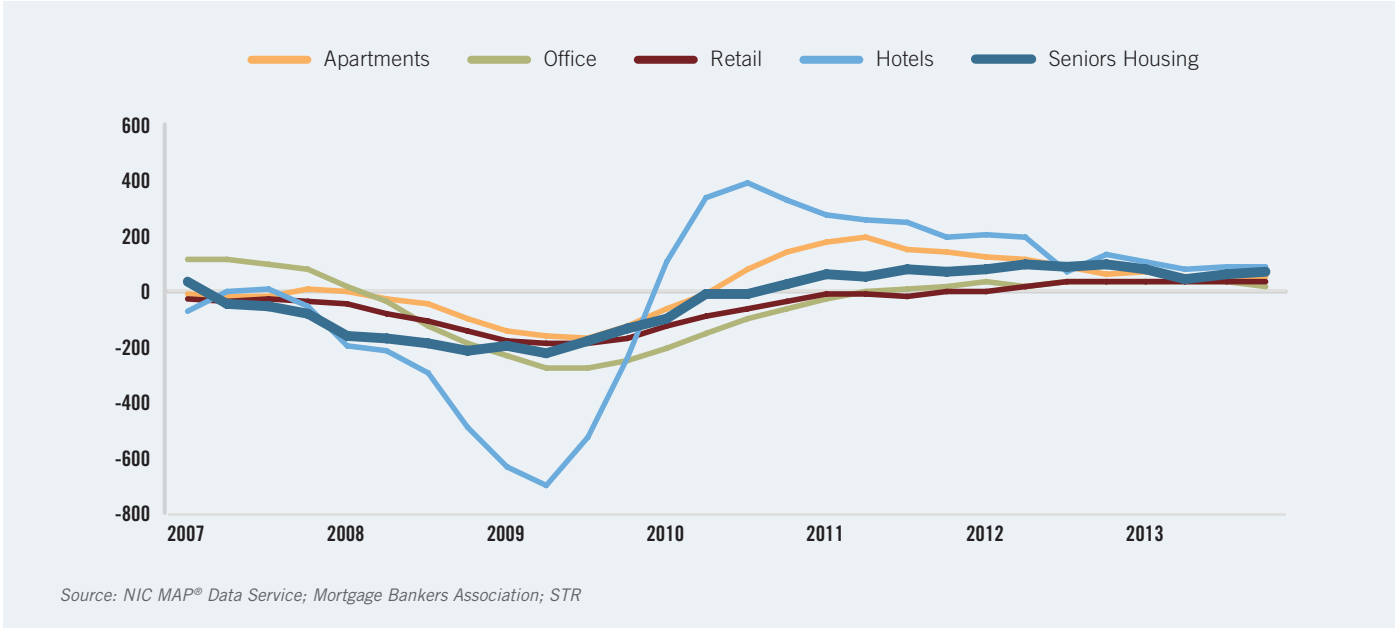
In addition to outperforming apartment and NPI returns, returns for seniors housing exhibited more stability during the latest economic recession. Seniors housing had a total return peak-to-trough loss of 7.9 percent versus 23.9 percent for the NPI and 24.7 percent for apartments.[10]

It should be noted that the seniors housing return data described above is based on a limited group of properties. As of the fourth quarter of 2013, eleven managers reported data on 70 stabilized seniors housing properties to NCREIF. The value of these assets totaled $2.0 billion.[10] Relative to the universe of seniors housing properties that exist in the U.S., this is a fairly small but representative sample of institutional private equity's investment to date in the sector. As of the fourth quarter of 2013, the National Investment Center for Seniors Housing & Care (NIC) tracks over 6,000 majority assisted living and majority independent living properties in the nation's 99 largest metropolitan markets.[1] While the sample size for the seniors housing returns is limited, it is similar to the initial sample size for the NPI apartment returns when that sub-index debuted in the 1980s and it does represent current institutional investment in the sector.

Exhibit 10.g

Commercial Real Estate Year-over-Year Occupancy Trends (bps)

1Q07 - 4Q13



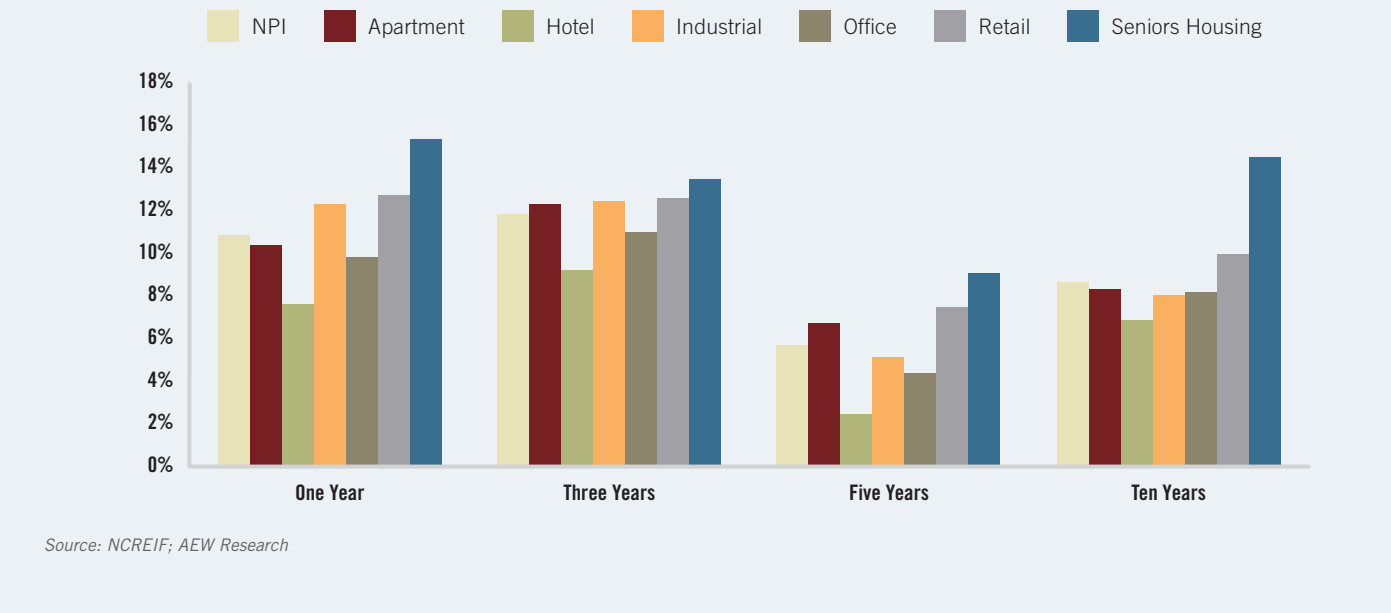
Source: NIC MAP® Data Service; Mortgage Bankers Association; STR

Exhibit 10.h
NCREIF Annualized Total Returns by Select Property Types
Periods Ending 12/31/2013

	NPI	Apartments	Hotel	Industrial	Office	Retail	Seniors Housing
One Year	10.98%	10.42%	7.69%	12.32%	9.86%	12.86%	15.51%
Three Years	11.92%	12.35%	9.23%	12.53%	11.02%	12.74%	13.60%
Five Years	5.69%	6.70%	2.48%	5.06%	4.35%	7.52%	9.14%
Ten Years	8.64%	8.40%	6.96%	8.14%	8.22%	10.09%	14.59%

Source: NCREIF

Exhibit 10.i
NCREIF Annualized Total Returns Across Select Property Types in 1-, 3-, 5-, and 10-year Periods
As of 12/31/2013



Source: NCREIF; AEW Research

Exhibit 10.j

NCREIF Annualized Total Returns

Periods Ending 12/31/2013

	NPI	Apartment	Seniors Housing
4Q2013	2.53%	2.48%	4.89%
3Q2013	8.25%	7.75%	10.12%
One Year	10.98%	10.42%	15.51%
Three Years	11.92%	12.35%	13.60%
Five Years	5.69%	6.70%	9.14%
Ten Years	8.64%	8.40%	14.59%

NCREIF Annualized Income Returns

Periods Ending 12/31/2013

	NPI	Apartment	Seniors Housing
4Q2013	1.34%	1.22%	1.59%
3Q2013	4.21%	3.90%	5.14%
One Year	5.61%	5.16%	6.81%
Three Years	5.85%	5.33%	6.96%
Five Years	6.10%	5.45%	7.07%
Ten Years	6.16%	5.36%	7.51%

NCREIF Annualized Appreciation Returns

Periods Ending 12/31/2013

	NPI	Apartment	Seniors Housing
4Q2013	1.19%	1.26%	3.30%
3Q2013	3.92%	3.75%	4.83%
One Year	5.16%	5.06%	8.29%
Three Years	5.81%	6.75%	6.32%
Five Years	-0.40%	1.20%	1.97%
Ten Years	2.37%	2.93%	6.71%

Source: NCREIF

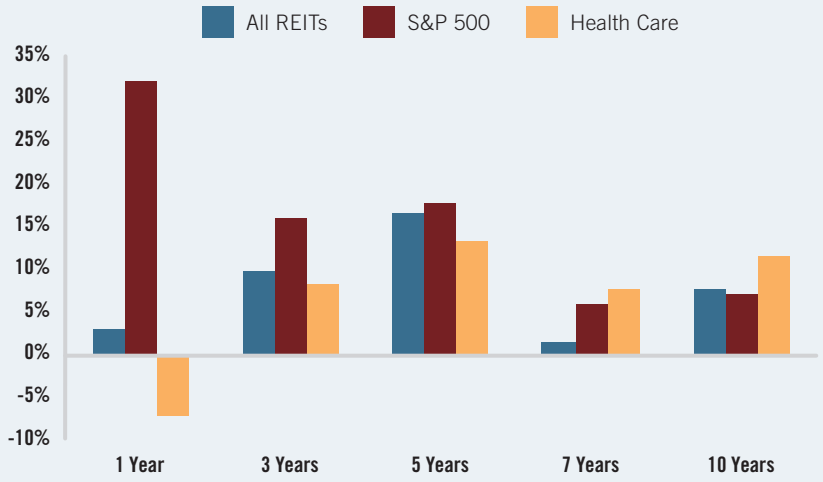
10.2.3 REIT Returns

Health care REITs, whose assets under management include seniors housing and care properties, have dramatically outperformed both the S&P 500 Index and the overall REIT market over the past 10 years as investors moved into more defensive investments. During bear markets, health care REITs are often considered defensive in nature because demand for health care is not as closely tied to the economy and the business cycle as other sectors. In the last bear market, the relatively low leverage of health care REITs enabled them to avoid the dilutive equity offerings needed by many other REITs to reduce debt. However, over the past year in 2013 the REITs, including health care REITs, have underperformed as interest rates have increased.

In the past 10 years, public health care REITs, for which seniors housing and care properties represents a significant share of their investment portfolios, have outperformed the FTSE NAREIT Equity REIT Index and the S&P 500 Index. An investment made 10 years ago in the S&P 500 would have realized an annualized total return of 7.4 percent, while an investment in the FTSE NAREIT Equity REIT Index would have realized an annualized total return of 7.8 percent. The health care REIT sector index outperformed both indices, with an annualized return of 11.7 percent during the same 10-year period.[25]

Exhibit 10.k
Annualized Total Equity Returns Across Select REIT Types and the S&P 500 in 1-, 3-, 5-, 7-, and 10-year Periods

As of 12/31/2013



Source: NAREIT; Bloomberg; NIC Research & Analytics

Exhibit 10.l
Annualized Total Returns by Select REIT Types and the S&P 500

Periods Ending 12/31/2013

	All REITs	S&P 500	Apartments	Retail	Hotels	Industrial	Office	Health Care
One Year	3.2%	32.4%	-6.2%	1.9%	27.2%	7.4%	5.6%	-7.1%
Three Years	10.0%	16.2%	4.9%	13.1%	7.0%	10.2%	6.1%	8.3%
Five Years	16.7%	17.9%	17.2%	19.7%	24.0%	12.3%	13.9%	13.6%
Seven Years	1.6%	6.1%	3.1%	1.0%	-1.2%	-7.4%	-1.2%	7.8%
Ten Years	7.8%	7.4%	10.3%	8.0%	5.5%	1.5%	6.4%	11.7%

Source: NAREIT; Bloomberg; NIC Research & Analytics

The health care REIT returns Exhibit 10.k and Exhibit 10.l are based on the performance returns of the 14 health care companies that are included in the FTSE NAREIT health care property sector, including:

Exhibit 10.m
Constituent Companies of the FTSE NAREIT Equity REIT Health Care Index
As of 12/31/2013

Company	Symbol	Equity Market Cap ($Millions)
Ventas	VTR	16,845
HCP, Inc.	HCP	16,572
Health Care REIT	HCN	15,464
Senior Housing Property Trust	SNH	4,183
Omega Healthcare Investors	OHI	3,662
Healthcare Trust of America	HTA	2,331
Healthcare Realty Trust	HR	2,043
Medical Properties Trust, Inc.	MPW	1,974
National Health Investors	NHI	1,854
LTC Properties	LTC	1,230
Sabra Health Care REIT	SBRA	990
Aviv REIT, Inc.	AVIV	891
Universal Health Realty	UHT	509
Physicians Realty Trust	DOC	259

Source: NAREIT; FTSE

While many of these firms are active in seniors housing, some are also involved in other health care real estate, including hospitals, and medical office and life science buildings. The equity market capitalization of health care REITs represented 11 percent of the overall FTSE NAREIT Equity REIT universe, or $68.4 billion as of December 31, 2013. The equity market capitalization of the whole index was $608.3 billion as of December 31, 2013.[25]

Health care REITs continue to trade at a discount to multifamily REITs, although it has contracted over the past couple years, as evident by the accompanying charts showing the funds from operations (FFO) multiples and current dividend yields as of December 31, 2013. The simple average FFO multiple from the list in the apartment REIT chart (Exhibit 10.o) represents a price-to-funds from operations of 16.5 compared to the health care REIT's (Exhibit 10.n) simple average FFO multiple of 15.4. The difference in the average multiples between these two sectors represents a discount of 6.7 percent in which health care REITs trade.[26]

In the interest of factoring in the market capitalization, a weighted average FFO multiple based on market capitalization also shows apartment REITs trading at a premium. The weighted average multiples from the lists in Exhibits 10.n and 10.o are 19 and 14.3 for apartment REITs and health care REITs, respectively, representing a health care REIT discount of 24.7 percent. These multiples suggest that the apartment REITs have larger capitalization REITs trading at higher FFO multiples when compared to health care REITs.[26]

Exhibit 10.n
Publicly Traded Health Care REITs
As of 12/31/2013

Symbol	Trailing 12-month P/FFO	Dividend Yield	Equity Market Cap ($M)	Stock Price ($)	2013 FFO/Share
VTR	14.0	5.06%	16,845	57.28	$4.09
HCP	12.3	5.78%	16,572	36.32	$2.95
HCN	16.1	5.71%	15,464	53.57	$3.32
SNH	13.3	7.02%	4,183	22.23	$1.67
OHI	11.6	6.44%	3,662	29.80	$2.56
HTA	15.6	5.84%	2,331	9.84	$0.63
HR	22.0	5.63%	2,043	21.31	$0.97
MPW	14.7	6.87%	1,974	12.22	$0.83
NHI	15.7	5.24%	1,854	56.10	$3.58
LTC	14.9	5.76%	1,230	35.39	$2.37
SBRA	14.3	5.20%	990	26.14	$1.83
AVIV	21.8	6.08%	891	23.70	$1.09
UHT	14.6	6.24%	509	40.06	$2.75

Source: Bloomberg; NIC Research & Analytics

Another measure of valuation is the dividend yield, which is also displayed in the charts for the two sectors. In comparing the simple average dividend yield of apartment REITs to that of health care REITs, it is also evident the health care companies are trading at a discount. The simple averages are 4.1 percent and 5.9 percent dividend yields for the apartment REITs and health care REITs, respectively. When factoring in market capitalization, the weighted averages result in dividend yields of 4.1 percent and 5.7 percent for apartments and health care, respectively, suggesting a premium paid for the apartment REIT income.[26]

10.4 Performance Summary

For many investors, the dual components of real estate and needs-driven services give seniors housing and care properties a unique resiliency, combining the benefits of real estate investment with the strength of health care. This resiliency was evident during the real estate downturn of 2008–2009, when seniors housing and care properties outperformed other commercial real estate property types in terms of investment returns and rent growth.

Exhibit 10.o

Publicly Traded Apartment REITs

As of 12/31/2013

Symbol	Trailing 12-month P/FFO	Dividend Yield	Equity Market Cap ($M)	Stock Price ($)	2013 FFO/Share
EQR	22.1	5.0%	18,695	51.87	2.35
AVB	23.4	3.6%	15,301	118.23	5.05
UDR	16.2	4.0%	5,855	23.35	1.44
ESS	18.9	3.4%	5,370	143.51	7.59
CPT	13.8	4.4%	5,105	56.88	4.11
MAA	14.0	4.8%	4,542	60.74	4.35
BRE	20.0	2.9%	4,223	54.71	2.74
AIV	12.7	3.7%	3,781	25.91	2.04
HME	12.3	5.2%	3,050	53.62	4.37
PPS	15.0	2.9%	2,451	45.23	3.01
AEC	12.6	4.7%	923	16.05	1.27

Source: Bloomberg; NIC Research & Analytics

Elmcroft Rancho Vista
Vista, CA

Appendix A: Glossary

Absorption	The net change in the number of occupied units from the prior period.
Activities of Daily Living (ADLs)	ADLs are defined as activities including bathing, grooming, dressing, eating, and medication management.
Asking Rent Growth (%)	The annual growth rate of "Asking Average Rent" for properties reporting rent data in the both the current quarter and the same quarter a year ago- a same-store-rent concept.
Average Monthly Rent	Asking private-room rent plus the average fee for care services. For nursing care, this represents the average per diem private-pay rate for private rooms. Average rent may also be referred to as AMR for independent living, assisted living, and memory care and ADR for nursing care.
CAMPUS TYPE	**The arrangement of the units and/or buildings of the property.**
Combined Campus	*A property offering at least two types of services, but where IL and NC are not jointly offered.*
CCRCs	*Properties that offer at least independent living and nursing care services.*
Freestanding	*A property offering a single type of service, e.g., exclusively independent living.*
CARE SEGMENT TYPE	**Levels of care and services provided by the property. This can also be referred to as segment or service type units/beds. One unit of IL, AL or MC is counted as equivalent to one NC bed.**
Independent Living Units	*The part or section of a property that provides independent living services. As part of the monthly fee, access to meals and other services such as housekeeping, linen service, transportation, and social and recreational activities is provided to residents. Independent living does not provide assistance with ADLs.*
Assisted Living Units	*The part or section of a property that provides assisted living services and is regulated by the state. The same services are provided as in independent living, but also provided is supportive care from trained employees to residents who are unable to live independently and require assistance with ADLs.*
Memory Care Units	*The part or section of a property that provides services to persons with Alzheimer's disease or other forms of dementia. These are generally separate or secured areas/wings, with specific programming for persons with memory impairment in addition to services provided for persons in assisted living.*
Nursing Care Beds	*The part or section of a property that provides only nursing care services. Residents receive 24-hour nursing and/or medical care. Properties offering nursing care are generally licensed for Medicaid and/or Medicare reimbursement.*
Inventory (units/beds)	The number of independent living units, assisted living units, memory care units, and nursing care beds that are operational and available for residence. One unit of independent living, assisted living, or memory care is equivalent to one nursing bed.
Inventory Growth	The amount of new inventory added within a quarter minus any deletions that have occurred.
Primary Markets (i.e. top 31)	The aggregate of data collected from 31 of the largest core-based statistical areas (CBSAs) in the continental United States. Data is available in these markets beginning in the fourth quarter of 2005.
Secondary Markets	The aggregate of data collected from 68 large core-based statistical areas (CBSAs) in the continental United States. Data is available in these markets beginning in the first quarter of 2008.

PAYMENT TYPE	The payment plan by which residents pay for services.
Entrance Fee	*A property that charges a lump sum amount of money paid by a resident at the beginning of their stay that provides the right to occupy the residence and generally charges an additional monthly fee.*
Rental	*A property that charges residents for their residence and services on a lease basis.*

Occupied Penetration (%)	The number of occupied units/beds divided by the number of households, generally the number of age 75+ households, unless otherwise noted.

PROPERTY TYPE	The building or buildings and grounds that house the residents, and common areas shared by the residents. Properties in the NIC MAP® database generally include at least 25 units/beds and are market rate. Properties are listed as Majority IL, Majority AL and Majority NC.
Majority Independent Living (IL)	*Properties where independent living units comprise the largest share of inventory. Majority independent living properties typically include services such as communal dining, housekeeping, transportation, emergency call, and social programming services in the monthly fee.*
Majority Assisted Living (AL)	*Properties where assisted living units and/or memory care units comprise the largest share of inventory. Residents receive personal care services such as assistance with bathing, dressing, eating, walking and toileting. Twenty-four hour protective oversight is provided, but twenty-four hour medical care is not. The majority assisted living properties included in NIC MAP® are only market-rate properties where 80 percent or more of the residents are 55 years or older.*
Majority Memory Care (MC)	*Properties where memory care units comprise the largest share of inventory. Residents receive specialized support for Alzheimer's Disease and/or dementia.*
Majority Nursing Care (NC)	*Properties where nursing care beds comprise the largest share of inventory. A majority nursing care property is generally a licensed long-term health care and residential property that serves persons who require constant medical supervision and/or who require significant physical assistance in transferring, management of continence and use of medical devices. The NIC MAP® database does not include properties that are limited to sub acute, properties limited to inpatient based, properties that are hospital based, or properties predominantly rehabilitation facilities where people come for short-term stays for nursing care.*

Occupancy (%)	The number of occupied units divided by the total number of open units.

RIDEA	REIT Investment Diversification and Empowerment Act of 2007—Amends Internal Revenue Code provisions relating to real estate investment trusts (REITs) to: (1) treat passive foreign exchange gains attributable to overseas real estate investment as qualifying REIT income; (2) increase from 20 percent to 25 percent the maximum value of a REIT's total assets that may be represented by securities of one or more taxable REIT subsidiaries; (3) revise safe harbor rules for the excise tax penalty on certain REIT sales activities; (4) treat rental payments made by a health care property to a REIT as qualifying REIT income; and (5) treat income from, and interests in, foreign-qualified REITs as qualifying REIT income and assets.

Appendix B:
Factors Affecting Demand

This section discusses the factors that affect demand for seniors housing and care properties, including demographics, the labor market and the residential housing market.

Demand for seniors housing and care is influenced by the age of and need for assistance by seniors themselves, their net worth and income, and the knowledge of and desire for seniors housing by seniors and their adult children. Additionally, for some care segments, the financial resources of adult children of seniors influence demand, as adult children can provide financial support for the cost of their parents' care. Most residents of seniors housing are over the age of 75, although more often in their early-to-mid 80s. The adult children of these residents are typically age 45 to 64. Accordingly, the discussion below focuses on these two cohorts.

B.1 Elderly

The following section discusses demographics, need for assistance, and wealth of seniors.

B.1.1 Demographics of the Elderly

As of 2012, there were 19.2 million individuals aged 75-plus, constituting 6.1 percent of the U.S. population.

Exhibit b.1

U.S. Population by Age Cohort

Estimates as of 2012

	Population (Millions)		Households (Millions)	
	Number	% of Total	Number	% of Total
45-64	82.9	26.4%	47.0	38.8%
65-74	24.0	7.6%	14.5	12.0%
75+	19.2	6.1%	12.3	10.2%
75-84	13.3	4.2%	8.7	7.2%
85+	5.9	1.9%	3.6	3.0%

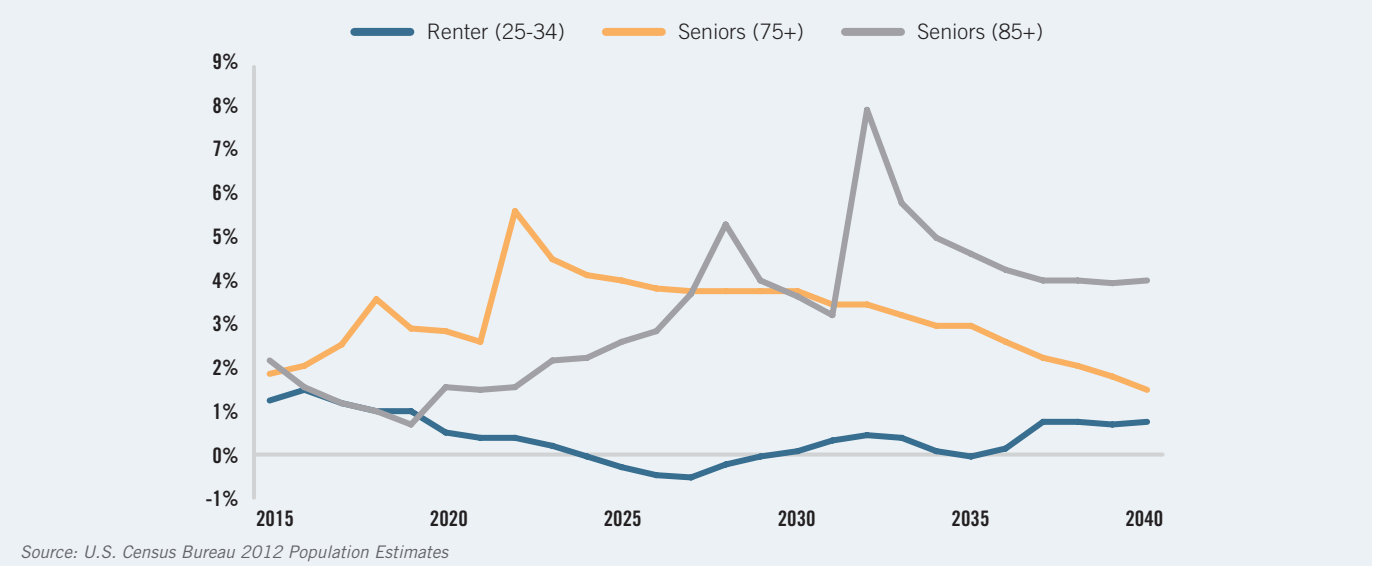
Source: U.S. Census Bureau

Since the economic recession, the average age of residents in seniors housing has risen to the mid-80s, so the population of individuals aged 85 years or older may provide a better benchmark for potential demand. As of 2012, the population of individuals aged 85 years or older was 5.9 million, which represented 1.9 percent of the U.S. population. Exhibit b.1 shows the age cohorts of the older adult age cohorts, inclusive of both adult children and the seniors themselves, in 2012.[8]

Exhibit b.2

Annual Population Growth Rates

2015-2040



Source: U.S. Census Bureau 2012 Population Estimates

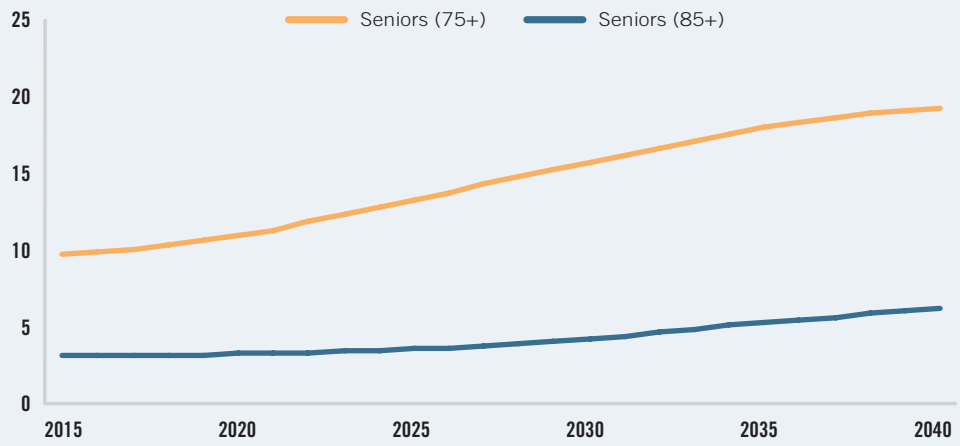
While the aging of the baby boomers (those born between 1946 and 1964) garners a great deal of attention, their impact on the demand for seniors housing will not truly be felt until well into the next decade. As the oldest baby boomers are only in their late 60s, they will not begin to reach the traditional age range for seniors housing for at least 10 years. Until then, while the rate of growth in the aged 75-plus population is projected to modestly accelerate, the growth rate of the 85-plus population will slow, but remain positive, until 2019.

The size of the 85-plus population is expected to increase at a rate of 1.2 percent annually during the remainder of the decade.

Exhibit b.3

Seniors Population Per 100 Individuals Aged 15-64

2015-2040

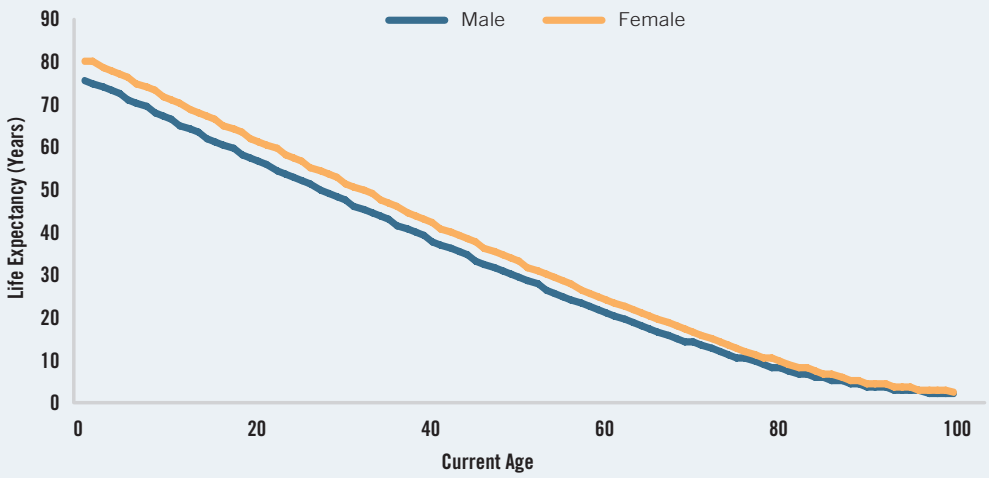


Source: U.S. Census Bureau 2012 Population Estimates; NIC Research & Analytics

Exhibit b.4

Actuarial Life Expectancy by Age Cohorts

As of 2009



Source: U.S. Social Security Administration

The early part of the next decade will see the 85-plus population growth rate accelerate modestly–averaging 1.8 percent from 2020 through 2024. The latter part of the decade will see the beginning of significant acceleration in this population, with the 85-plus population growth rate averaging 3.7 percent from 2025 through 2029.[7]

While the elderly population is expected to increase rapidly, younger age cohorts are expected to grow at a much slower rate. This will cause an increased dependence on the younger population and reduce the feasibility of providing informal care in the home (a declining caregiver support ratio). The number of individuals aged 85-plus per every 100 individuals aged 15 to 64 is expected to more than double by 2040. This dynamic implies that there will be fewer individuals in the younger age groups that can act as caregivers per elderly adult.[7]

In addition to the surge in growth the baby boomers will present, actuarial estimates show once an individual reaches one of the target demographic groups (aged 75-plus), their life expectancy is still significant. An individual currently 75 years old is expected to live an additional 11.8 years, and an individual 85 years old is expected to live an additional 6.4 years.[27]

B.1.2 Need for Assistance

As discussed in this publication, for many types of seniors housing and care properties, the need for assistance is an important demand driver. Exhibit b.5 shows the levels of assistance needed with activities of daily living (ADLs) for three seniors' age cohorts over time.

Although the population is living longer, several diseases are becoming more prevalent that increase dependence on others and introduce additional need for personal and health care. These diseases include Alzheimer's, obesity and diabetes.

Exhibit b.5

Percentage of Disability Group Estimates by Age, NLTCS 1982-2004/2005

	1982	1984	1989	1994	1999	2004/2005
Age 65-74						
Non-disabled	85.8%	86.7%	88.1%	88.2%	89.3%	91.1%
IADL only	4.3%	4.1%	3.0%	3.2%	2.5%	1.8%
One or two ADLs	4.1%	4.0%	3.8%	3.7%	3.4%	3.1%
Three or four ADLs	1.8%	1.8%	1.7%	1.7%	2.0%	1.6%
Five or six ADLs	2.0%	1.7%	1.5%	1.6%	1.4%	1.5%
Institutionalized	2.0%	1.7%	1.9%	1.6%	1.4%	0.9%
Age 75-84						
Non-disabled	69.3%	70.2%	70.6%	73.8%	76.6%	78.1%
IADL only	7.0%	7.5%	5.8%	5.2%	3.6%	2.5%
One or two ADLs	8.2%	8.1%	8.6%	7.5%	8.0%	6.7%
Three or four ADLs	3.4%	3.5%	4.5%	4.1%	4.2%	4.5%
Five or six ADLs	3.9%	3.6%	3.5%	3.0%	3.4%	4.0%
Institutionalized	8.1%	7.1%	7.0%	6.3%	4.3%	4.1%
Age 85+						
Non-disabled	37.9%	34.1%	38.6%	41.5%	44.4%	50.3%
IADL only	7.5%	9.4%	6.8%	7.1%	5.5%	4.2%
One or two ADLs	13.3%	14.6%	11.9%	11.6%	12.9%	12.1%
Three or four ADLs	6.2%	6.6%	8.9%	7.7%	9.2%	10.2%
Five or six ADLs	7.8%	8.6%	7.7%	7.6%	8.5%	7.6%
Institutionalized	27.2%	26.6%	26.1%	24.6%	19.5%	15.6%

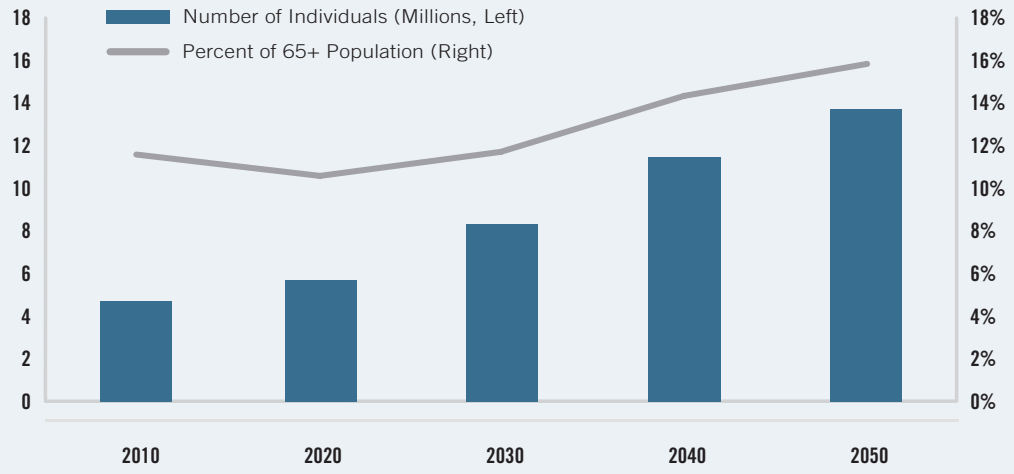
Note: Columns may not sum to 100% due to rounding.

Source: Manton, Kenneth, "Change in chronic disability from 1982 to 2004/2005 as measured by long-term changes in function and health in the U.S. elderly population." Proceeding of the National Academy of Sciences of the United States of America (PNAS). Volume 103, Number 48, Nov. 28, 2006.

Exhibit b.6

Projected Number of Individuals Aged 65+ with Alzheimer's Disease

As of 2009



Source: Hebert et al; 2013 Alzheimer's Disease Facts and Figures; NIC Research & Analytics

Alzheimer's disease is the fifth-leading cause of death for Americans age 65-plus. Alzheimer's is the most common form of dementia and greatly disrupts normal brain functionality. The vast majority of Americans suffering from Alzheimer's disease are aged 65-plus, with the 65-plus age group accounting for approximately 96 percent of diagnosed cases. Among the aged 65-plus, 11 percent, or 5.2 million, have Alzheimer's disease. The risk of Alzheimer's increases with age, as three percent of the aged 65 to 74 population had Alzheimer's in 2013, compared to 18 percent of the aged 74 to 84 population and 30 percent of the aged 85-plus population. Alzheimer's occurs more often in females than males, but evidence suggests this may be due to the longer life expectancy in females compared to males instead of an increased risk of developing the disease.[12]

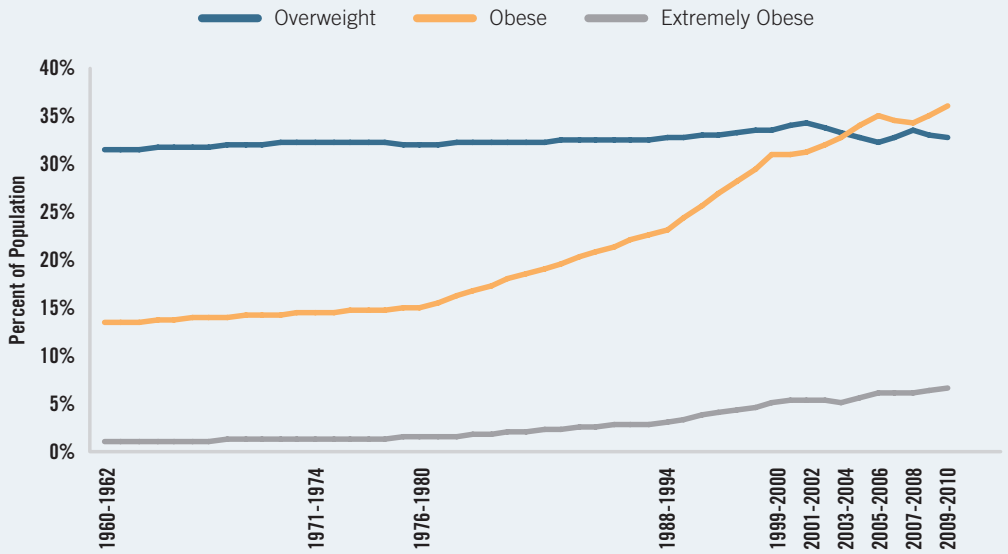
The prevalence of Alzheimer's is projected to increase in the foreseeable future. As of 2013, there were 5.0 million cases of Alzheimer's disease within the age 65-plus cohort, but this is projected to increase to 8.4 million in 2030. While the net increase in Alzheimer's cases is projected to grow by 3.4 million by 2030, the relative prevalence of the disease is not expected to change significantly, as the percent of the aged 65-plus population with Alzheimer's is expected to oscillate between 11 and 12 percent during that time. In 2050, it is projected that 13.8 million individuals age 65-plus will have Alzheimer's disease, which does imply a slight increase in the prevalence of the disease.[12]

One of the underlying factors increasing the prevalence of chronic care is increasing obesity rates. Nearly 70 percent of the adult population is now considered overweight or obese—a substantial increase from 1962, when 45 percent of the adult population was estimated to be overweight or obese. This trend experienced significant growth from the late 1980s to the present because of increasingly sedentary lifestyles and poor diet. One of the most significant risks associated with obesity is the increased possibility of more dangerous diseases.[28]

Obesity has been linked as a factor for diabetes in adults. Complications of diabetes include high blood pressure, blindness, kidney disease, nervous system disease, amputation and dental disease. All of the aforementioned complications increase the burden on healthcare. The total direct and indirect costs associated with diabetes were estimated to be $245 billion in the U.S. in 2012. As people age, the risk for diabetes increases; less than 2 percent of individuals under the age of 45 have diagnosed diabetes, compared to 12 percent for the population aged 45-60, 19 percent for individuals in their 60s,

Exhibit b.7

Trends in Overweight and Obese Adults Aged 20-74 Years



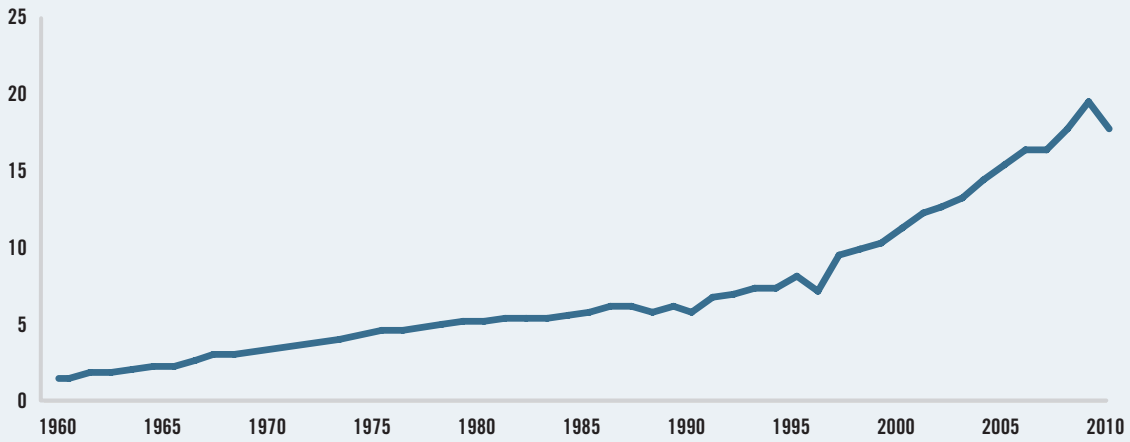
Note: Data interpolated between survey years.

Source: CDC/NCHS; NHES

Exhibit b.8

U.S. Population Diagnosed with Diabetes (Millions)

1960-2010



Source: CDC

and 21 percent for those at least 70 years old.[29]

These trends threaten to reverse the declining disability rates of the last several decades. Increased care demands for Alzheimer's, diabetes and other obesity-associated diseases, increasing life expectancy and continued growth of the target age cohort will lead to a larger demographic group with higher levels of needs than that of the current generation. At the same time, the relative number of potential caregivers (individuals aged 15-64) is expected to decline. Taken together, these factors will likely cause the overall demand for care services to increase, especially since the elderly population will increase significantly and likely be in poorer health than previous generations.

B.1.3 Wealth

Home equity is the largest asset for most seniors. Almost half (47 percent) of age 75-plus households reported that the equity in their home made up the majority of their net worth. In addition, 74 percent of age 75-plus homeowners own their homes free and clear of a mortgage.[13]

Home values rose significantly from 1999 through 2006, providing opportunities for homeowners to realize significant capital gains in a liquid market that facilitated sales. Home values averaged annual gains of 7.4 percent from 2000 through 2006 on a nominal basis and 4.8 percent after adjusting for inflation. These were not sustainable gains and ultimately contributed to a housing bubble, which contributed to the depth of the financial crisis.[11]

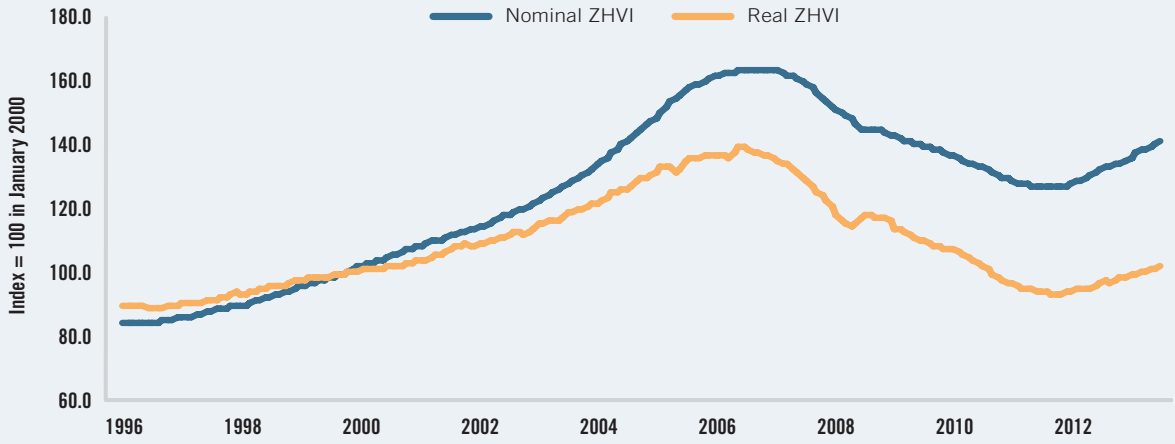
Conversely, home values began a sharp decline in 2007, which continued until the introduction of the homebuyer tax credit that helped stabilize prices in 2009. After the expiration of the homebuyer tax credit, home values resumed their decline and established new post-bubble lows, ultimately establishing its cyclical low in the beginning of 2012. Home values declined 23 percent peak-to-trough on a nominal basis and 31 percent after adjusting for inflation.[11]

The sharp decline in prices, coupled with historically low interest rates and low levels of inventory, created a strong buyer's market and spurred the beginning of housing's recovery. As of

Exhibit b.9

Zillow U.S. Home Value Index (ZHVI)

4/1996 - 12/2013



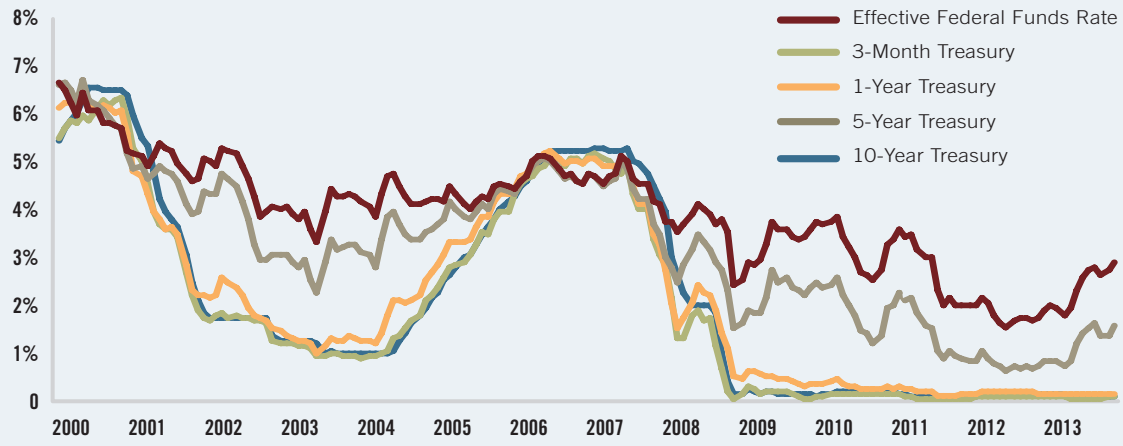
Note: ZHVI adjusted for inflation using CPI less shelter.

Source: Zillow; NIC Research & Analytics

Exhibit b.10

Treasury Yields by Maturity

1/2000 - 12/2013



Source: FRED; Federal Reserve

December 2013, home values had risen 11 percent from their lows and were 6.4 percent higher than year-earlier levels. In real terms, home values increased 5.4 percent during 2013, significantly outpacing gains in real income.[11] The rise in home values has caused affordability to revert back to pre-bubble levels, implying growth in home values could moderate in the near-term. As the stage is also set for mortgage rates to rise, this could also act to calm outsized home value growth in the coming years.

Despite the fact that the largest gains in home values may be behind us, housing market fundamentals are expected to continue strengthening in the near-term. While the strength of existing home sales faded towards the end of 2013, the next few years should see a larger share of conventional sales and fewer distressed sales, which would be indicative of continuing improvement in the market.

Although the stock market has generally rebounded, some traditional savings vehicles of seniors, such as certificates of deposit (CDs), have yet to rebound. Interest rates on CDs and money-market accounts typically follow yields on the federal funds rate and short-term treasury securities, which have remained near 0.0 percent since the height of the financial crisis. Yields on these accounts are unlikely to rise until the Federal Reserve upwardly adjusts the federal funds rate, which is unlikely to happen until late-2014 at the earliest. Until then, seniors with investments in these vehicles will continue to earn very meager returns, too small even to offset inflation.

While the traditional investment vehicles for seniors remain challenged, seniors' income has remained stable. During 2012, median income for aged 75-plus households was $26,606, which was down three percent from 2009 after adjusting for inflation.[30] While incomes have not been able to grow since the financial crisis, incomes of the elderly have been more stable than for the broader population. As most of the income for elderly individuals is from Social Security and other annuitized sources, their income is inherently more stable than that of age groups where the main source of income comes from employment.

As nominal income for the elderly has been generally rising above rent inflation, asking rents (as a multiple of income) have

remained essentially flat since the financial crisis. This implies seniors housing and care services have (1) not become more expensive on a relative basis and (2) rents generally exceed income of the residents. The actual shortfall for most residents is likely less than what Exhibit b.12 suggests, as there is evidence the resident base of private-pay seniors housing is richer than the broader elderly population. The income distribution of residents is heavily skewed, however; one-quarter to one-third have income of at least $3,500 a month, compared to only 15 percent of the broader aged 85-plus population.[31]

To make up for the shortfall in income, residents also rely on the spending down of their assets and/or financial assistance from their adult children.

B.2 Adult Children

Adult children are often involved in the decision-making process for moving parents to seniors housing and care properties as well as often providing financial support and care for elderly parents.

B.2.1 Demographics of Adult Children

The cohort representing most children of seniors is the population aged 45 to 64. As of 2012, there were 82.9 million people in this cohort representing 26.4 percent of the U.S. population. This population age cohort represents 38.8 percent of all U.S. households.[8]

B.2.2 Income of the Adult Children

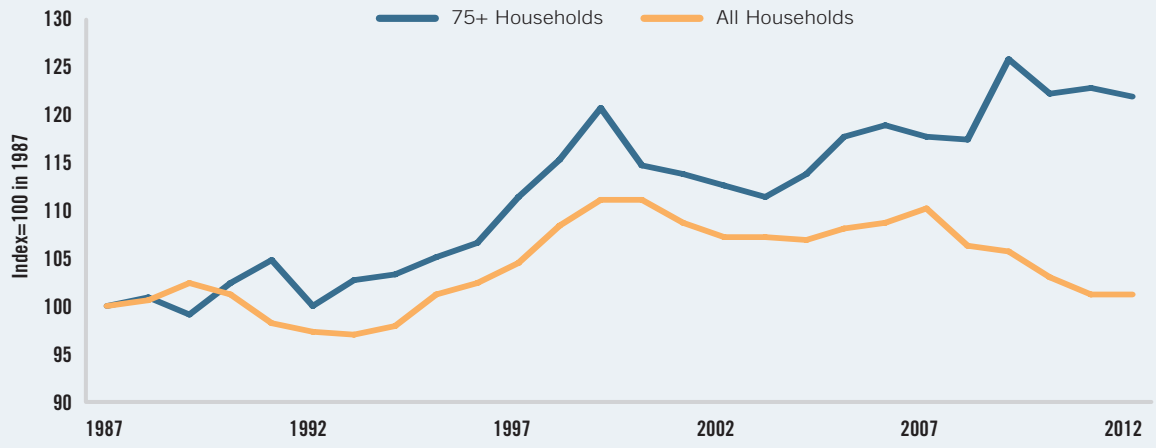
The adult children of seniors who live in seniors housing are often a source of payment for the housing and services. Adult children are more often secondary payment sources rather than primary payment sources. Payment directly from the resident is the largest form of primary payment (66 percent), but payments from family do represent 10.6 percent of all primary payments in assisted living. In terms of secondary payments, 24.1 percent of families contribute toward the payment for the assisted living resident.[3]

Income of adult children has been under pressure since the financial crisis, and has recovered minimally since the recovery began. Real household income fell 7 percent from 2006 to 2012 for the adult children, as the recovery in the labor market has been quite slow. As incomes remain pressured, it could affect how the children of the elderly are able to provide financial assistance for their parents' housing and care.[30]

Exhibit b.11

Real Median Income by Age Cohort

1987 - 2012

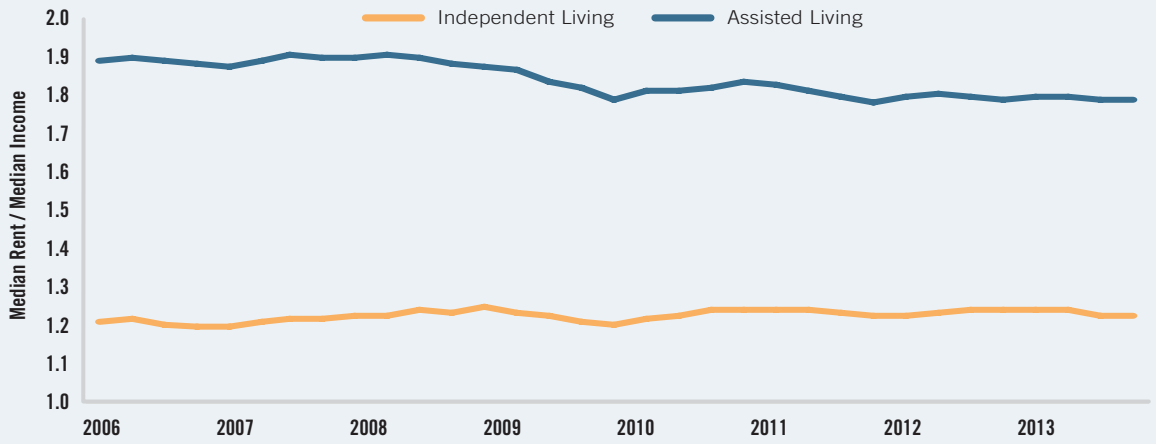


Source: U.S. Census Bureau; NIC Research & Analytics

Exhibit b.12

Median Asking Rent

As a Multiple of Median 75+ Income | 4Q05-4Q13



Source: NIC Research & Analytics

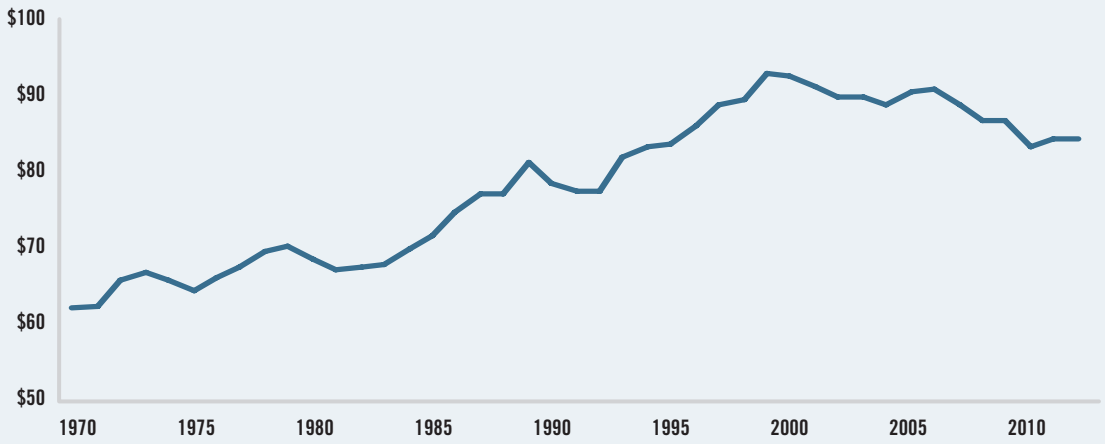
The income of adult children is driven by employment, which has been under pressure during the past few years as the unemployment rate has remained persistently high. The unemployment rate first reached above 8 percent in February 2009, peaking at 10.1 percent in October 2009. When the recession officially ended in June 2010, the unemployment rate remained near its high at 9.5 percent. As of December 2013—two-and-a-half years into the economic recovery—the unemployment rate was still 6.7 percent. The unemployment rate of adult children peaked at a lower level than for the overall population at 8.0 percent, but has also shown only moderate improvement during the economic recovery.[15]

The increase in unemployment has multiple effects on seniors housing demand. Due to the relationship between employment and income, the poor employment market has lessened discretionary income among adult children, decreasing their ability to financially assist in the cost of care for their elderly parents. This will inevitably cause families with stressed finances to seek less expensive forms of care and/or delay the move into a seniors housing property. Another effect involves unemployed adult children transitioning to informal caregivers. Unemployed adults can act as informal caregivers for their elderly parents and the increase in the number of unemployed individuals has caused the number of potential caregivers to increase.

Exhibit b.14

Average Real Household Income of the Adult Children ($Thousands)

1970 - 2012

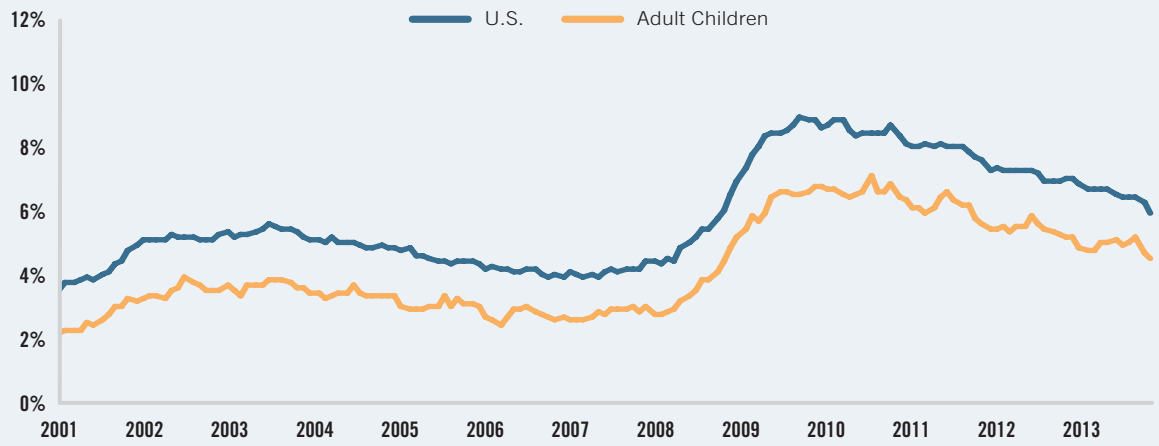


Source: U.S. Census Bureau; NIC Research & Analytics

Exhibit b.15

Unemployment Rate (Seasonally Adjusted)

1/2001 - 12/2013



Source: BLS; FRED; NIC Research & Analytics

Appendix C:
Needs Assessment and Pricing

This appendix focuses on the assessment of needs and the various methods of charging residents for increased services. We begin by reviewing the needs assessment process and then consider pricing models.

C.1 Needs Assessment

Typically, when a resident enters into assisted living or memory care (and usually upon a change in condition or at a certain frequency proscribed by policy or regulation thereafter), he or she receives a functional assessment. The resident is assessed based on the help he or she will require with activities of daily living (ADLs) and other personal care services. The table below displays the ADLs tracked by The National Center for Health Statistics and the percentage of usage by residents in residential care communities.

Exhibit c.1
ADL Usage by Residents in Residential Care Communities

Bathing	61%
Dressing	45%
Toileting	37%
Eating	18%

Source: National Center for Health Statistics, December 2013

Other services which require assistance and are assessed and charged include functions such as:

- Medication Monitoring/Administration;
- Respiratory Needs;
- Escorts/Mobility;
- Cognitive/Psychosocial; and
- Behaviors Requiring Redirection

The functional assessment will result in a measured level of need for additional services, which the resident typically pays for in addition to base rent and basic services (such as meals and housekeeping). There are many different systems employed in seniors housing and care properties to assess new and existing residents as their needs and preferences change. While there is no industry standard, all assessment tools help to determine which ADLs and personal care services residents will require from the property. The number of ADLs and other personal care services help to define care fee pricing and the personal service plan for the individual. A summary of the pricing methods (associated with ADLs and other personal care services) is provided below.

C.2 Pricing Models

Three basic pricing models are in use. These models are the (1) all-inclusive, (2) level of care, and (3) a la carte:

C.2.1 All-Inclusive

Some properties employ an all-inclusive pricing system, which encompasses base rent/services as well as access to all ADL and personal care services offered by the property. All-inclusive pricing systems are more prevalent for dementia care than for assisted living care segments. Properties that employ this method may appear to be priced higher than properties that advertise only their base rent/services without factoring in ADLs and personal care services. However, these all-inclusive properties may have an advantage in marketing and pricing their units based on simplicity and transparency to prospective residents and families. Even so, all-inclusive pricing bears the risk of reduced profitability and possible unprofitability because of the multiplicity of services associated with caring for higher-need/higher-risk residents. In addition, low-need prospects may feel they would be paying for services they do not need. In addition, the property's pricing method may attract high-need/high-risk move-ins. Clear and consistent discharge criteria, identified in advance, are critical to identify residents for whom the property is not able or willing to provide care (e.g., incontinence).

C.2.2 Levels of Care

Most properties that offer assisted living care base pricing of ADL and other personal care services on a system of levels of care. The assessment tool helps to determine the care level that drives the care fee pricing. Care fees for properties that employ this pricing system generally run between $200 and $2,000 per month for assisted living care segments over and above the basic rent/services, depending upon which types of ADL and personal care services the resident receives. Levels-of-care

systems have maximum care charges for each level of care. The top level is similar to that of the all-inclusive pricing model in which discharge criteria must be identified. The prevalent methods to set levels of care are as follows:

C.2.2.1 Points

In this system, points are assigned for each ADL or personal care service for which a resident requires staff assistance, as determined by the assessment. The number of points will generally fall into one to six levels, with six representing the highest level of assistance. The level will determine the monthly care fees.

C.2.2.2 Time

Similar to "Points" (C.2.2.1), the amount of staff time the resident will require for ADLs and other personal care service is calculated based on the assessment. The amount of time determines the resident's level of care and the charges. Properties that use time-based systems usually offer between one and six levels.

C.2.2.3 Care Question

In this system, the answers to specific assessment questions place the resident into a level (usually from one to four), with four representing the highest level of assistance and the most expensive option. The unique element of this system is that a "Yes" answer to one particular question (e.g., insulin dependent diabetes) may place a resident in a level for which they do not need the other available services.

C.2.3 À la carte

Many properties market their assisted living care segment at a price point starting with base rent/services only. Any staff assistance required for ADLs or other personal care service is priced separately and individually, usually through a points, or time system.

C.2.4 Additional charges

Some communities charge additional fees to participate in programs or services outside of those identified in their usual and customary pricing system. For instance, there may be additional charges for participation in an incontinence product program based on usage, or for the care of a resident's pet.

Appendix D:
Entrance Fee CCRCs

Entrance fee continuing care retirement communities (CCRCs) differ from rental-based seniors housing due to the lump sum payment required at entry that gives the resident the right to occupy the property. These entrance fees are generally $200,000. This type of property, in addition, typically charges a monthly service fee. Entrance fee CCRCs represent roughly 49 percent of all CCRCs. An overwhelming percentage (82.5 percent) of entrance fee CCRCs are owned by not-for-profit companies on a unit-basis.[1]

This appendix will further discuss payment arrangements associated with entrance fee CCRCs, as well as discuss occupancy and supply information.

D.1 Payment Arrangements

This section discusses the payment arrangements of entrance fee CCRCs including the contract options that residents have available when moving into entrance fee CCRCs. The types of contracts that will be discussed are referred to as types A, B and C. Each contract type has different entrance fee requirements and monthly fee amounts. A CCRC may offer more than one contract type. In addition, contracts may offer different refund options.

D.1.1 Type A (Full Continuing Care Contract)

Under a Type A or full continuing care contract (sometimes called life care), a resident typically pays an entrance fee and an ongoing monthly fee for the right to occupy an independent living unit, access amenities and receive certain services. Residents who require assistance or health care may receive some services in their apartments, or they may move to an assisted living or nursing care portion of the community, but the monthly fee remains the same as when they lived in their apartments. In essence, long-term care insurance is bundled into the housing and services delivery for this contract type. For the contract, prospective residents need to meet certain asset, income and health parameters in order to qualify for admission.

D.1.2 Type B (Modified Contract)

Under a Type B or modified continuing care contract, a resident will also pay an entrance fee and an ongoing monthly fee for the right to occupy an apartment. However, in a Type B contract, a CCRC is obligated to provide an appropriate level of assisted living or nursing care as in a Type A contract, but only for a specific period of time (e.g., 30 to 60 days); or at a discounted rate for a stated period of time; or indefinitely, after which the market rate is paid.

D.1.3 Type C (Fee for Service)

A Type C contract generally also requires an entrance fee and a monthly fee, but the fees do not include any discounted health care or assisted living services. Under a Type C contract, residents pay the standard per diem if they need assisted living or nursing services; however, they may receive priority access to those services.

D.1.4 Percentage Refund or Repayment

Entrance fees can range from zero to 100 percent refundable or repayable. Repayment terms also vary. In some cases, repayment is contingent on the resale of the unit for at least a specified price. In other cases, the community specifies a guaranteed repayment after a certain amount of time, often 180 or 360 days after vacating the property. Many states have created regulation around the conditions of the repayment depending on the contract type.

The entrance fee that a CCRC charges is generally a function of the property, amenities, market, unit type, contract type and refund options. The entrance fee that a resident pays under a Type A contract is generally higher than that paid under a Type B or Type C contract.

D.1.5 Entrance Fee Accounting

While investment modeling for entrance fees typically employs net entrance fee cash flows to account for payments and refunds or repayments, GAAP entrance fee accounting takes only the non-refundable portion of the entrance into income and amortizes it over the resident's life expectancy or at the end of the contract. The refundable portion of the entrance fee is treated as a long-term liability unless the refund is pending due to contract termination. This has led some publicly traded companies to report adjusted earnings using cash flow from operations, or CFFO.

Because of the large transaction sizes of entrance fees and the random nature of payments and repayments, entrance fee cash flows are more volatile than monthly rent payments. While this volatility tends to smooth out for periods of several years, it is another factor that makes publicly traded operators reluctant to own entrance fee CCRCs.

D.2 Occupancy

Occupancy is the number of occupied units divided by the total number of open units in the top 31 metropolitan markets.

As of the fourth quarter of 2013, occupancy in entrance fee CCRCs was 89.4 percent, down from a high of 94.1 percent in the first quarter of 2007. From 2011 through most of 2013, occupancy in entrance fee CCRCs oscillated near 89 percent. The 50 basis point increase in occupancy during the fourth quarter of 2013 was the first significant increase during the current economic cycle.[1]

Entrance fee CCRCs have the lowest median annual resident turnover rate among seniors housing and care property types at 12.2 percent for the independent living units. This implies a typical length of stay of 98.2 months.[2] This is likely due to the fact that CCRCs attract new residents who tend to be in better health than those drawn to other types of independent living properties.

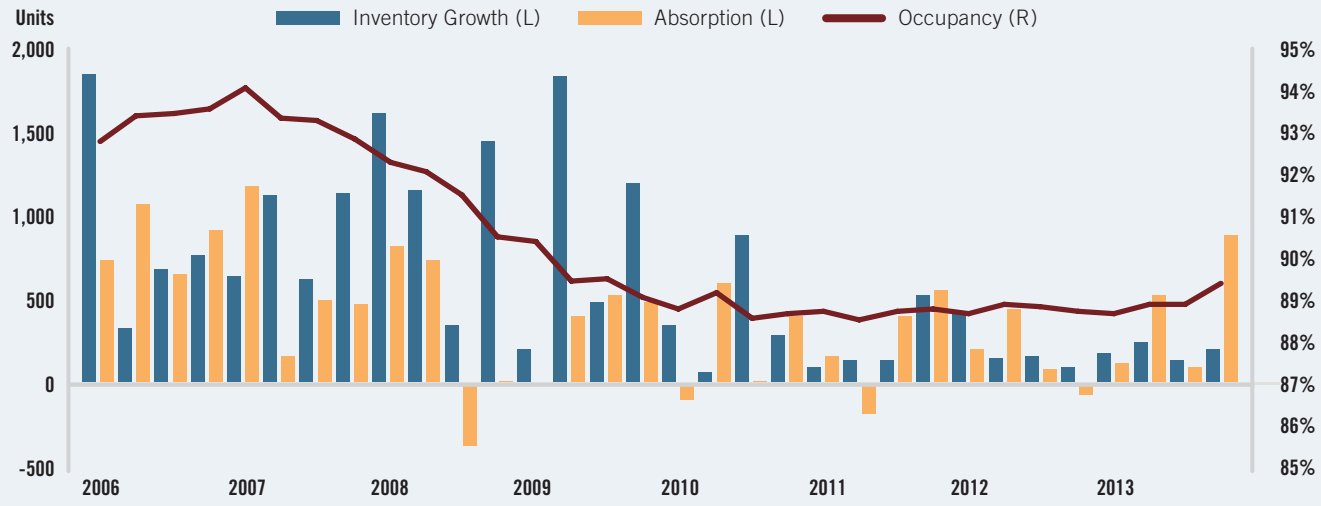
D.3 Supply

There are approximately 950 entrance fee CCRC properties, containing approximately 365,000 units in the U.S.[1]

Exhibit d.1

Entrance Fee CCRC Supply-Demand in the Top 31 Metropolitan Markets

1Q06 - 4Q13



Source: NIC MAP® Data Service

Appendix E:
Alternative Housing and Services

This appendix summarizes the housing and services that often serve as alternatives to the seniors housing and care options outlined in this document. These alternatives are presented in order, starting with options for individuals who require the least amount of service up through alternatives for individuals who require high levels of service.

Current public policy initiatives are focused on caring for seniors in the home or community or "least restrictive setting" as encompassed in the Olmstead decision and the American Disabilities Act (ADA).

E.1 Home- and Community-Based Services

Home- and community-based services (HCBS) reflect the desire to provide services and care to seniors in the home or community and to deliver those services and care in a residential setting instead of in an institutional setting. Public financing of the long-term care market in the U.S. has historically been allocated to nursing care properties. Since the advent of Medicare and Medicaid, federal and state policies as well as a range of political and practical factors have contributed to an "institutional bias" in long-term care service delivery, favoring nursing care properties over more homelike alternatives. There has been a recent effort, however, to redirect more dollars to HCBS in order to provide a non-institutional setting for the delivery of care and services for the elderly. HCBS are the most significant competitors to the services provided in the traditional, institutional-type nursing home. The growth of assisted living has been driven by consumer demand for an alternative to the institutional nursing home environment. At the same time, other HCBS options, such as adult day care, the Program of All-Inclusive Care for the Elderly (PACE) and home health care, have developed as alternatives to assisted living or memory care, especially for those dependent on government funding. In addition, while technology solutions that help enable aging in place in one's home are still in their infancy, such innovations should have an increasingly important role in shaping the future of elder care. We are beginning to see some examples of what works, albeit on a small scale.

E.1.1 Cohousing

One alternative for older individuals is called cohousing, or a cooperative living property. In particular, Baby Boomers (born 1946–1964) are driving this movement. Seniors cohousing is for proactive, healthy, educated adults who want to live as they age in a socially and environmentally responsible property while maintaining their independence, quality of life and financial health. Housing is generally fashioned using universal design, mobility and access principles. Space is provided for shared caregivers to live on site with property members. For more information, refer to the Senior Cohousing Handbook, by Pamela Biery and Charles Durrett, released in September of 2009.

Sometimes cohousing properties occur without planning, and these are called naturally occurring retirement communities (NORCs). One example of a NORC is the Watergate apartments in Washington, D.C., whose average tenant's age is 50-plus. In many NORCs, citizens or a local nonprofit help to bring in aging resources, such as home care, meals, transportation and activities.

E.1.2 Villages

Started in 2001, Beacon Hill Village was the first village, or membership organization, to provide services found in seniors housing while members remain in the comfort of their own homes. While villages are generally classified as NORCs, they offer more CCRC-like services and have become an alternative for some to the traditional CCRC. Usually, groups of neighbors band together to create an organization (usually a non-profit 501(c)(3)) to act as a concierge and one-stop-shop for needs that may be related to aging. For a nominal fee of typically less than $100 per month per household, villages usually provide grocery shopping trips; activities and exercise options; and referrals with discounts to a network of vetted handymen, electricians, plumbers, home care companies and home health (skilled) care companies. The central office with the main phone line is usually staffed with geriatric social workers.

E.1.3 Informal Care

The vast majority of long-term care in the U.S. is provided by informal, volunteer caregivers, most often family members. A family member or other volunteer caregiver serves as the primary caregiver and provides in-home care and assistance. Many family members will try to provide the required assistance as long as they are able, particularly in an economic environment like the U.S. has experienced since 2008.

E.1.4 Home Health Care

A common alternative service for both assisted living and nursing care (and recently for independent living) is certified home health care providers. The resident pays a third-party home health operator to visit and provide the needed assistance with activities of daily living (ADLs). The home health care industry consists of more than 20,000 service operators and grew rapidly at an annual rate of 13 percent from 2000 to 2005. By 2015, industry growth is expected to stabilize at 10.9 percent annually. Home health care providers are usually certified by Medicare. There are 5.2 million recipients of home health services over the age of 65, of which 62.3 percent are women.[32] The downside of in-home care is that the recipient of the services typically does not experience the benefits of the social environment and the supervision of caregivers that are found in an assisted living property. In addition, when the amount of home health care services exceeds eight hours per day, the costs usually exceed those of assisted living.

E.1.5 Private Duty Care

Private duty home care agencies are companies that provide home care aides, companion care, and homemaker services and may provide nursing services in the client's home or place of residence. "Private duty" means private pay. In other words, no government monies are used for the cost of care. Unlike home health care providers, private duty home care agencies are not certified by nor do they accept Medicare. The most common methods for covering the cost of private duty home care are through long-term care insurance benefits, out-of-pocket payments or other types of savings. The agencies employ trained caregivers and assume all responsibility for the payroll and all related taxes; this is not passed on to the client.

Assisted living operators and, to a lesser but growing extent, independent living operators have tried to compete with this alternative service by offering home health care even within their properties. Approximately 17 percent of assisted living properties have a formal contract with a home health operator and 66 percent have a variety of home health companies that provide services on a contract basis with individual residents.[3]

E.1.6 PACE

The Program of All-Inclusive Care for the Elderly (PACE) model is focused on the belief that it is better for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible. PACE serves individuals who are age 55 or older, are certified by their state to need nursing home care, are able to live safely in the community at the time of enrollment, and live in a PACE service area. Although all PACE participants must be certified to need nursing home care to enroll, only about 7 percent of PACE participants nationally reside in a nursing home. If a PACE enrollee does need nursing home care, the PACE program pays for it and continues to coordinate the enrollee's care.

PACE provides all the care and services covered by Medicare and Medicaid, as authorized by the interdisciplinary team, as well as additional medically necessary care and services not covered by Medicare and Medicaid. PACE provides coverage for prescription drugs, doctor care, transportation, home care, checkups, hospital visits and nursing home stays whenever necessary. With PACE, there is never a deductible or copayment for any drug, service or care approved by the PACE team. With PACE delivering all needed medical and supportive services, the program is able to provide the entire continuum of care and services to seniors with chronic care needs while maintaining their independence in their homes for as long as possible.

E.1.7 Adult Day Care

The following material was excerpted from LeadingAge's Adult Day Services Factsheet.

Adult day programs vary greatly from state to state. However, all adult day programs have one characteristic in common: they provide a wealth of services at a reasonable cost to individuals who would otherwise need property-based care. Adult day services can provide three different models of care. A social model provides services for individuals, including those with dementia, who have minimal chronic conditions. A medical model helps individuals manage their chronic conditions. A third model features both social and medical services. Some adult day providers may offer disease-specific programs for individuals with brain injury, HIV, dementia, mental illness, mental retardation or developmental disabilities.

Adult day providers offer a number of skilled services, including physical therapy, occupational therapy, speech therapy, nursing and nutrition counseling. However, the availability of these services can vary from state to state. Almost all adult day programs accept individuals who use wheelchairs and those who are incontinent. Most programs provide assistance with

toileting, test participants' blood sugar, administer medications and offer case management services. About half of adult day programs provide bowel and bladder training, oxygen treatments, wound care, injections, and catheter and colostomy care. Some programs also offer tube feeding, tracheotomy care and overnight care.

Today, more than 3,500 adult day services programs serve more than 150,000 Americans each year. Thirty-nine percent (39 percent) of adult day programs are open 10 or more hours on weekdays, while others also offer weekend hours to meet the needs of working caregivers. The main sources of reimbursement for adult day services are the Medicaid 1915(c) Waiver, OAA Title III and Title IV funds, Social Services Block Grants, the U.S. Department of Veterans Affairs and private payers. Expansion of Medicaid coverage and regulation since 2002 has also increased the amount of skilled and specialized services offered by adult day programs. The daily reimbursement rate for adult day services, including the cost of transportation, can range from $32 per day in Texas to $141 per day in Vermont.

E.1.8 Assisted Living

Among HCBS options is assisted living, which is described in detail within Section 4.

E.1.9 Increasing Role and Influence of Technology

With the growing adoption and affordability of smart devices and tablets, technology solutions are positioned to provide greater possibilities for aging in one's home. An example of this would be CareMore, a Medicare Advantage program that utilizes purpose-built clinics in combination with remote monitoring technologies and call centers to help seniors age in place, most often in their homes. While such technologies and innovative solutions will help aging in place in one's home, it should also be noted that these advances should also represent opportunities for seniors housing to deliver higher quality of care at potentially less cost.

E.2 Institutional

Institutional alternatives to nursing care include inpatient rehabilitation facilities and long-term acute care hospitals. Each of these is offered in the traditional institutional setting. These primarily act as alternative services for the short-stay nursing care resident who requires rehabilitative services with the goal of returning home.

E.2.1 Inpatient Rehabilitation Facilities (IRFs)

Inpatient rehabilitation hospitals are licensed and certified properties, which primarily promote special rehabilitative health care services rather than general medical and surgical services. Rehabilitation is defined as restoration of a disabled person to self-sufficiency or maximal possible functional independence. An inpatient rehabilitation program utilizes an interdisciplinary coordinated team approach that involves a minimum of three hours of rehabilitation services daily. These services may include physical therapy, occupational therapy, speech therapy, cognitive therapy, respiratory therapy, psychological services, prosthetic/orthotic services or a combination thereof.

E.2.2 Long-Term Acute Care Hospitals

Long-term acute care hospitals (LTACHs) specialize in managing the complex medical care and rehabilitation of residents with multiple acute health care needs. Programs are designed to medically stabilize and strengthen residents so they can return to their highest level of function. Many LTACH residents are admitted directly from short-stay hospital intensive care units with respiratory/ventilator-dependent or other complex medical conditions. A resident's average length of stay is between 25 and 30 days. LTACHs are equipped to treat a wide range of residents. LTACHs differ from chronic care settings in that they focus on treating critically ill or high-acuity residents in an intensive way, using specialized treatment programs geared to the resident's illness and requirements. The goal is medical recovery and return to the home and family.

The first generations of LTACHs were located in freestanding properties and were established in the early 1980s. The second generations of LTACHs employ the "hospital-within-a-hospital" (HWH) model. Under this approach, a third-party-owned acute care hospital occupies part of a building used by another "host" acute care hospital. An HWH-type LTACH must be separately owned and licensed, maintain a separate board and administrative structure, and have a separate medical staff. Under this model, the LTACH usually leases space from the host hospital and purchases ancillary services (e.g., food services, housekeeping, laboratory, etc.) from the host.

The following are some of the more common types of medical conditions appropriate for a LTACH:

- Respiratory conditions, including ventilator support;
- Wound and skin conditions;
- Circulatory disorders with varying medical complexity;
- Digestive system disorders of varying complexity;
- Stroke residents as an alternative to nursing care;
- Cardiovascular disease;
- Congestive heart failure;
- Renal failure requiring hemodialysis; and
- Neurological disease and complications.

Appendix F:
Development Considerations

This appendix discusses lease-up trends, market feasibility assessment and miscellaneous costs that can occur during construction.

F.1 Lease-up Trends

The following exhibits show the median occupancy, by care segment, of newly opened properties by the number of quarters the segment has been open. The data blends together properties in the top 31 metropolitan markets since the fourth quarter of 2005 and properties in the secondary markets since 2008. To help assess upside and downside probabilities, the exhibits outline the realized range for the 25th and 75th percentiles as well.

For independent living care segments that opened during this period, the median community took 12 quarters (three years) to reach 92 percent occupancy. At the same time, the lowest-performing quartile of these communities had less than 76 percent occupancy and the highest quartile had above 98 percent. In subsequent years, median occupancy was 92 to 94 percent and the lowest quartile ran in the mid-80s percent and below. (Note: the lowest quartile is not always comprised of the same communities, as low-performers improve and previously strong performers slip). The median size of an independent living segment opened during this period was 114 units.[1]

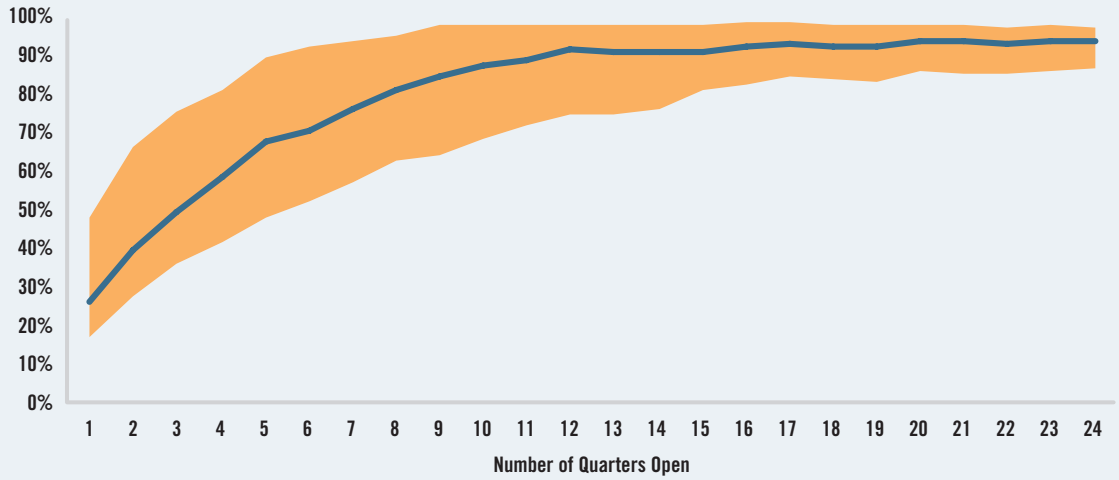
For assisted living, the median community took eight quarters (two years) to reach 92 percent occupancy. At the same time, the lowest quartile of these communities had less than 79 percent occupancy and the highest quartile had above 98 percent. In subsequent years, median occupancy was 92 to 96 percent and the lowest quartile ran in the high 80s percent and below. The median size of an assisted living segment opened during this period was 52 units.[1]

For memory care, the median community took eight quarters (two years) to reach 93 percent occupancy. At the same time, the lowest quartile of these communities had less than 79 percent occupancy and the highest quartile had 100 percent. In subsequent years, median occupancy was 92 to 97 percent and

Exhibit f.1

Median Occupancy of Independent Living Care Segments

By Number of Quarters Open



Note: Shaded region represents interquartile range.
Source: NIC MAP® Data Service

the lowest quartile consistently ran in the high 80s percent and below. The median size of a memory care segment opened during this period was 24 units.[1]

For nursing care, the median community took 10 quarters (2.5 years) to reach 92 percent occupancy. At the same time, the lowest quartile of these communities had less than 81 percent occupancy and the highest quartile had above 97 percent. In subsequent years, median occupancy was 92 to 93 percent and the lowest quartile consistently ran in the mid-80s percent and below. The median size of a nursing care segment opened during this period was 108 beds.[1]

F.2 Market Feasibility

To find the best places and products to develop, the industry has created various feasibility methods.

Demand is estimated using several statistics. For many independent living projects, income-qualified seniors households are the primary demand indicator. A commonly used metric is households aged 75-plus with $35,000+ income, which indicates some source of income beyond Social Security is needed to pay for seniors housing. Assisted living and memory care demand is often estimated by looking at both income-qualified seniors and income-qualified adult children, since the children are often significant influencers in the purchase decision and sometimes payers. A commonly used metric to gauge income-qualified adult children is households aged 45-64 with income $75,000+.

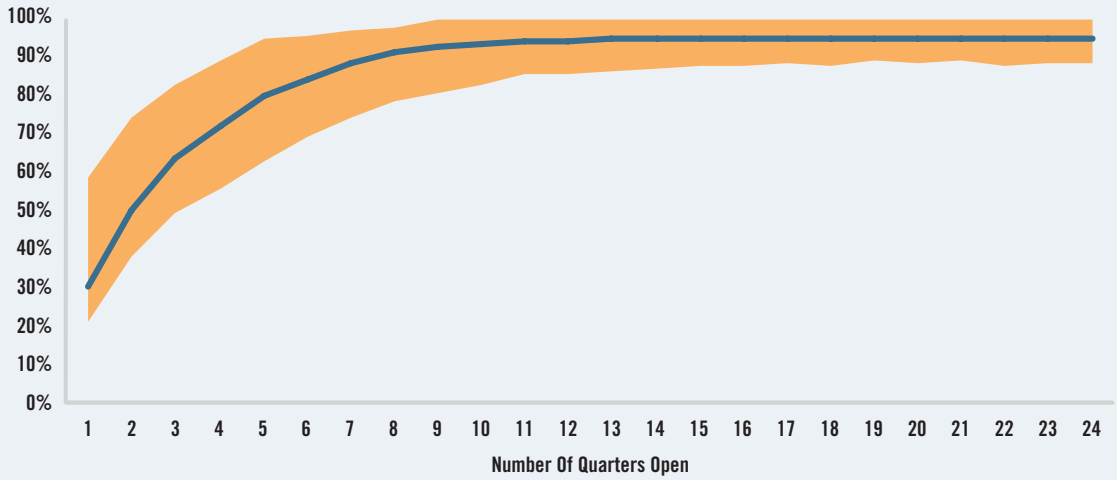
Nursing care properties typically serve three demand pools: Medicare recipients, who primarily receive short-term rehabilitation services; Medicaid recipients, lower-income individuals who primarily receive long-term care services; and "other payor" residents, whose nursing services are paid for by private insurance companies and/or individuals. Low Medicaid reimbursements typically cannot justify new development, leading the other two categories to be the key demand drivers of new projects.

To calculate these demand statistics, a primary market area (PMA) is defined. PMAs can vary widely depending on whether a site is urban, suburban, or rural; whether it is upscale or downscale compared to surrounding neighborhoods; and

Exhibit f.2

Median Occupancy of Assisted Living Care Segments

By Number of Quarters Open



Note: Shaded region represents interquartile range.
Source: NIC MAP® Data Service

whether it is split by psychographic, geographic or physical barriers. Nonetheless, for typical suburban independent living, assisted living or memory care development, a 10-to-15 minute drive time or five-mile radius is often considered a reasonable approximation of a PMA. For nursing care development, demand is clustered both around where potential residents live and where hospitals are located. Hospital referrals are an important part of high-reimbursing Medicare demand; therefore, many nursing care developments choose to locate nearer to the hospitals than to seniors' homes.

Once the basic demand statistics are calculated, often feasibility consultants will attempt to further narrow demand estimates by applying additional qualification criteria. For Medicare demand, one important qualifier is the nursing care utilization rate in a given geography. Other qualifiers sometimes used are estimated rates of dementia or the proportion of the population that needs assistance with activities of daily living (ADLs).

Limitations exist, however, as to how accurately demand can be estimated simply by demographic factors, particularly for independent living, assisted living, and memory care. To calculate a "net need" statistic requires a viewpoint, for example, on how much assisted living demand should exist per 100 qualified seniors. By such reasoning, markets with low supply penetration should enjoy high occupancies because they have few competitors chasing a pool of demand, while markets with high supply penetration should have lower occupancy because they are saturated with supply. However, analysis of industry data shows relatively low correlation rates between supply penetration and occupancy. Many markets with high supply penetration have high occupancies (such as southeast Pennsylvania) due to seniors there having decades of familiarity with seniors housing, while many markets with low supply penetration (such as Las Vegas) have low occupancy, likely because local seniors lack familiarity with the seniors housing product.

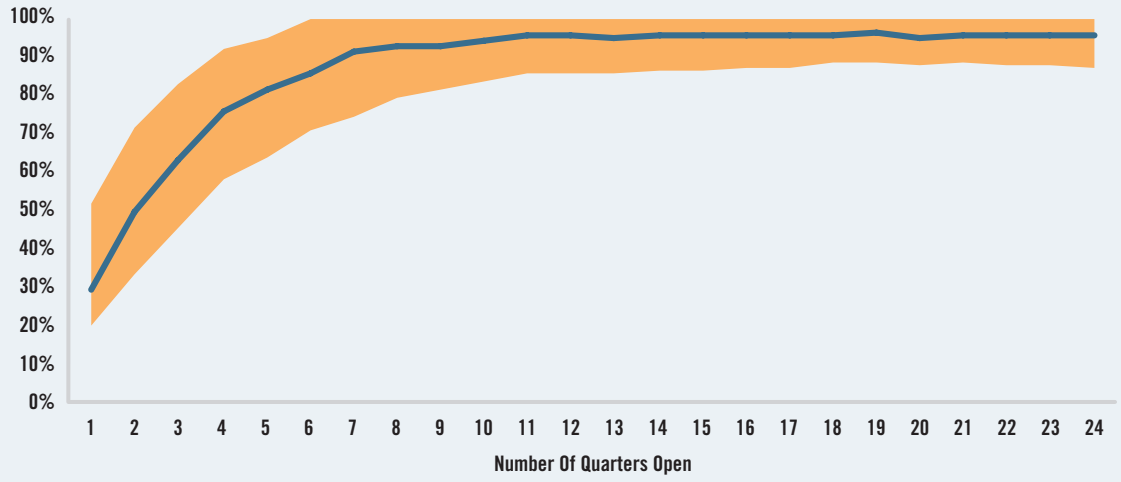
An alternative methodology employs the use of an empirically derived capture rate among age-income qualified households within a PMA with adjustments made to estimate the influence of competitive senior living communities within the PMA.

Some feasibility professionals stress the importance of competitor occupancies in assessing opportunity for new

Exhibit f.3

Median Occupancy of Memory Care Segments

By Number of Quarters Open

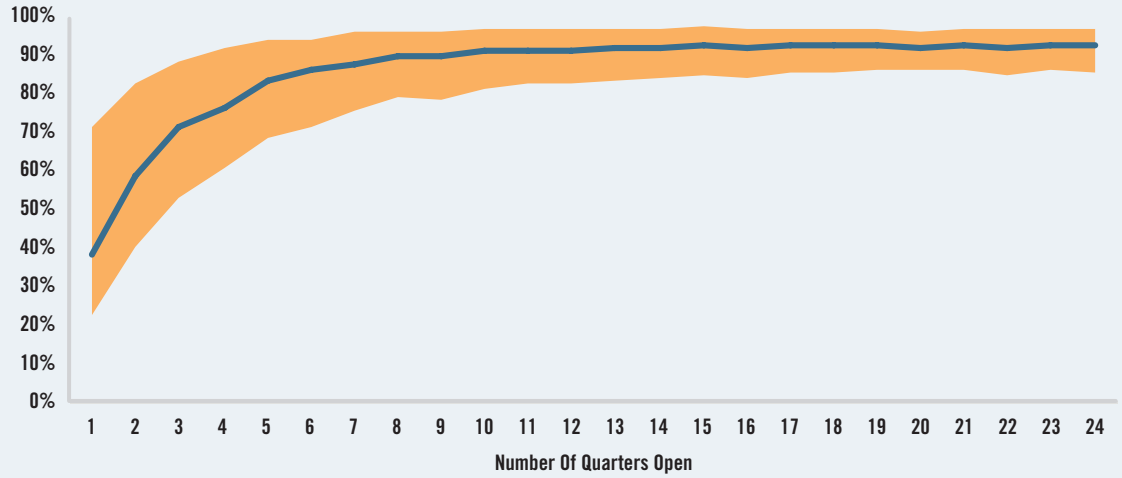


Note: Shaded region represents interquartile range.
Source: NIC MAP® Data Service

Exhibit f.4

Median Occupancy of Nursing Care Segments

By Number of Quarters Open



Note: Shaded region represents interquartile range.
Source: NIC MAP® Data Service

development. If a local market's competitors are full, they reason, the market may have room for additional supply, regardless of the market's penetration rate. If competitors are only 80 percent full, however, that is a sign the market has more supply than is currently demanded.

Two additional factors complicate supply/demand estimates in market feasibility: 1) Even in a market with ample supply, some supply may be tired and unappealing so a new development has an opportunity to take market share; 2) Industry data shows a correlation between new supply being added to a market and an increased pace of supply absorption, suggesting that, to some extent, new supply stimulates additional demand (although, unfortunately for developers, not enough demand growth to broadly support a "build-it-and-they-will-come" approach).

Another key factor in market feasibility is to understand what revenue can be charged in a market. While on-the-ground research is still the best way to assess local competitor performance, the NIC MAP® Local service (affiliated with the publishers of this publication) offers its subscribers data on the rates and occupancies of clusters of local competitors surrounding a potential development site.

Beyond factors described above, most market feasibility analysts will assess additional factors such as site location, market affluence, quality of existing supply, population growth rates and barriers to entry.

F.3 Furniture, Fixtures and Equipment (FFE)

A project's FFE costs may vary significantly based on the intended market, but the cost is typically somewhere between the costs of those for a multifamily and hotel project. Unlike multifamily, seniors housing's more extensive service package includes meals, health care, and activities that generate higher FFE costs. Unlike hotels, independent living, assisted living and memory care units are usually provided unfurnished to residents. Nursing care costs for FFE are above those of other seniors housing segments, due to the need to fully outfit each unit with an electric bed, a flat-screen TV, and various types of durable medical equipment.

Pro forma FFE costs should include procurement, shipping, warehousing and arrangement. Some development agreements also include the initial provisioning of consumables needed to open a property.

F.4 Municipal Fees

For infrastructure, various fees are paid to governments and public entities to cover their expenses for extending the utilities (e.g., sewer, water, telephone, electricity) and roads to

the property. Independent living properties often have costs comparable to those of multifamily, since each unit is treated by many utilities and municipalities as a separate apartment. Assisted living and memory care properties sometimes have lower hook-up costs since they often lack a full kitchen in each unit. Nursing care properties also sometimes have lower infrastructure fees, since they are viewed as a single integrated health care building.

Nursing care properties also sometimes have lower infrastructure fees, since they are viewed as a single integrated health care building.

Primarily at the permitting stage, governments charge various approval fees: plan review fees, building permits, and permits for roadway, sewer, water, storm water, and health and fire, among others. Nursing care properties also need to obtain a certificate of need (CON) to operate in most states, while a CON is needed for assisted living in some states as well.

F.5 Professional Fees

Specific seniors housing expertise is particularly useful in several professional areas, as described below.

F.5.1 Architects

Considerable innovation in building design has occurred to create an environment that allows seniors to maintain autonomy and dignity while reducing property operating expense. To pick one example, short hallway runs allow a frail senior to walk himself or herself to the dining room, whereas a longer hallway run may cause a senior to ask an aide to walk slowly alongside. In addition, a qualified architect helps ensure that local building codes and state health regulatory requirements are reconciled: state licensing frequently occurs upon completion of construction, which is an unfortunate time to find out something was missed.

F.5.2 Interior Designers

Interior designers must understand both the marketing and operations of seniors housing. A good designer, for example, needs to pick a sofa covering that can handle the inevitable moments of resident incontinence while not feeling or looking cheap like the vinyl furniture in an old-school nursing care property.

F.5.3 Developers

Myriad development decisions must be attuned to seniors' needs: positioning the property—through location, product design, price, promotion—to compete effectively; picking an architect, a designer and an operator; and programming the right mix of care segments and unit types, among other decisions. For the development of nursing care properties, additional expertise is needed to obtain CONs. For the development of CCRCs, expertise in obtaining continuing care provider permits is required.

Appendix G:
Underwriting Criteria and Financing Terms

This section discusses the underwriting criteria and financing terms of the primary capital sources used for seniors housing and care properties.

G.1 Fannie Mae and Freddie Mac

Exhibit g.1
As of 4Q13

	Fannie Mae	Freddie Mac
Property Type	IL/AL/MC; properties may include a small percentage of NC as part of a continuum of care (case by case basis)	IL/AL/MC; properties may include a small percentage of NC as part of a continuum of care (case by case basis)
Transaction Type	Acquisition; refinance; tax exempt bond financing*	Acquisition; refinance; tax exempt bond financing*
Max LTV	75% (no cash out) & 70% (cash out) for IL, AL & combination properties 70% (stand-alone MC or inclusion of NC beds) Reduce 5% for < 7 year term & supplemental loans	75% (no cash out) & 70% (cash out) for IL, AL & combination properties 65% MC Reduce 5% for < 7 year term
Min. DSCR	1.30x (IL) 1.40x (AL) 1.45x (MC) 1.50x (any property with NC beds) Use weighted average DSCR for combination properties Add 5 bps for co-terminus supplemental Loans	1.30x (IL); add 5 bps for cash out refinance 1.40x (AL); Add 5 bps for cash out refinance MC (case by case basis) Add 5 bps for cash out refinance Add 5 bps for a term less than 7 years
Occupancy	90% average - trailing 12 months (IL) 90% average - trailing 15 months (AL/ MC)	90% for 90 days (IL/AL/MC)
Sponsors	For profit and not-for-profit	For profit and not-for-profit
Owner/ Operator	Min 5 properties/5 years' experience	Min 5 properties/5 years' experience
Borrower	Single-asset entities	Single-purpose entities
Min. Loan Amount	Generally, $5 million	Generally, $5 million
Max. Loan Amount	None	None
Term	5 to 30 years	5 to 30 years
Amortization	Generally, 30 years	Generally, 30 years
Interest Rate	Fixed over T-Bill Variable over LIBOR	Fixed over T-Bill Variable over LIBOR
Prepayment	Yield maintenance or defeasance (fixed) Graduated prepayment (variable)	Yield maintenance or defeasance (fixed) Graduated prepayment (variable)
Escrow	Property taxes, insurance, replacement reserves	Property taxes, insurance, replacement reserves
Capital Reserves	Potentially, immediate repairs	Potentially, immediate repairs
Collateral	First mortgage	First mortgage

Source: KeyBank

* See separate table for tax-exempt financing.

G.1 HUD

Exhibit g.2

As of 4Q13

Eligible Property Type	AL/MC/NC; 25% or less of total units can be IL units
Transaction Type	Acquisition; refinance; construction; substantial rehabilitation
LTV	Up to 75% REITs, up to 80% for profit, up to 85% not-for-profit
Min. DSC	1.45x
Occupancy	Market occupancy determined with market study
Sponsors	For profit and not-for-profit
Sponsor Criteria	Owner & operator experienced with seniors housing and healthcare assets
Borrower	Bankruptcy remote single asset entity
Min. Loan Amount	N/A
Max. Loan Amount	Subject to headquarters review and approval; HUD-determined cap rates prevail
Term	Acquisition/refinance: lesser of 35 years or 75% of remaining economic life New construction: 40 years
Amortization	Fully amortizing, matching loan terms
Interest Rate	Fixed rate + 65 bps Mortgage Insurance Premium (MIP) on principal balance
Prepayment	Generally, 2-year lockout then eight years graduated prepayment premium, 1% thereafter.
Escrows	Property taxes, insurance, and replacement reserves.
Reserves	Potentially, for capital improvements or debt service
Collateral	Blanket first lien on real estate, operating license and major-movable assets

Source: KeyBank

G.1 Commercial Banks

Exhibit g.3
As of 4Q13

	PROPERTY TRANSACTION TYPES LTV	IL/AL/MC/NC Acquisition/Refinance Up to 75%	IL/AL/MC/NC Construction Up to 70%
Underwriting Criteria	Min. DSC	1.35x - 1.55x (IL/AL/MC) 1.40x - 1.50x (NC) Generally, min DSC is also needed for refinance test using appraisal stabilized NOI plus stressed note rate, i.e., a rate higher than actual or underwritten rate	1.35x - 1.5x (IL/AL/MC) 1.40x - 1.50x (NC) Based on underwritten Proforma NOI. A min debt yield may be used with annualized NOI divided by loan amount
	Occupancy	No minimum or appraisal stabilized occupancy	Underwritten at 90%, stabilized or appraisal stabilized occupancy
	Sponsors	For-profit and not-for-profit; experienced owner/operators; institutional investors	For-profit and not-for-profit; experienced owner/operators; institutional investors
	Sponsor Criteria	Experienced owners/operators with scale and consistent cash flow. Analysis will be performed of sponsors' liquidity, projects in development (if any), amount of contingent liabilities, state of REO, free cash flow, schedule of debt maturities/refinance risk	Experienced owners/operators with scale and consistent cash flow. Analysis will be performed of sponsors' liquidity, projects in development (if any), amount of contingent liabilities, state of REO, free cash flow, schedule of debt maturities/refinance risk
	Guarantee	Personal or corporate guarantee may be required subject to sponsor strength, market, asset quality and performance. Burn down of guarantee possible during the term of the loan subject to asset performance.	Generally, 100% completion guarantee required. Some personal or corporate guarantee may also be required subject to sponsor strength, experience, asset quality, and market. Burn down of guarantee possible during the term of the loan subject to asset performance.
Financing Terms	Borrower	Single asset entity; obligated groups; parent corp. plus subsidiaries	Single asset entity; obligated groups; parent corp. plus subsidiaries
	Min, Loan Amount	$5 million - $10 million	$5 million - $10 million
	Term	Generally, up to 5 years including extensions; some lenders will go up to 10 years	3 - 4 years including extension options
	Amortization	25 - 30 years	Interest only during construction, then 25 - 30 years amortization
	Interest Rate	LIBOR + 200 - 400 bps	LIBOR + 275 bps and up
	Prepayment	No	No
	Escrow	Taxes and insurance may be waived subject to underwriting	Taxes and insurance may be waived subject to underwriting
	Reserves	$300 - 500/unit (IL/AL/MC/NC) subject to property condition and underwriting	Generally, construction and lease-up interest reserves funded until property has positive cash flow after interest payment
	Collateral	First mortgage	First mortgage

Source: KeyBank, PNC Real Estate, Bank of The West

G.4 Commercial Finance Companies

Exhibit g.4

As of 4Q13

Underwriting Criteria	Property Type	IL/AL/MC/NC
	Products	Senior mortgage debt; mezz debt; preferred equity; AR financing
	Transaction Type	Construction/addition/renovation; acquisition; refinance; stabilized; pre-stabilized; turnaround
	LTV	Up to 80 - 85%; mezz debt up to 90%; preferred equity up to 95%
	Min, DSC	None
	Occupancy	No mandatory minimum
	Sponsors	Local, regional, and national operators
	Sponsor Criteria	Large local/experienced owner/operator with a strong track record
Financing Terms	Borrower	Special purpose entities
	Min, Loan Amount	$3 - $5 million senior debt; $1 million mezz debt
	Max, Loan Amount	$250 million real estate; $250 million A/R secured working capital
	Term	Up to 5 years
	Amortization	20 - 30 years; interest only period possible
	Interest Rate	Fixed and floating
	Prepayment	Declining prepayment & other options
	Escrow	R/E taxes, insurance
	Reserves	Min. $350/bed or unit

Source: MidCap Financial, Contemporary Capital

G.5 Life Companies

Exhibit g.5

As of 4Q13

Underwriting Criteria	Property Type	IL/AL/MC/NC
	Products	Permanent loans & participations
	Transaction Type	Pre-stabilized; stabilized; acquisition; refinance
	LTV	Lower leverage; but will go to 70 or 75% case by case
	Min. DSC	None
	Occupancy	No mandatory minimum
	Sponsors	Well-capitalized, experienced seniors housing owner-operators
Financing Terms	Borrower	Special purpose entities
	Min. Loan Amount	$10 million
	Term	Fixed: 5 - 20 years; floating: 3 years plus extensions
	Amortization	Up to 30 years
	Interest Rate	Fixed and floating
	Prepayment	Fixed: yield maintenance; floating: lockout period or LIBOR floor
	Escrow	R/E taxes, insurance sometimes waived
	Reserves	Amount variable

Source: Prudential, KeyBank

G.6 Tax-Exempt

Exhibit g.6

As of 4Q13

Underwriting Criteria	Property Type	IL/AL/NC/CCRCs	IL/AL/NC/CCRCs
	Transaction Type	Acquisition/refinance for AL/NC/CCRC	New construction for IL/AL/NC/CCRC
	Min, DSC	1.30x	1.30x
	Occupancy	85% minimum	70% pre-sales
	Sponsors	Not-for-profit	Not-for-profit, for-profit
	Sponsor Criteria	Strong viable sponsor	Strong viable sponsor
Financing Terms	Borrower	Single asset entity; obligated group	Single asset entity; obligated group
	Min, Loan Amount	$5 million	$5 million
	Max, Loan Amount	No limit	No limit
	Term	30 Years	30 - 35 Years
	Amortization	Level	Level
	Interest Rate	4.0 - 6.0%	7.25 - 7.75%
	Prepayment	10-year call protection	10-year call protection
	Reserves	One-year Debt Service Reserve Fund (DSRF)	One-year Debt Service Reserve Fund (DSRF)
	Security	First mortgage, gross revenues pledge	First mortgage, gross revenues pledge; liquidity support agreement

Source: Ziegler

G.7 REITs

Exhibit g.7

As of 4Q13

		IL/AL/MC	Nursing Care
Target Opportunities	Transaction Structure	Triple-net lease, operating (i.e., RIDEA/TRS), joint venture	Triple-net lease
	Operational Performance	stabilized, lease-up or turn-around opportunities	Stabilized, high quality mix or positive trend preferred
	Market	Above average 75+ seniors growth and low percentage (< 10%) of construction as a % of inventory	Above average 75+ seniors growth and low percentage (< 10%) of construction as a % of inventory
	Demographics	Top 100 MSA or better	Top 100 MSA or better
	Sponsors	Local, regional and national operators	Local, regional and national operators
	Sponsor Criteria	Experienced with a solid track record	Experienced with a solid track record
Lease Terms (Stabilized)	Yield	6.0% - 8.0%, plus annual escalator	8.0% - 10.0%, plus annual escalator
	Term	10 - 15 Years, plus renewal options	10 - 15 Years, plus renewal options
	Escrow	Property taxes, insurance, replacement reserves	Property taxes, insurance, replacement reserves
	Capital Expenditures	Minimum annual expenditure per unit	Minimum annual expenditure per unit
	Financial Covenants	Minimum EBITDAR to rent ratio	Minimum EBITDAR to rent ratio
		Minimum occupancy	Minimum occupancy
	Security Deposit	Yes	Yes
	Guarantor	Creditworthy entity and/or key principals	Creditworthy entity and/or key principals

Appendix H:
General Legal Requirements

Seniors housing and care properties are subject to a number of federal, state, and local laws, and, depending upon the property type, may be subject to laws that are generally applicable to real estate, operating businesses, and health care, and, in the case of continuing care retirement communities (CCRCs), insurance regulation. Applicable federal laws include, but are not limited to the Americans with Disabilities Act and the Fair Housing Act (except to the extent that state analogs exist). State and local laws—such as zoning, building code, landlord and tenant, health code, and employment laws—may apply. In addition to generally applicable laws, seniors housing and care properties are subject to laws specific to the property types as detailed below.

H.1 Independent Living Properties

Except for local age restrictions (i.e., limiting occupants to age 55-plus or 62-plus), the regulation of independent living is similar to that of traditional multifamily apartments. A new independent living property requires, at a minimum, a certificate of occupancy and may, if applicable, require a food establishment operating permit. Depending upon the location and property, a number of other local laws may be applicable.

H.2 Assisted Living Properties

Assisted living properties are regulated in all states, but there are considerable differences among the states. Most state regulations are focused on the following:[21]

- Philosophy of care;
- Resident rights;
- Admission agreements, including terms of such agreements;
- Resident funds, including the safeguarding or accounting of funds;
- Care plans and care plan updates;
- Elder abuse prevention;
- Mandatory resident services, such as the number of meals, activities of daily living (ADLs) care, transportation, housekeeping and laundry, activities, health-related services including medications management and medication storage, and monitoring;
- Permitted services, such as medication assistance and administration, and intermittent nursing (short of 24-hour care);
- Staff and staffing requirements, including administrator education, continuing training, and availability, and nursing staff (RN, LPN, CNA, etc.) education requirements, additional training, and required hours given the size of the property;
- Mandatory discharge criteria, under which residents must be discharged by law from the property;
- Physical plant requirements, such as the number of toilets and baths/showers and the square footage required per resident, and other amenities that must be provided in resident units;
- Life safety requirements that apply to assisted living found in the building codes; and
- Egress restrictions on doors and windows subject to regulation for assisted living/memory care buildings.

In recent years, as a more cost-effective alternative to nursing care properties, many states have been granted federal waivers to use Medicaid monies in "home- and community-based care" including in assisted living properties.

In addition, all states require an assisted living license or certification to operate a property, often with the requirement to undergo an annual or semiannual state inspection. Licensing, level of resident care, and ownership requirements vary by state. Some states require a CON, or certificate of need (sometimes referred to as a determination of need, and information regarding this type of certificate can be found at a website maintained by the National Conference of State Legislatures, http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx), issued by the relevant state regulatory agency. A CON application typically must demonstrate an unmet assisted living demand in the area prior to opening a new assisted living property. Some states also require food service licenses under certain circumstances.

The creation of special units within an assisted living property reserved for specific types of residents is a recent trend in

assisted living care. Common types of assisted living units include Alzheimer's, dementia, and memory care units. Such units are often subject to additional regulatory requirements, including resident admission and discharge criteria, and additional staff training. State law governs the regulations and licensing requirements for special assisted living units and there is variation in the requirements from state to state. Further, these types of special units are not authorized in all states.

H.3 Nursing Care Properties

Nursing care properties are a highly regulated segment of seniors housing and care because they actually provide health care services and the federal government is the predominant payor, by way of Medicare and Medicaid. Other payer sources include private long-term care insurance companies and residents who pay from their own resources. In particular, properties receiving Medicare and Medicaid funding must adhere to strict regulations to ensure that residents ". . . attain or maintain the highest practicable physical, mental, and psychosocial well-being."

H.3.2 Federal Level

Legislation enacted in the 1960s broadened both the federal role in purchasing services and in setting specific regulations governing services provided at nursing care properties, methods and amounts of payment for such services. The enactment of the 1987 Omnibus Budget Reconciliation Act (OBRA) established the modern-day standards for the vast majority of properties accepting Medicare and/or Medicaid funding. These regulations are detailed in the Code of Federal Regulations (42 CFR Part 483) and cover the following areas:

- Requirements to ensure and communicate residents' rights;
- Admission (including resident assessment), transfer, and discharge regulations;
- Minimum nursing staff and staffing standards;
- Required staff training hours and content;
- Dietary services, including staffing, nutritional requirements, and food palatability;
- Activities;
- The obligation to provide or arrange for all of the residents' care needs;
- Property and room environment, size, sharing, and standards requirements;
- Physician services, other medical care (rehab, dental, pharmacy); and
- Mental health services.

Furthermore, the U.S. Department of Health and Human Services (DHHS) delegates administrative responsibility for the regulations, funding, training and overall policy making to the Centers for Medicare and Medicaid Services (CMS). CMS then delegates the certification, survey assessment, and enforcement of the regulations to each state survey agency (SSA).

H.3.2 State Level

States require licensure to operate a nursing care property. In addition, approximately two-thirds of states require a CON for new properties, additional beds, changes in ownership, or for capital expenditures above a threshold level. Depending on the state, changes in ownership may require a Change in Effective Control or Change of Ownership application and approval of the same by the relevant state regulatory agency. The change of ownership requirements may be in addition to or in place of the CON requirements. Lastly, some states have instituted a moratorium on new nursing home beds, subject to certain exceptions, such as the building of a replacement property.

In addition to the initial recommendation to CMS for certification of a property, each state's SSA surveys properties regularly on unannounced visits for compliance with regulations. These surveys usually occur every nine to 15 months and include both health and Life Safety Code (LSC) reviews, as described below.

H.3.2.a Health Surveys

Health surveys comprise more than 150 areas related to care and life in the nursing care property. The surveyor team includes social workers, dieticians, at least one registered nurse, and professionals of other disciplines. In general, industry operators consider health care deficiencies on surveys to be the most significant and serious of the survey outcomes.

H.3.2.b Life Safety Code Surveys

Life Safety Code (LSC) surveys rely on the LSC standards set by the National Fire Protection Agency (NFPA). The surveyor team consists of engineers, architects and fire safety specialists. Nursing care properties with a waiver from the health occupancy provision of the LSC or which have a plan of correction to ameliorate deficiencies are considered in compliance with standards.

CMS has generally reported the results of these surveys on its website. CMS reports nursing care property survey results using a five-star quality rating system. The purpose was to help consumers, families and caregivers by simplifying the comparison process of nursing care properties. The scoring range is one to five stars: nursing care properties with five stars are much above average, and nursing care properties with one star are much below average.

Each property has an overall quality rating, in addition to separate ratings for its health inspection, staffing inspection, and physical and clinical quality measures (CMS maintains a website with an explanation of and links to overviews and other relevant information relating to the five-star quality rating system: https://www.cms.gov/CertificationandComplianc/13_FSQRS.asp. It also maintains a website that allows comparisons of various nursing homes' ratings: http://www.medicare.gov/nursinghomecompare/search.html). In addition, the health care reform legislation enacted by President Obama ties certain Medicare reimbursement rates for nursing homes services to the applicable nursing home's rating.

H.3.2.c Extra-Regulatory Considerations

Created under the Older Americans Act and overseen by the Federal Administration on Aging, the long-term care ombudsman program is now present in every state. The purpose is to help resolve complaints made by long-term care property residents or their friends/families, to educate operators and the general public about residents' rights, and to be advocates for long-term care property residents.

H.3.2.d Penalties

When a nursing care property fails to meet regulation standards, and depending on the severity of the deficiencies cited, CMS may impose penalties that include fines, temporary denial of funding, suspension of admissions, or termination of the property's operator status. After deficiencies have been cited during a surveyor team visit and the property implements an acceptable plan of correction, the SSA revisits the property to ensure the regulations have been met.

Egregious noncompliance results in the installation of a temporary manager or closure of the nursing care property. Placement of a nursing care property on the Special Facility Focus (SFF) list subjects the property to surveys on a more frequent basis (i.e., every six months) and notification to the public of the property's status as an SFF property.

All entities, including nursing care properties, that bill Medicare and/or Medicaid are subject to the federal False Claims Act based on information provided by the nursing care property in connection with reimbursement claims and face exposure to large potential liability for filing reimbursement claims deemed to contain false representations regarding quality of care, nature of services provided and/or any other material components of the reimbursement claim. In particular, properties should pay attention to the billing practices of third-party vendors, such as occupational, physical, or speech therapy providers that deliver services at the property. Depending upon the terms of the billing arrangement, improprieties on behalf of the third-party vendors, may subject the nursing property to liability.

H.4 Memory Care Properties

Laws and guidelines for memory care properties vary widely. Generally, operators must at a minimum adhere to all the regulations of independent living and assisted living properties. While some states have no guidelines specific to memory care properties, more than half of the states detail the admission and retention criteria of individuals with cognitive impairments. In addition, many states describe memory care–specific programs in their assisted living regulations, including safety (particularly exit controls), staffing levels and specialized training, medication management and disclosure of the memory care special care unit itself.

Furthermore, those operators who receive Medicaid reimbursement for specialized memory care/nursing care beds must also adhere to the CMS guidelines described in Appendix J.

H.5 Continuing Care Retirement Communities

The CCRC industry is regulated by the federal-, state- and municipal-level agencies that oversee the types of care available on campus, such as assisted living and nursing care. For instance, if a property offers nursing care units on campus for its residents, it must obtain the appropriate state and federal licensure and certificates. Some CCRCs receive Medicare reimbursement for sub-acute residents, but operate their long-term care beds on a private pay basis without Medicaid certification or funding.

At the federal level, the Fair Housing guidelines apply to CCRCs. In particular, if a CCRC offers fee-for-service care, questions used during the screening process regarding the prospective resident's health should be limited to those relevant to the type and scope of care the property may need to provide to that individual. Because CCRCs frequently guarantee continued residency and care if a resident becomes unable to pay the monthly costs of residency and also for long-term care, CCRCs typically qualify prospective residents with respect to their financial and health conditions. These questions may be similar to those used under health insurance underwriting processes since the circumstances are similar. Additionally, many CCRCs operate with tax-exempt status, which prescribes restrictions on the activities in which the CCRC can engage without losing the exemption.

At the state level, most laws regulate the financial circumstances and activities of CCRCs with a focus on mandatory disclosures to

residents, required terms of residency agreements, and the handling of entrance fees. In general, entrance fee CCRCs are more heavily regulated because many states categorize and regulate the entrance fees as insurance contracts.

Most states regulate some or all of the following areas of entrance fee CCRCs:[21]

- Application and CCRC disclosures as well as requirements around the distribution of financial statements (to the state and/or the resident);
- Escrow requirements, including the factors that influence releasing resident entrance fees from escrow;
- CCRC minimum sales requirements before development can begin, license applications, and/or final certification from the state (to protect residents and potential residents from project risks);
- Required reserve levels, usually calculated with a formula using the amount of deposits received, costs of operations, and/or entrance fee refund obligations;
- Requirements for surety bonds, if any;
- Contract terms, particularly around the refund of the entrance deposit under early termination circumstances or upon death;
- Advertising content and whether the state governing agency must approve advertisements; and
- Residents' rights to organize into associations and/or rights to a seat on the board of directors.

CCRCs operating as nonprofit entities must comply with state nonprofit laws. In addition, the Continuing Care Accreditation Commission (CCAC), now part of the Commission on Accreditation of Rehabilitation Facilities (CARF) assesses the quality of services and financial performance of CCRCs and offers an accreditation program for CCRCs. CARF offers accreditation programs for other types of seniors housing, including nursing homes and assisted living properties. Additional information regarding accreditation and CARF-CCAC is available at www.carf.org.

Appendix I:
Medicare and Medicaid

This appendix provides a brief overview of the federal Medicare program and the federal- and state-administered Medicaid program. In addition, long-term care insurance, the Veterans Administration Aid and Attendance program, and other commercial and government sources of income/funding also underwrite some of the costs associated with seniors housing and care.

I.1 Medicare

Medicare is a federal program that provides certain health care benefits to eligible beneficiaries. Medicare eligibility is generally available to individuals 65 years of age or older, individuals younger than 65 with qualifying permanent physical disabilities, and individuals with certain qualifying conditions, most notably end-stage renal disease. Medicare provides health insurance benefits in two primary parts or services.

I.1.1 Medicare Part A

Hospital insurance that provides reimbursement for inpatient services for hospitals, nursing care properties and certain other health care operators and residents requiring daily professional nursing care and other rehabilitative care. Coverage in a Medicare participating nursing care property is limited for a period of up to 100 days, if medically necessary, after the individual has qualified for Medicare coverage as a result of a three-day or longer hospital stay. Medicare pays for the first 20 days of a stay in a nursing care property in full, and the next 80 days to the extent above a daily coinsurance amount. Covered services include supervised nursing care, room and board, social services, pharmaceuticals and supplies, as well as physical, speech and occupational therapies, and other necessary services provided by nursing properties. Medicare Part A also covers hospice care.

I.1.2 Medicare Part B

Supplemental Medicare insurance that requires the beneficiary to pay monthly premiums and covers physician services, limited drug coverage and other outpatient services, such as physical, occupational and speech therapy services, nutrition, certain medical items and X-ray services received outside of a Part A covered inpatient stay.

To achieve and maintain Medicare certification, a health care operator must meet the Centers for Medicare and Medicaid Services (CMS) “Conditions of Participation” on an ongoing basis, as determined in the property survey conducted by the state in which the operator is located.

Medicare reimburses nursing care properties under a prospective payment system (PPS) for inpatient Medicare Part A covered services. Under the PPS, properties are paid a predetermined amount per resident per day, based on the anticipated costs of treating residents. The amount to be paid is determined by classifying each resident into a resource utilization group (RUG) category, which is based upon each resident’s acuity level. Each RUG encompasses estimates for all costs associated with treating a resident in the applicable RUG, including routine, ancillary and capital costs. Payment rates are then adjusted for geographic variations in wages and other costs. Nursing care properties are required to submit Medicare Part A claims in consolidated form, i.e., for all services a resident receives at the property, regardless of whether the services are provided by an outside vendor, physician or non-physician practitioners, etc.

The Medicare program and its reimbursement rates and rules are subject to frequent changes. These include statutory and regulatory changes, rate adjustments (including retroactive adjustments), administrative or executive orders and government funding restrictions, all of which may materially adversely affect the rates at which Medicare reimburses providers for services. Additionally, providers may be subject to billing audits that could result in an obligation to repay funds already received for reasons that include lack of required documentation supporting a claim, inaccuracies in billing documents, and other related issues. Lastly, health care reform is likely to have a major impact on Medicare and Medicaid reimbursement rates and methodologies. In particular, health care reform aims to transition payments to a system based on value (better resident outcomes) rather than based on volume or type of service provided. It also encourages the use of bundled payments, which pays providers a flat rate for certain types of care (e.g., a surgery) rather than paying separately for each aspect of that care (i.e., labs, tests, anesthesia, etc.). The changes to Medicare provider reimbursements types and methodologies are ongoing and should be closely monitored.

Exhibit i.1
Changes to SNF Medicare Reimbursement
Initial Index = 100

			Index Values	
Effective	Action	Key Provisions	Impact	Index
				100.00
Oct-99	CMS Market Basket Update	2.1% increase	2.10%	102.10
Apr-00	Balanced Budget Refinement Act of 1999	20% increase to 3 RUG categories	20.00%	
		~4% across the board increase	-4.00%	
	Total Impact		**16.00%**	**118.44**
Oct-00	CMS Market Basket Update	3.2% increase	3.20%	122.23
Apr-01	Benefit Improvement & Protection Act of 2000	6.67% increase to all RUG categories	6.67%	
		16.67% increase to nursing case mix	16.67%	
	Total Impact		**23.34%**	**150.75**
Oct-01	CMS Market Basket Update	2.8% increase	2.80%	154.97
Oct-02	CMS Market Basket Update	2.6% increase	2.60%	
	Statutory Expiration of Two Givebacks	Sunset of 16.67% case mix and 4% across the board	-20.67%	
	Total Impact		**-18.07%**	**126.97**
Oct-03	CMS Market Basket Update	3.0% increase	3.00%	
	Administrative Adjustment	3.26% market index "catch-up"	3.26%	
	Total Impact		**6.26%**	**134.92**
Oct-04	CMS Market Basket Update	2.8% increase	2.80%	138.70
Oct-05	CMS Market Basket Update	3.1% increase	3.10%	143.00
Jan-06	RUG-III Refinement	Adding 9 new RUGs categories	6.01%	151.59
Oct-06	CMS Market Basket Update	3.1% increase	3.10%	156.29
Oct-07	CMS Market Basket Update	3.3% increase	3.30%	161.45
Oct-08	CMS Market Basket Update	3.8% increase	3.80%	167.59
Oct-09	RUG-IV Refinement	Planned 3.3% decrease for case mix adjustments	-3.30%	
	CMS Market Basket Update	2.2% increase	2.20%	
	Total Impact		**-1.10%**	**165.74**
Oct-10	CMS Market Basket Update	1.7% increase	1.70%	
	RUG-IV Actual Utilization	Unanticipated 12.8% increase	12.80%	
	Total Impact		**14.50%**	**189.78**
Oct-11	Adjustment for Over-Payments in RUG-IV	12.6% decrease	-12.60%	
	CMS Market Basket Update	2.7% increase	2.70%	
	Affordable Care Act - Productivity Factor	1.0% decrease	-1.00%	
	Total Impact		**-10.90%**	**169.09**
Oct-12	CMS Market Basket Update	2.5% increase	2.50%	
	Multifactor Productivity Adjustment	0.7% decrease	-0.70%	
	Total Impact		**1.80%**	**172.13**
Apr-13	Sequestration Cut	2% decrease	-2.00%	168.69
Oct-13	CMS Market Basket Update	2.3% increase	2.30%	
	Multifactor Productivity Adjustment	0.5% decrease	-0.50%	
	Inflation Forecast Error Adjustment	0.5% decrease	-0.50%	
	Total Impact		**1.30%**	**170.88**

I.2 Medicaid

Medicaid is a state-administered medical assistance program for individuals with limited resources and income, operated by the individual states with the financial participation of the federal government, providing health insurance coverage for certain persons in financial need, regardless of age, which may supplement Medicare benefits for financially needy persons age 65 and older. States administer their own, often complex "means tests" to determine an individual's eligibility for Medicaid. Seniors who enter nursing care properties as private pay clients can often become eligible for Medicaid if they have substantially depleted their assets in a manner that is in accordance with applicable state and federal regulations. Medicaid is the largest source of funding for nursing care properties. Medicaid typically covers residents who require standard room and board services, and provides reimbursement rates that are generally lower than the rates paid by other sources.

Under Medicaid, most state expenditures for medical assistance are matched by the federal government. The federal medical assistance percentage, which is the percentage of Medicaid expenses paid for by the federal government, ranges widely depending on the state in which the program is administered (from approximately 50 to 76 percent). In most states, Medicaid reimbursement is typically much less than any other payor source.

To generate funds to pay for the increasing costs of the Medicaid program, many states utilize financial arrangements such as provider assessments and/or quality assessments. Under the provider tax arrangements, states collect taxes from health care operators and then often return a portion of the revenue to providers as a Medicaid expenditure, whereby the states can then claim additional federal matching funds. The states cannot guarantee repayment of such revenue to the providers. Under current law, taxes must be applied uniformly across all health care operators in the same class. The states must request these types of taxes from and get approval by the federal government for the imposition of these taxes. As of 2013, Alaska was the only state without such a provider tax.

The Deficit Reduction Act of 2005 (DRA) limited the ability of individuals to become eligible for Medicaid by increasing from three to five years the time period ("look-back period") in which the transfer of assets by an individual for less than fair market value will render the individual ineligible for Medicaid. Under the DRA, people who transferred assets for less than fair market value during the look-back period will be ineligible for Medicaid for so long as they would have been able to fund their cost of care absent the transfer or until the transfer would no longer have been made during the look-back period. This period is referred to as the penalty period. The DRA also changed the calculation for determining when the penalty period begins and prohibits states from ignoring small asset transfers and certain other asset transfer mechanisms. Recent health care reform aims to increase access to Medicaid for low income individuals and families and increase the amount of federal funds available to state Medicaid programs.

States administer the Medicaid program within broad national guidelines established by federal law and regulations. Within this framework, each state can establish its own eligibility standards; determine the type, amount, duration and scope of services; and set the rate of payment for services. States have broad discretion in determining the payment methodology and payment rates for services, but are required to use a public process for making those determinations. Federal law requires that payment rates must be sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population. Medicaid payment methodologies for nursing care properties vary considerably among the states.

Most methods used to calculate Medicaid nursing care rates take cost information from a past year as a base for the current year's rates. The base year for the rate and the methodology for updating are important. Generally, when the base year for the rate system is more recent, rates will be closer to the actual expenditures on care than when the base year is farther in the past. Most states classify costs into discrete defined cost centers; specific cost limit parameters are applied to each of these cost centers. A number of states have adopted case-mix payment methodologies to adjust direct care cost center payments to reflect the acuity levels encountered. Rules for the recognition of property costs vary from state to state; states have developed intricate, complex payment methodologies for property reimbursement. All aspects of the revenue and cost cycles are subject to audit and adjustment.

Appendix J:
Health Care Reform

This appendix discusses ongoing health care reform and the associated implications for seniors housing and care. President Obama signed the Patient Protection and Affordable Care Act (the "Act") into law in 2010. Since then, some of the Act's key provisions have been implemented or will commence in the coming years.

Although implementation dates vary greatly, the Act makes significant changes that will affect seniors housing and care owners and operators, and the health benefits provided to seniors housing and care employees, and seniors housing and care residents. In particular, major changes include:

- New individual and employer mandates with respect to insurance coverage;
- Insurance market reforms that would guarantee access to health insurance;
- Major changes in Medicare Advantage programs and Medicare prescription drug benefits;
- Creation of a new Independent Payment Advisory Board (IAPB) that would make binding recommendations on Medicare payment policy; and
- Sizeable tax increases to help fund new premium subsidies that will assist Americans with modest incomes to pay the costs of mandatory insurance coverage.

Key provisions of the Act that have already been implemented include:

- Insurance reforms (such as a prohibition on lifetime limits and a requirement that plans extend dependent coverage to adult children up to age 26);
- Implementation of state-based health exchanges as marketplaces for individuals and employers to purchase individual and group health insurance. State health exchanges opened in fall 2013. Middle- and low-income families are eligible for tax credits to help cover a portion of the cost of insurance purchased through the state exchanges;
- Some preventive care to be provided free to seniors on Medicare, including annual wellness visits with a physician;
- Implementation of the Community Care Transitions Program to help reduce preventable hospital readmissions for high-risk Medicare beneficiaries through coordination of care and community outreach;
- Prohibition on insurance company discrimination based on pre-existing conditions or gender.
- New individual mandate requirements, beginning in 2014, stipulating that individuals have qualifying coverage or otherwise pay a penalty;
- New payroll tax of 0.9 percent on the employee effective starting in 2013 tax year for individual incomes above $200,000; and
- Over-the-counter drugs may not be charged to flexible spending agreements (FSAs), except with a prescription. This does not apply to insulin, contact lenses, eye glasses, medical devices and similar health care expenses.[30]
- The Social Security Act was added to Section 3025 of the Affordable Care Act as section 1886(q), which has established the Hospital Readmissions Reduction Program. This program requires the Centers for Medicare and Medicaid Services (CMS) to reduce monetary payments to Inpatient Prospective Payment Systems (IPPS) hospitals with excess readmissions for three conditions that will be effective for discharges beginning October 1, 2012. Potential payment adjustments began in fiscal year 2013 for certain excessive or preventable readmissions within 30 days of discharge that are above the averages for hospitals with similar risk characteristics.
- In tax year 2013, contributions to FSAs became limited to an amount adjusted annually based on inflation.
- Also in tax year 2013, the threshold for deducting medical expenses on tax returns increased from 7.5 to 10 percent of income.
- Seniors are temporarily exempted from increased limitation on medical expense deductions through 2016;

- Medicare Part D "donut hole," or coverage gap, to be closed incrementally between 2011 and 2019; and
- Significant changes to Medicare Advantage plans;
- Medicaid used to subsidize premium costs for low-income individuals that are now subject to the individual mandate.

For more information, go to: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html

Appendix K:
Risks and Mitigating Factors

Investors in all asset classes, including stocks, bonds and real estate, face an array of risks including economic, valuation, interest rate and exit risk. In addition, real estate investors bear obsolescence risk (i.e., the physical plant no longer meets the needs of its tenants) and supply risk (possibility that new competition arises and siphons off tenants). The seniors housing sector is not immune from any of these risks and, in fact, introduces an additional set of risks that investors need to consider. Investors must either mitigate risks or be compensated (e.g., higher yield) for the specific risks faced in each transaction in order to achieve an appropriate risk-adjusted return. The risks that seniors housing investors bear include the following:

Operator Risk. Success in seniors housing depends on the skill of the team managing the specific asset. Buyers of seniors housing assets will need an operator dedicated to serving the needs of their residents in a manner that provides profits to ownership. Operators must have strong policies and procedures that ensure resident safety and compliance with the law, while simultaneously creating a warm and caring environment that is appealing to their customers. Operator risk is best mitigated by working with an experienced team with an established track record of success in the sector and by including the operator in the ownership group, thereby creating a strong alignment of interests.

Liability Risk. The profile of the tenant—an elderly person with physical and/or cognitive limitations that prevent him/her from caring for himself/herself—exposes a seniors housing property to lawsuits related to health matters. The extent of the liability risk varies from jurisdiction to jurisdiction and is dictated by, among other things, a jurisdiction's tort reform laws and the aggressiveness of the plaintiffs' bar. Good operators mitigate this risk by adopting and implementing policies and procedures designed to ensure quality of care by hiring competent aides to provide direct care to the residents. Some properties hire a registered nurse to manage the medication reminder program and/or oversee the care program. Ongoing communication with the resident's doctor and children can identify potential health issues and minimize the potential for surprises and lawsuits.

Insurance Risk. Unfavorable claims experiences can lead to an increase in a property's annual premium or a cancellation of coverage. Establishing procedures, documenting appropriate care in following the procedures, outsourcing medical care to certified physicians, and hiring qualified caregivers can minimize risk of insurance coverage loss. A strong operator uses best practices and controls costs and covered losses.

Credit Risk. Seniors housing residents typically have low incomes, given that they are retired, offset by substantial net worth. Many residents pay their monthly fees out of accumulated assets; others rely on their children for support. Seniors housing operators can mitigate credit risk by conducting credit checks and carefully monitoring collections. Good operators have relationships with the adult child (or adult children) and include a regular financial check-in.

Employee Risk. The executive director (ED) or administrator of the property is critical to successful, profitable operations, and sets the tone for the entire property, both for residents and staff. Successful operators control employee risk by hiring a competent director who can build a strong team with service-oriented personalities and those who enjoy working directly with people in an intimate relationship. Employees tend to be self-selecting, with a committed group who like the challenges and rewards of working with elderly people.

Care staff often has basic education but no formal training, relying primarily on company-directed workshops and on-the-job learning. Turnover can be a factor given that the direct care jobs often pay competitively, on the lower end of the pay scale, and that employees are asked to perform a range of tasks. Employee turnover can be reduced by establishing incentive programs to reward reliable attendance and longevity. The operator's track record provides clues as to the likely experience with personnel.

Turnover Risk. Seniors housing resident turnover rates average between 32 and 54 percent annually, with assisted living turnover at 54 percent and independent living turnover lower at 32 percent. Continuing care retirement communities (CCRCs), which attract residents based on the lifetime care model, have

the lowest turnover at 17 percent.[2]

Turnover cannot be mitigated, although health-extending programs such as physical therapy may lengthen the stay of some residents. Serving an elderly pool of customers means that their needs often increase beyond what an operator can provide, resulting in a move. In other cases, the resident may die. The outcome in either case is a vacancy to fill. The operator must maintain a pipeline of new residents to fill the units. Locating the property in a prime area with a population of age- and income-qualified seniors can make a difference, along with the creation of links to local hospitals, churches and universities. Seniors housing operators can benefit from the use of demand-analysis techniques, such as gravity models pioneered by retailers.

Unexpected Increases in Acuity. During the Great Recession, the sluggish housing market made it more difficult for some prospective residents to sell their homes, delaying the timing of a move into seniors housing. As this happened, the average age of residents increased along with their level of acuity (illness). As a result, staffing needs also rose. Circumstances such as these require operator flexibility and the ability to adjust staffing accordingly. The operator must also be able to modify care charges in response, if the operation is to remain profitable. Operators should re-assess residents on a regularly scheduled basis, and update resident care charges accordingly. Now that the Great Recession is over, it will be important to monitor the acuity level of new residents to gauge whether the trend shows signs of reversal, or that the high-acuity resident is the new normal.

Technology Risk. Increasingly, seniors housing and care will be affected, both positively and negatively, by technology. Some of these technology-related changes include the following:

- Remote monitoring and telemedicine: Technologies like bedroom sensors that detect changes in sleep patterns and blood-pressure cuffs that communicate results to health care providers may allow seniors to live longer in their own homes, reducing demand for seniors housing and care. On the other hand, some seniors feel challenged when integrating technology into their own homes, so a community that offers turnkey technological packages in its apartments may attract seniors who seek the benefits of technology without facing the implementation issues.

- Social media: For many customers, the purchase decision is full of uncertainty with questions such as, "Will my mother be well cared for in this community?" While the track record of most operators is broadly favorable, unfortunate incidents can happen. If complaints are aired in forums like chat rooms and Facebook, isolated complaints can get amplified quickly into a general perception of poor quality in a community (or in the industry). Conversely, good word-of-mouth has historically been an important marketing tool; such feedback will become more powerful through social media.

- Treatments for Alzheimer's disease: One concern with memory care assets is that, someday, a cure for Alzheimer's will make the asset obsolete. However, another plausible scenario is that a cure is not found, but instead a treatment protocol will be proven to slow the disease's progression through a mix of medication, diet and brain exercise. Such a protocol may be most effective in a seniors housing and care community which could drive additional demand.

Reimbursement Risk. Nursing care properties typically generate a significant share of revenue from government payors (Medicare and Medicaid). With current fiscal challenges, however, rates paid by Medicare and Medicaid may not keep pace with cost growth or population enrollment could be constrained. Reimbursement risk is the primary reason why cap rates paid for nursing care communities exceed those for seniors housing communities.

Most independent living, assisted living and memory care properties receive most revenue from private payers, which limits reimbursement risk. (Third-party payers like long-term-care insurers typically pay a cash benefit to the resident, not to the community, so they have no leverage on the rates charged by a community.) However, certain operators or geographies receive sizable revenue from governments through programs such as Medicaid waivers. Such strategies carry higher reimbursement risk and lower rate growth and need to be underwritten at the time of acquisition.

Appendix L:
About NIC MAP®

In 2004, the National Investment Center for Seniors Housing & Care (NIC) launched the NIC MAP® Data Service to create transparency for investors by offering credible and objective market-level data. As of the fourth quarter of 2013, NIC MAP® tracked approximately 13,200 properties, including 1.72 million units, in the top 99 metropolitan markets within the United States.[1] Data is collected quarterly on qualifying independent living, assisted living and nursing care properties. To qualify for the database, properties must have at least 25 units and charge market rates for the housing and services offered.

The data service originally covered the largest 31 metropolitan markets (primary markets) and expanded coverage in 2008 to 68 additional markets (secondary markets). Data is available beginning in the fourth quarter of 2005 for the primary markets and the first quarter of 2008 for the secondary markets. Since there is a longer time series available for the primary markets, any trends presented are typically only representative of those markets. The below table outlines NIC MAP®'s geographical coverage.

In 2010, NIC and Real Capital Analytics (RCA) formed a strategic alliance to actively track all seniors housing and care property sale transactions in the U.S. with a closing price of at least $2.5 million. Comprehensive information is available beginning in the first quarter of 2008 and through the fourth quarter of 2013, and included information on more than 1,500 distinct transactions, representing more than $66 billion in closed transactions volume.[1]

Primary Markets	
Atlanta, GA	San Antonio, TX
Baltimore, MD	San Diego, CA
Boston, MA	San Francisco, CA
Chicago, IL	San Jose, CA
Cincinnati, OH	Seattle, WA
Cleveland, OH	St. Louis, MO
Dallas, TX	Tampa, FL
Denver, CO	Washington, D.C.
Detroit, MI	
Houston, TX	
Kansas City, MO	
Las Vegas, NV	
Los Angeles, CA	
Miami, FL	
Minneapolis, MN	
New York, NY	
Orlando, FL	
Philadelphia, PA	
Phoenix, AZ	
Pittsburgh, PA	
Portland, OR	
Riverside, CA	
Sacramento, CA	

Secondary Markets		
Akron, OH	Fresno, CA	Ogden, UT
Albany, NY	Grand Rapids, MI	Oklahoma City, OK
Albuquerque, NM	Greensboro, NC	Omaha, NE
Allentown, PA	Greenville, SC	Portland, ME
Augusta, GA	Harrisburg, PA	Providence, RI
Austin, TX	Hartford, CT	Raleigh, NC
Bakersfield, CA	Indianapolis, IN	Richmond, VA
Baton Rouge, LA	Jackson, MS	Rochester, NY
Birmingham, AL	Jacksonville, FL	Salt Lake City, UT
Boise, ID	Knoxville, TN	Sarasota, FL
Bridgeport, CT	Lakeland, FL	Scranton, PA
Buffalo, NY	Lancaster, PA	Springfield, MA
Charleston, SC	Little Rock, AR	Stockton, CA
Charlotte, NC	Louisville, KY	Syracuse, NY
Chattanooga, TN	Madison, WI	Toledo, OH
Colorado Springs, CO	McAllen, TX	Tucson, AZ
Columbia, SC	Melbourne, FL	Tulsa, OK
Columbus, OH	Memphis, TN	Ventura, CA
Dayton, OH	Milwaukee, WI	Virginia Beach, VA
Daytona Beach, FL	Modesto, CA	Wichita, KS
Des Moines, IA	Nashville, TN	Worcester, MA
El Paso, TX	New Haven, CT	Youngstown, OH
Fort Myers, FL	New Orleans, LA	

Appendix M:
Data Sources

This appendix outlines all of the data sources referenced in this publication.

Sort	Data Source/Description
1	NIC, *NIC MAP®*. NIC MAP® is the seniors housing and care industry's leading data provider, tracking asking rents, occupancy, inventory and construction data in 99 of the largest metropolitan markets in the U.S. on a quarterly basis. Data used within this publication is as of the fourth quarter of 2013. NIC MAP® restates its historical data each quarter, therefore the data included within this publication may differ slightly from more recent releases. http://www.nicmap.org/
2	ASHA/ALFA/LeadingAge/NCAL/NIC, *The State of Seniors Housing*. The report provides data on financial and performance measures including resident turnover, operating margins, and other key financial performance metrics. The most recent data is available from the 2013 edition, which summarizes data for 2012.
3	ASHA/ALFA/LeadingAge/NCAL/NIC, *The 2009 Overview of Assisted Living*. This report provides facts and figures about assisted living when defining the business to investors, media, and consumers. The most recent data is available from the 2009 edition, which summarizes data for 2008.
4	ASHA, *The Independent Living Report*. This report contains key insights for the seniors housing provider to better understand the decision-making process and the dynamics that drive occupancy. The most recent data is available from the 2009 edition, which summarizes data for 2008.
5	NIC, *NIC National Housing Survey of Adults 55+*. This report includes information about the characteristics of older adults related to their needs and search for seniors housing. The most recent data is available from the fourth edition, which summarizes data for 2007.
6	ASHA/LeadingAge/NIC/Ziegler, *Continuing Care Retirement Communities 2011 Profile*. This report provides resident profiles, operating margins, and other key performance indicators for CCRCs. The most recent data is available from the 2011 edition, which summarizes data for 2010.
7	U.S. Census Bureau, Population Division. All demographic projections used were based on the file "Projected Population by Single Year of Age, Sex, Race and Hispanic Origin for the United Stated: 2012 to 2060." It is available for download at: http://www.census.gov/population/projections/data/national/2012.html
8	U.S. Census Bureau, Population Division. Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties, and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2012.
9	Centers for Medicare and Medicaid Services (CMS), Nursing Home Compare. http://www.medicare.gov/nursinghomecompare/search.html
10	National Council of Real Estate Investment Fiduciaries (NCREIF), NCREIF Property Index (NPI). The NPI is a quarterly time series composite total rate of return measure of investment performance of a very large pool of individual commercial real estate properties acquired in the private market for investment purposes only. http://www.ncreif.org/
11	Zillow Real Estate Research, *Zillow Home Value Index*.
12	Alzheimer's Association, *2013 Alzheimer's Disease Facts and Figures*. This report details the escalation of Alzheimer's disease. The report is available at: http://www.alz.org/alzheimers_disease_facts_and_figures.asp
13	ASHA, *A Statistical Survey of Senior Homeowners*. This report provides a demographic profile of age 75+ homeowners and describes their perceived home values, the length of time they have lived in their homes and features of their homes. The report summarizes data that was collected during the spring of 2008.
14	Avalere. An advisory company focused on the healthcare industry.
15	U.S. Bureau of Labor Statistics, *Current Population Survey*. This program is a monthly survey of households providing data on the labor force and other demographic characteristics. http://www.bls.gov/
16	Medicare & Medicaid Research Review/ 2012 Statistical Supplement (1999-2012) and CMS Office of the Actuary (1998-2012)
17	Federal Reserve. Various U.S. macro data is available via the Federal Reserve's website. http://www.federalreserve.gov/
18	Mortgage Bankers Association, *MBA Commercial Real Estate/Multifamily Finance Quarterly Databook, 4Q13*. This report is a quarterly compendium of the latest research on trends and conditions in the commercial/multifamily mortgage industry. The occupancy and rent growth data within the report was provided by REIS, a provider of commercial real estate data.
19	Elijay LLC for the American Health Care Association, A Report on Shortfalls in Medicaid Funding for Nursing Center Care (Dec 2012).
20	Valuation & Information Group (V & IG). The firm's primary focus includes appraisals and market feasibility studies. http://valinfo.com/
21	ASHA/LeadingAge, *Assisted Living and Continuing Care Retirement Community State Regulatory Handbook*. This report features key state licensure and regulatory requirements in all 50 states and the District of Columbia for assisted living properties and CCRCs.

22 ASHA, Residents of Independent Living: *How Today's Residents Compare to Residents of 2001*. This report provides information regarding the demographic characteristics of independent living residents.

23 ASHA, *Senior Living for the Next Generation Volume I*. This report explores attitudes and perceptions of seniors housing from adult children.

24 Green Street Advisors. A firm specializing in real estate and REIT research. http://www.greenstreetadvisors.com/

25 FTSE NAREIT. FTSE is a provider of financial data on various business sectors and collaborates with NAREIT to produce indices for REITs.

26 Bloomberg. A leading provider of financial news and data. http://bloomberg.com/

27 U.S. Social Security Administration, Period Life Table 2009. http://ssa.gov/OACT/STATS/table4c6.html#ss

28 Centers for Disease Control and Prevention. *Prevalence of overweight, obesity and extreme obesity among adults: United States, trends 1960-62 through 2009-2010 (2012).*

29 The American Diabetes Association, Economic Costs of Diabetes in the U.S. in 2012.

30 U.S. Census Bureau, Income. This provides income estimates. Income by age of householder is found in table h.10.

31 Norma B. Coe and April Yanyuan Wu, *Financial Well-being of Residents in Seniors Housing and Care Communities: Evidence from the Residents' Financial Survey.* The paper was part of a series of research conducted by Boston College's Center for Retirement Research.

32 MSG Consultants, *Home Health Care: An Industry Study (2006)*. This report contains a brief analysis of the home health care industry.

Sunrise at Fountain Square
Lombard, IL

Valencia Terrace
Corona, CA

National Investment Center
1997 Annapolis Exchange Parkway, Suite 480
Annapolis, MD 21401
Phone: (410) 267-0504
Fax: (410) 268-4620
www.nic.org

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