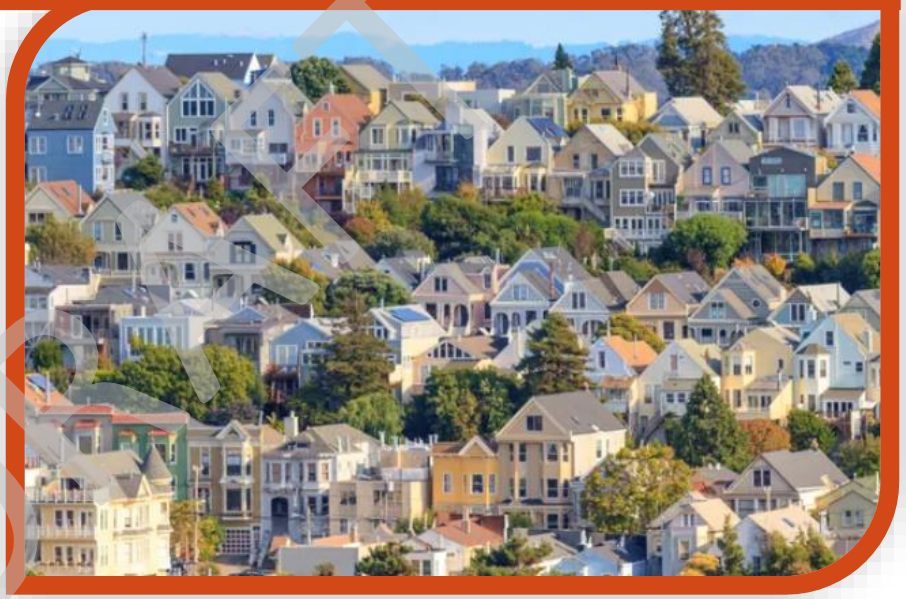
Affordable Assisted Living in San Francisco: Feasibility Study



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Executive Summary

This report summarizes findings of financial feasibility analyses conducted for two models of affordable assisted living to be developed in San Francisco–a licensed Residential Care Facility for the Elderly (RCFE) and a Housing with Enhanced Services community. This study involved: 1) conducting research and interviewing key stakeholders to inform the potential development, 2) researching innovative housing with service projects that serve frail elders, 3) conducting a preliminary market assessment to quantify the demand for the project by income and level of need, 4) and developing financial feasibility analyses for each model.

Target Population. Interviews and strategy discussions with various stakeholders helped define several working assumptions about who the project should be primarily serve. To address the growing lack of access to affordable assisted living, the project for both models should be primarily designed to serve older adults living in San Francisco with: a) long-term care and chronic health care needs; b) inadequate formal and informal care supports to remain safely at home; c) scheduled and unscheduled service needs; and (d) inadequate financial resources to afford services at home or higher cost licensed RCFEs. This could include individuals with chronic mental health or supportive housing needs who also need long-term care. Applicants would either be relocating from community-based settings or relocating from institutional, as well as acute care settings.

For the licensed model, the project should serve a mixed income population that includes individuals with the financial resources to pay for monthly costs or who qualify for available state and local service subsidies. Serving a mixed income population would serve a broader and more rapidly growing segment of the market while allowing the project to be more operationally self-sustaining and able to secure needed financing. For the housing with enhanced services model, the project should primarily serve a lower income, Medi-Cal eligible resident population. Focusing on a lower-income segment for this model would provide access to financing sources that may be less readily available for the licensed model while ensuring the project is able to coordinate community-based services that the frail population will need. As for the building, it is assumed to have 95 private studio apartment units and common areas that meet: changing resident needs, RCFE licensing and public financing requirements; consumer preferences for market-rate demand. The service capacity of the project should enable the provision and/or coordination of services to meet both scheduled and unscheduled needs.

Summary Findings

Market Analyses

Based on local RCFE supply and demographic data, the study examined the current and projected need for assisted living among the following three segments of San Francisco's older (age 75+) population:

1. *Medi-Cal eligible*: Meet California's eligibility criteria for Medi-Cal home and community-based services
2. *"Middle" Market*: Have incomes greater than the Medi-Cal income threshold but less than needed to afford monthly assisted living costs without financial assistance from family or other available subsidy sources
3. *Private-pay*: Households who likely could afford market-based rates for licensed assisted living

Supply. As of June 2021, San Francisco had 60 licensed RCFEs with the capacity to serve 3,301 residents. The population-adjusted supply is relatively low and prices for less institutional accommodations are high.

- When adjusting for the size of the population most likely to need assisted living, San Francisco has 55 percent fewer licensed beds than California overall -- 15 beds per 100 older (age 85+) in San Francisco compared with 23 beds per 100 older (age 85+) in California.
- Average base rates for private studio or one-bedroom apartments in larger AL communities (16+ beds) were $6,635 per month. Additional monthly service charges averaged almost $800 per level.

Demand analyses. Demographic estimates and projections show considerable unmet need across all three market segments. Demand is projected to increase within the "middle market" segment and the "private pay" segment. Specifically:

1. Medi-Cal eligible households: Total potential demand may decrease somewhat from 1,694 age, income and needs eligible households in 2021 to 1,616 such individuals by 2026.

2. "Middle-market" households: Total potential demand may increase 2,798 age and needs eligible households in 2021 to 3,057 such in 2026 without the financial resources to afford market-rate assisted living.
3. Private-pay households: Total potential demand may increase from 1,798 age, income and needs eligible households in 2021 to 2,362 such individuals by 2026 who could afford monthly assisted living costs.

These projections suggest that developing a mixed-income project for the licensed model would be more feasible in terms of likely demand, while potentially enabling the project to generate sufficient revenues for covering operating expenses considering rent and service subsidy limitations.

Licensed Assisted Living – Programmatic, Regulatory and Financing Factors

Developing a licensed, affordable assisted living project in San Francisco will require considerable pre-development efforts to secure non-debt capital funding. Operating such a project will require serving a mixed-income population and working with several state and local service subsidy sources. Recent and anticipated policy developments suggest that service subsidies should become more available and sustainable in future years.

Programmatic Financing – Rent and Service Subsidy Considerations

Since Medi-Cal subsidies may be used for services but not room and board, the Supplemental Security Income/State Supplementary Payment (SSI/SSP) program is the most widely available subsidy source in California for assisted living rent and service costs. Considering that revenues from SSI/SSP benefits total less than $1,100 per month, lower-income residents will need to qualify for subsidies from one or more state and local service subsidy sources. The following are the primary sources of service subsidies that assisted living residents of the proposed project should be able to access:

- **Assisted Living Medi-Cal Waiver**: Considering the small size and large waiting list for this program, it is assumed that a relatively small portion of the project's residents will be subsidized by the AL Waiver program. However, recent developments suggest this program may play a larger role in the future. California has made significant investments during the past few years to address: 1) access barriers by increasing the size of this relatively small program and 2) provider participation barriers by substantially increasing reimbursement rates (i.e. about nine percent per year since 2017). Medi-Cal eligible applicants who are relocating or being diverted from institutional settings are more likely to qualify on a more expedited basis than those relocating from community-based settings.
- **Program of All-inclusive Care for the Elderly (PACE)**: Unlike the AL Waiver program, enrollment in PACE is not capped. And since reimbursement rates are negotiated with individual providers, they may be more responsive to local operating costs. As a result, the PACE program could be a more accessible option than the AL Waiver program for the Medi-Cal eligible market.
- **Community Living Fund (CLF):** Considering the large and growing size of the "middle market" in San Francisco that may not qualify for Medi-Cal, as well as CLF's recent experience contracting with RCFEs, increasing the size of the CLF program would enable the proposed project to serve individuals who lack the financial resources to afford market-rate assisted living. Since the program is currently capped, expanding the CLF program is considered one of the key policy levers that can be addressed locally for providing access to affordable assisted living.
- **Department of Public Health (DPH):** It is assumed that "patch" subsidies will continue to be available for applicants who have behavioral needs, as well as complex medical needs, particularly for those transitioning from institutional settings. These subsidies could address both the: 1) funding gap for residents with more complex needs who are already enrolled in other subsidy programs and 2) timing gap for residents who are on the AL Waiver waiting list.
- **Medi-Cal Managed Long-Term Care:** Statewide long-term care integration plans for the dual-eligible population suggest that the project would likely become a contracted provider to serve eligible beneficiaries who will be enrolled in one of San Francisco's two managed care plans (MCPs). Building on the experience of MCPs in other counties, future discussions with the San Francisco Health Plan about resident characteristics, service capacity and reimbursement rates should inform project feasibility assumptions.

Licensing and Regulatory Considerations

State regulations for Residential Care Facilities for the Elderly (RCFEs) specify under what conditions the proposed project would need to be licensed while also specifying eligibility criteria for residents and the range of services that can be provided or arranged. Without an RCFE license, the project may not directly provide, coordinate and/or contract for

services that meet resident care and supervision needs. Licensing is also a condition for securing a Medi-Cal provider contract for the AL Waiver program. These licensing regulations have implications for the project's eligibility for federal development subsidies as noted further below.

One of the project's potential barriers for serving Medi-Cal eligible residents is its location being adjacent to the Laguna Honda Hospital and Rehabilitation Center (LHH). Specifically, AL projects adjacent to public institutions are presumed by the Centers for Medicare and Medicaid Services (CMS) to be ineligible for receiving Medicaid home and community-based service (HCBS) subsidies. However, despite CMS having discouraged such projects from being developed, examining CMS' "heightened security review" process and initial discussions with representatives from the California Department of Health Care Services indicates a feasible path forward for addressing this regulatory barrier. This would involve adopting modern building and programmatic design features that comply with new HCBS requirements.

Development Financing Considerations

Financing the development of the proposed project will require a complex and layered approach, as well as considerable advocacy efforts to secure non-debt capital sources. As the primary federal subsidy program for developing affordable housing, which may include assisted living, the Low-Income Housing Tax Credit (LIHTC) program is considered an essential source for financing the proposed project. Based on experience with comparable projects in other states, future consultation with the California Tax Credit Allocation Committee should explore the possibility of adding RCFEs as a special-needs housing type and set aside allocations. Recognizing that assisted living can be viewed as a risky use of tax credits due to regulatory concerns and Medicaid funding availability, addressing those risks will require a clear understanding about: 1) the precedence established in other states and qualified projects, 2) the project's service delivery model to be compatible with LIHTC requirements, and 3) the history and reliability of future service subsidies in California. Alternatively, grant and loan financing might also be obtained through the California Department of Housing and Community Development, such as through the Multifamily Housing Program, which makes low-interest, long-term deferred-payment permanent loans for eligible projects. The HUD Section 232 loan program and/or tax-exempt bond financing are assumed to be the primary sources of construction and long-term debt for the proposed project. Each program provides terms that may be negotiable more favorably considering the nature of the project and contingent on net operating income projections, as well as other non-debt capital sources.

HOUSING WITH ENHANCED SERVICES – KEY PROGRAMMATIC FACTORS

The feasibility of a housing with enhanced services model was evaluated as an alternative to a licensed AL facility because of the challenges associated with securing adequate development capital and service subsidies to develop and operate a RCFE. This analysis assumed the target population for the housing with services model would be comparable to the RCFE model in terms of resident characteristics and level of service.

Service Delivery Model

As with many senior affordable housing properties, the proposed model would employ resident service coordinators for connecting residents with supportive services and facilitating access to benefits, entitlements, and community-based resources. Needed services would then be delivered by community-based service providers with funding from a variety of sources including but not limited to Medi-Cal, the Department of Public Health, the Community Living Fund, and PACE, as is the case currently with affordable senior housing projects (see Appendix C for a summary of currently available funding sources by type of service). To accommodate the average level of care found in a licensed RCFE, the housing with enhanced services model would need to build on innovations around service delivery in the affordable senior housing field. The proposed enhanced service model would include the following components each of which have barriers to implementation:

- **Frailty Preference for All Units**: To serve a resident population that would otherwise be found in licensed assisted living facilities, an affordable housing with enhanced services project would need to be able to screen and prioritize potential residents based on level of frailty, for which a precedence exists at existing properties. Although there is not yet a known precedence for the application of a frailty preference for all units, initial consultation with legal counsel determined this to be a potentially viable option.

- **Rental Subsidies for All Units**: Because residents will need to be Medi-Cal eligible in order to access the majority of the service programs available in the County, rental subsidies will be needed for all units. Application for PRAC subsidies through the HUD 202 program will be made for all units, there is some uncertainty about how many subsidies would be allocated to the project considering recent funding limitations to this program. As a result, any remaining subsidies would need to be provided through local sources, such as HUD's Section 8 program, the Scattered Site and Rental Subsidy Administration, and/or the Senior Operating Subsidies program.
- **A "Clustered Care" Model for IHSS Workers:** The clustering of IHSS hours would allow for more efficient use of IHSS authorized hours and the ability to meet the unscheduled and nighttime needs of residents, utilizing Homebridge as the contract mode provider. The potential barriers to this model include the willingness of IHSS clients to utilize Homebridge instead of a family or friend as the service provider and the ability to obtain approval from CDSS to bundle IHSS hours for billing purposes.
- **Funding for Resident Service Coordinators.** Funding for resident service coordinators in HUD 202 buildings is typically provided by HUD. However, having a larger proportion of residents with an AL-level of care will require additional resident service coordinator positions and it is not known whether these additional costs would be approved by HUD.
- **Funding for a Wellness Nurse.** A full-time wellness nurse will be an essential component to providing the higher level of care projected for the project. With a precedence set in other California counties for funding of such positions by managed care health plans, and because of the upcoming implementation of CalAIM which will give all plans responsibility for long-term care benefits, it is thought that the San Francisco Health Plan might partner with the project by providing funding for this position. Preliminary discussion with a Health Plan leader included interest in a possible pilot project for exploring the options available to its members in a residential setting.
- **Meal Service Coordination.** Residents at higher acuity levels typically need assistance with meal preparation, with RCFEs required to provide three meals a day plus snacks to residents. Coordinating needed meal services would thus be an important component of the housing with enhanced services model. Having a co-located Community-Based Adult Services (CBAS) or Adult Day Program equipped with a commercial kitchen at the property could provide project residents with access to at least one meal per day. Additional congregate meals could also be prepared using bundled IHSS hours with shared or after-hours access to the commercial kitchen

As stated earlier, these recommendations assume a level of resident acuity comparable to that seen in licensed assisted living facilities, with all residents meeting pre-determined frailty criteria. If for some reason that higher level of care is not attained, the recommendations may not be operationally viable due to insufficient economies of scale.

If approval for a clustered model of IHSS care is not obtained, partnerships with On Lok, as well as the Institute on Aging, could be explored as an alternative approach to coordinating a higher level of care than is typically found in affordable senior housing properties. Selected units could be set aside for PACE clients, with the possible co-location of a PACE center at the site. On-Lok, the primary PACE provider in San Francisco, has expressed interest in a potential partnership with the project and reportedly has a need for additional affordable housing units.

Finally, having a CBAS or adult day program primarily designed to serve the larger community would also benefit project residents. In addition to congregate meal services, enrolled residents would have convenient access to the other broad range of services provided by such programs.

Financial Feasibility – Licensed Assisted Living Model

Based on preliminary development costs, operating revenue and cost assumptions, and potential financing sources, financial feasibility analyses were conducted to determine the operating and capital subsidies that would be needed to develop the proposed project as a licensed RCFE. In addition to the previously noted project assumptions, it is assumed that:

- The majority of residents will be eligible for state and local service subsidies.
- Pricing for market-rate units will be just below average rates for comparable units and services in San Francisco.
- Medi-Cal eligible residents will mostly be subsidized by either the AL Waiver program or PACE, with possible DPH "patch" funding for a few eligible residents.
- Additional investments in the Community Living Fund (CLF) will provide access for lower-income, community-based applicants who are either ineligible for Medi-Cal or pending AL waiver enrollment.
- A third-party operator with affordable AL experience will be engaged to manage the project.

- The project will employ at least 48 staff for administrative, personal care, limited nursing, social services, housekeeping, maintenance, and other functions.
- An 18-month lease-up period is consistent with industry trends including for affordable AL projects.

Financial projections indicate that the project could be operationally self-sustaining once it reaches stable occupancy in year two of operations. Specifically, the project could generate enough revenues to cover total operating expenses when it reaches 65 percent occupancy by month 11 and could break even to also cover mortgage payments at 85 percent occupancy by month 15. During the first year of operations, lease-up reserves will be needed to cover operating deficits and mortgage payments estimated at $2.3 million depending on financing terms. Stabilized occupancy will lead to more sustainable financial results in subsequent years with the Net Operating Income projected at just over $1.2 million for the second year of operations and $1.4 million by the third year.

The financial analyses considered multiple scenarios to illustrate how key drivers would make the estimated $77 million licensed AL project more or less financially feasible in terms in terms of development funding gaps. These scenarios included:

1. A base scenario projects a $21 million gap assuming the project can secure: a) $22 million in loans from a Section 232 loan and a smaller gap loan, b) $34.2 million in combined equity capital from LIHTC and City funding.
2. Without LIHTC financing, the gap would be almost twice as large or $38.5 million.
3. With LIHTC financing, the gap could be reduced to $16.9 million if able to secure approval for more favorable loan terms from HUD considering the need for new affordable AL units in San Francisco.
4. Assuming Base scenario financing and increasing the mix of private-pay residents from 45 to 55 of the total units would reduce the gap to just under $14 million.
5. More favorable loan terms and a larger private-pay case mix would reduce the gap further to $10.4 million.
6. Using scenario 5 assumptions and increasing private-pay rates by 9% would enable the project to carry more debt, thereby reducing the funding gap to $1.6 million.

FINANCIAL FEASIBILITY – HOUSING WITH ENHANCED SERVICES MODEL

Preliminary development cost estimates, operating revenue and cost assumptions, and potential financing sources were included in a financial feasibility analysis for the housing with enhanced service model. In addition to the programming assumptions noted above, following are key factors and findings for the financial analysis:

- Residents will all be at the lowest income levels in order to access available service programs, so rental subsidies will be needed for all units.
- Non-labor and personnel costs are assumed to be similar to currently operating affordable senior housing properties in San Francisco, with additional resident services staff and direct costs projected due to the higher level of resident acuity assumed. Approximately 15 FTEs were included in the financial projections.
- Because of the targeted resident income levels, the project will generate no cash flow after expenses and will thus not be able to support debt. Sources of funds for the $74.3 million project (escalated to 2024 dollars) were assumed to be drawn from the HUD 202 program, four percent Low-Income Housing Tax Credits, the Multifamily Housing Program, and the Federal Home Loan Bank's Affordable Housing Program. The remaining funding gap, projected to be $23.4 million, would need to be provided by the City.

Background

In response to concerns about the declining supply of assisted living beds in San Francisco available to lower-income older and disabled adults, the Long-Term Care Coordinating Council convened an Assisted Living Workgroup in 2018 to examine contributing factors and make a range of policy and programmatic recommendations. In addition to summarizing the range of city subsidies providing transitional, short- and long-term access to assisted living (AL) settings, particularly in smaller AL homes, key findings noted concerns about:

1. A pronounced decline in smaller homes serving adults under age 60;
2. Persistent cost barriers considering public subsidies are unable to adequately cover operating costs;
3. Considerable unmet needs for AL among lower-income San Francisco residents

Workgroup recommendations specific to the proposed project included: (a) Increasing both the number of City-funded subsidies and provider payment levels; (b) Co-locating enhanced services with affordable housing; and (c) increasing the use of Assisted Living Waiver Program slots.[1]

Since that report was completed in 2019, there have been several developments that adversely impact access to affordable assisted living (AL) in San Francisco. First, the supply of ALWP-contracted RCFEs has continued to decline with only one 15-bed RCFE currently participating in the program. Second, the impact of the COVID-19 pandemic continues to be very challenging for AL residents, families, staff and providers. In addition, revenue declines from historically low occupancy rates combined with increased labor costs related to worsening workforce shortages will likely take a heavier toll on providers who serve lower-income residents. Increasing labor and other operating costs are also reflected in the rapidly increasing cost of assisted living services purchased for Community Living Fund beneficiaries.

Several promising developments have also occurred, including anticipated increases in the number of Assisted Living Waiver slots, which was last increased in 2018 by 2,000 slots to serve 5,744 participants. On July 12, 2021, California submitted an updated spending plan for federal approval that included adding another 7,000 slots to the AL waiver program using additional federal funds. These funds have become available through the American Rescue Plan for states to expand HCBS programs. Second, DHCS has been prioritizing certain Assisted Living Waiver applicants, which has reportedly made it much easier and faster to place applicants who are moving from a skilled nursing or hospital setting, in part due to a shorter prior stay requirement. Third, CalAIM developments could address barriers to access assisted living in San Francisco as: (a) requirements for mandatory enrollment in Medi-Cal managed care take effect by January 2023; (b) institutional long-term care gets carved into those managed care plans; and (c) managed care plans are able to get reimbursed for purchasing alternative support services including assisted living.[2]

Current Scope of Work

The scope of work for this project was developed in response to a Request for Qualifications (RFQ) issued by the Mayor's Office of Housing and Community Development on November 18, 2019. This RFQ sought the services of a qualified development team to work with the City to develop permanently affordable independent senior housing on the campus of Laguna Honda Hospital. The proposed project would include assisted living units and/or residential care beds for the frail elderly, including those who are low income. Because of the challenges around developing and operating affordable RCFEs in San Francisco, the scope of work developed in response to the RFQ included an evaluation of two models of assisted living: a licensed RCFE and a housing with enhanced services project.

This report summarizes the findings of financial feasibility analyses conducted for these two models of affordable assisted living that involved: 1) conducting research and interviewing key stakeholders to inform the potential development, 2) researching innovative housing with service projects that serve frail elders, 3) conducting a preliminary market assessment to quantify the demand for the project by income and level of need, 4) and developing financial feasibility analyses for a licensed RCFE and a housing with enhanced services project.

[1] City and County of San Francisco, 2019, "Supporting Assisted Living in San Francisco," report by the Assisted Living Workgroup as convened by the Long-Term Care Coordinating Council

[2] California Health Care Foundation (2021), "Meeting the Moment: Strengthening Managed Care's Capacity to Serve California's Seniors and Persons with Disabilities."

Current Supply

As of June 2021, there were 59 licensed RCFEs in San Francisco licensed to serve up to 3,301 residents.[3] Since the City and County of San Francisco examined affordable assisted living in 2018, approximately 6 smaller RCFEs closed that were licensed to serve 45 residents. This continues the previously reported decline in smaller facilities that have been more accessible to lower-income residents. At the same time, the San Francisco Campus for Jewish Living opened the Frank Residences, which is licensed to serve up to 220 assisted living residents including a 77-unit secured memory care program. In addition, the licensed bed capacity of Portola Gardens was increased from 77 to 123 beds when it was purchased by a new owner. As noted above, only one 15-bed RCFE was reportedly participating in the Medi-Cal Assisted Living Waiver program.

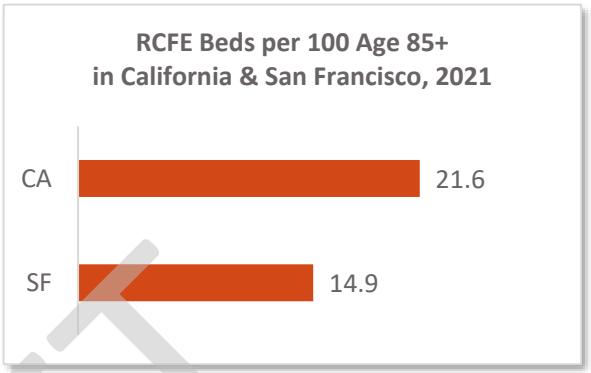
Residential Care Facilities for the Elderly in San Francisco, 2021

Size	# RCFEs	Licensed Bed Capacity
15 or less	35	320
16 - 25	2	42
26 - 50	6	237
51 - 100	4	263
101 or more	13	2,439
Total	**59**	**3,301**

Source: CA Dept. of Social Services, June 2021

Note that a large majority of RCFEs in San Francisco (57 percent) are licensed for 15 or fewer beds; however, they represent a very small proportion (10 percent) of the city's licensed bed capacity. Most of the licensed RCFE beds (82 percent) are located in larger RCFEs licensed to serve 50 or more residents.

Just as San Francisco has had a disproportionately low supply of nursing facility beds, there are also significantly fewer RCFE beds available to serve the oldest segment of the population who are most likely to need long-term services and supports. Specifically, San Francisco has 31 percent fewer RCFE beds per 100 individuals aged 85 years and older than California overall—14.9 vs 21.6 beds respectively.



[3] This includes about 984 RCFE beds located within larger campus settings that were excluded in the 2019 report "Supporting Affordable Assisted Living in San Francisco" by the City and County of San Francisco's Affordable Assisted Living Workgroup of the Long-Term Care Coordinating Council (LTCC)

Defining the Target Population for the Proposed Project

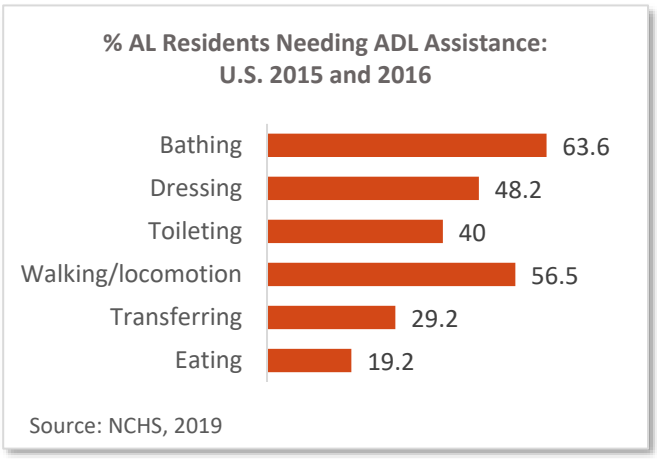
Among the first steps for determining the feasibility of a new affordable AL project is specifying the target market to be served, which has implications for financing, marketing, design, programming, and budgeting. Building on the project's initial objective for developing affordable assisted living for older adults, local stakeholders were interviewed to identify any other specific unmet needs that the proposed project should consider addressing, whether in terms of funder expectations or broader community support.

> *'**Residential Care Facility for the Elderly**' means a housing arrangement chosen voluntarily by the resident, the resident's guardian, conservator or other responsible person; where 75 percent of the residents are sixty years of age or older and where varying levels of care and supervision are provided, as agreed to at time of admission or as determined necessary at subsequent times of reappraisal. Any younger residents must have needs compatible with other residents.*
>
> *Title 22, Div. 6, Chap. 8, 87101, (5)*

Age – Licensed ALFs primarily serve older adults, particularly larger facilities with 50 or more beds in which most residents (96 percent) are age 65 years or older.[4] In California, ALFs are licensed as Residential Care Facilities for the Elderly (RCFEs), with regulations requiring that most residents are older and otherwise have compatible needs. Based on the initially reported focus of the proposed project and consistent feedback from key informant interviews, the project will primarily serve older adults. Although the project might also serve some younger adults with a compatible need for long-term services and supports, the demand analyses summarized in this report do not examine this secondary market demand.

Income and Assets – In the event the project can be developed as a licensed RCFE, it will likely serve a mixed income population due to a combination of financing, pricing, demand and supply considerations. Otherwise, it will serve primarily low-income residents. As noted previously, access to service subsidies for licensed assisted living is very limited in California. Furthermore, considering how available subsidies do not adequately cover operating costs, a licensed AL project will need to maintain a financially sustainable proportion of low-income residents who qualify for subsidies, as well as higher-income segments of the older population. This includes a large segment of the older population that may not qualify for Medi-Cal and may not have the financial resources to afford typical monthly fees without financial assistance from family members[5] or other available subsidies. It also includes a segment of the population with adequate financial resources from income and assets to afford below-market AL rates. Since retirement income alone may not cover monthly AL costs, such residents may supplement their income with proceeds from the sale of their home, benefits from a long-term care insurance policy or eligibility for the Veteran's Aid and Attendance program. Alternatively, developing the project as an enhanced housing with services model would involve primarily serving low-income residents who can qualify for available housing and service subsidies. This is in consideration of the high cost of housing and community-based services, as well as financial eligibility criteria for subsidies available in San Francisco.

Service Needs – The proposed project will need to accommodate a broad range of service needs to serve as a viable long-term option for individuals eligible for available service subsidies. Recognizing individual preferences to remain in one's own home with available supports, typical AL residents need assistance with services that can be scheduled (e.g. meals, medication assistance, and assistance with activities of daily living), as well as those that are less predictable and difficult to schedule with a paid or family caregiver who lives elsewhere. Almost two-



[4] Caffrey C & Sengupta M. (2018), "Variation in residential care community resident characteristics, by size of community: United States, 2016." NCHS Data Brief, no 299. National Center for Health Statistics.

[5] Recent studies have not examined financial assistance from family members; however, almost 16% of assisted living residents in a national survey from 1998 were receiving such assistance. See NIC (1998) "National Survey of Assisted Living Residents: Who is the Customer?" Annapolis, MD

thirds of AL residents in the US need assistance with bathing [6], with the most common unscheduled needs including assistance with toileting, as needed ("PRN") medications and protective oversight due to memory loss. Additionally, residents will need assistance with managing chronic health care conditions including Alzheimer's disease or other dementias, heart disease, depression, diabetes, and respiratory disease. New AL residents are increasingly more likely to need assistance than in prior years when home and community-based services were less widely available to older adults with disabilities.

Prior location – Most AL residents tend to move from their own homes, with moves often prompted by an acute episode with a hospital stay or longer stay receiving inpatient rehabilitation services. To a lesser extent, residents may relocate from another RCFE, whether due to dissatisfaction, increased service needs, Medicaid "spenddown" or proximity to family members. For purposes of estimating demand for the proposed project, this study conservatively assumes all potential residents are living in San Francisco County and are not already living in another RCFE or institutional setting. For financial feasibility purposes, this study assumes that the proposed project will serve as an option for relocating residents from short- and longer-term stays in institutional settings, as well as other RCFEs. The project would also likely serve as an option for San Francisco residents who may be relocating from elsewhere.

Community outreach, programming and service delivery should be designed to address barriers to access among traditionally underserved segments of the older population. Studies have shown disproportionately lower AL use by people of color compared to their proportions in the national and state populations, which may be due to language and cultural factors. LGBT older adults are also likely to avoid accessing AL services due to having experienced housing discrimination or having fears about moving into assisted living. Current RCFE regulatory requirements for cultural competency training, language accommodations and person-centered care are intended to ensure more welcoming and inclusive AL communities.

AL Subsidy Eligibility -- For each of the two assisted living models being examined in this study, it is assumed that lower income residents will need to meet the financial and service needs eligibility criteria for various subsidy programs that will enable the proposed project to provide or coordinate needed services. In some cases, residents may already be receiving Medi-Cal funded Home and Community-Based services available through the In-Home Supportive Services (IHSS) program, the Program of All-Inclusive Care for the Elderly (PACE) or other programs (See Appendix B: AL Service Subsidy Sources, Eligibility Criteria & Availability). They might also be receiving services purchased by San Francisco's Community Living Fund (CLF). Other residents may be relocating from a nursing facility, their own home or another RCFE after being qualified for the Assisted Living Waiver program. And beginning in 2023, dual-eligible residents may be diverted or relocated from more institutional settings with subsidies from one of the two managed care health plans in San Francisco as discussed further below.

[6] National Center for Health Statistics (NCHS), 2019, "Long-term Care Providers and Services Users in the United States: 2015–2016," Series 3, Number 43

Demand Analyses Summary

This section summarizes analyses of demographic and supply data [7] conducted to determine the current and projected need for assisted living among three segments of San Francisco's older population:

1. Households who meet California's Medi-Cal income-eligibility criteria
2. Households with incomes greater than the Medi-Cal income threshold but who likely could not afford to pay privately for assisted living without other financial assistance (i.e. "Middle Market"), and
3. Households who likely could afford to pay market-based rates for assisted living.

For additional information about market study methods and additional tables with detailed results, as well as the demand for Memory Care specialized assisted living, see Appendix A: Demand Analyses.

To inform demand estimates, the analyses examined current supply data by focusing on 25 of the larger AL communities in the City licensed to serve 16 or more residents for a combined 2,981 total AL beds.

- Ten of these projects reported having a combined total of 388 memory care (MC) beds designated for residents with Alzheimer's or related dementias.
- Seven of the AL communities served an estimated 210 Medi-Cal eligible residents across the communities.
- The 16 AL communities offering private bedrooms or apartments had an average base monthly rate of $6,635 (median = $6,318) with additional monthly service costs ranging from $465 to $1,200 per additional level of care.
- Note that newer apartment-style units (i.e. private units with kitchenettes and bathrooms) seemed less common in older properties that were more likely to have semi-private rooms with shared bathrooms.

The following table shows the total Medi-Cal-eligible market potential in San Francisco to be 1,694 in 2021 and 1,616 in 2026, representing an estimate of the current and projected number of Medi-Cal-eligible households that would need the services provided in a RCFE. Assuming 15 percent of these eligible households might choose to move to the proposed project, this total market potential translates into a current demand for an additional 254 Medi-Cal-eligible RCFE beds in the County, with a need of 242 beds projected for 2026. This modest decline (-4.6 percent) is based on demographic projections showing fewer older adults in the lowest income categories.

Demand Analysis for Medi-Cal Eligible Assisted Living

Age, Income and Needs Qualified Households	2021	2026
Total Age 75+	64,130	71,260
Medi-Cal Income Eligible*	11,124	10,776
Medi-Cal LTC Eligible*	1,904	1,826
- Already living in 16+ bed RCFEs	(210)	(210)
Total Market Potential	**1,694**	**1,616**
With 15% Market Penetration	**254 units**	**242 units**

* Medi-Cal Income Eligible (<138% FPL or $17,775 for individual); Medi-Cal LTC Eligible (2+ Activities of Daily Living (ADLs))

The study also examined the "Middle Market" demand, defined as individuals age 75 years or older needing help with one or more ADLs who are: a) renters with $25,000 to $85,000 annual income or b) homeowners with $17,775 to $35,000 annual income. As shown below, the total market potential for the middle (or gap) market in San Francisco for assisted living is 2,798 in 2021 and 3,057 in 2026. This market potential results in an estimated demand for 420 additional RCFE units in 2021 and 459 additional units in 2026, assuming a 15 percent market penetration rate.

Demand Analysis for "Middle Market" Assisted Living

Age, Income and Needs Qualified Households	2021	2026
Total Age 75+	64,130	71,260
Middle Market Income*	13,542	14,915
Medi-Gap and Needs Eligible**	2,798	3,057
- Already living in 16+ bed RCFEs	Info NA	Info NA
Total Market Potential	**2,798**	**3,057**
With 15% Market Penetration	**420 units**	**459 units**

* Assumes $6,000 / mo starting rate for AL and that 85% of income is needed for the monthly rate. Homeowners may supplement annual income drawing upon net proceeds from a home sale or other assets.

** Needs eligible: 1+ ADL Needs

[7] Demographic data were obtained from Claritas, Inc., a national supplier of demographic information, and is based on 2010 Census data, with current year estimates and five-year projections developed by Claritas. Supply data were obtained from the California Department of Social Services and individual provider website data, as well as calls to selected providers.

Note that the above figures include potential residents who may qualify for subsidies through the Community Living Fund and/or DPH "patch," as well as individuals receiving financial assistance from family members or other sources, such as a long-term care insurance benefit. These population estimates and demand projections suggest a 9.3 percent increase in the market segment that is less likely to afford assisted living and less likely to qualify for public subsidies through Medi-Cal

Finally, the study examined the private-pay demand for assisted living among the segment of the population with the financial resources to afford market-rate monthly costs. These were defined as individuals age 75 years or older needing help with one or more ADLs and who are: a) renters with $85,000 or more annual income or b) homeowners with $35,000 or more annual income. As shown below, there is a total market potential (age, income and need-qualified households) for market-rate assisted living of 1,798 in 2021 and 2,362 in 2026. This market potential results in an estimated demand for 270 additional RCFE units in 2021 and 354 additional units in 2026, assuming a 15 percent market penetration rate.

Demand Analysis for "Middle Market" Assisted Living

Age, Income and Needs Qualified Households	2021	2026
Total Age 75+	64,130	71,260
Income Eligible*	15,509	18,620
Needs Eligible**	2,980	3,543
- Already living in 16+ bed RCFEs	1,182	1,182
Total Market Potential	**1,798**	**2,362**
With 15% Market Penetration	**270 units**	**354 units**

* Assumes $6,000 / mo starting rate for AL and that 85% of income is needed for the monthly rate. Homeowners may supplement annual income drawing upon net proceeds from a home sale or other assets.

** Needs eligible: 1+ ADL Needs

Underlying this estimated 31.3 percent increase in private-pay demand is the projected increase in older adults with greater resources. (See Appendix A for additional analyses conducted to examine the demand for memory care specialized assisted living not summarized in this section.)

Licensed RCFE Model – Barriers, Opportunities and Other Considerations

The feasibility of a licensed model for affordable assisted living was evaluated considering the range of current financial barriers previously identified for San Francisco,[8] as well as opportunities that also exist both locally and at the state level. It is assumed that that the population served by the licensed model and the level of care provided would be more likely to align with the needs of a lower- to middle-market segment of the older population with somewhat higher service needs than a typical market-rate AL project in San Francisco. The following sections summarize information obtained through program research and interviews about:

1. Current and future financing options for subsidizing resident service costs
2. Licensing and regulatory considerations relevant to both models
3. Key financing options being considered for developing the project as a RCFE

Programmatic Financing – Service Subsidies

In San Francisco, assisted living service costs in licensed RCFEs are subsidized by multiple state and local sources. The Supplemental Security Income/State Supplementary Payment (SSI/SSP) is the most widely available subsidy source in California for AL rent and service costs. As of January 1, 2021, the maximum SSI/SSP benefit for an individual was $1,217.37 of which AL providers receive $1,079.37 and residents keep $138 for personal and incidental expenses. Although residents of licensed AL projects may also qualify for tenant- or project-based rental assistance, this analysis does not assume such subsidies will be available in San Francisco for the licensed assisted living model.

In most other states, Medicaid is the primary source of financing the cost of AL services for eligible residents. However, California has chosen not to make AL as accessible to lower-income residents. According to the most recently available comparison of AL-resident characteristics by state, California ranked 48th with only three percent of residents having some or all their services paid by Medicaid in the prior 30 days compared with 45 percent in Oregon, 28 percent in Washington and 17 percent nationally.[9] As a result, the proposed project will

[8] LTCC (2019) "Supporting Affordable Assisted Living in San Francisco"

[9] NCHS (2018), "2016 National Study of Long-Term Care Providers Web Tables of State Estimates on Residential Care Community Residents," www.cdc.gov/nchs/nsltcp/nsltcp_webtables.htm

need to rely on subsidies from other local government and program sources.

Eligibility for these local subsidies varies by program both in terms of income criteria and functional needs (see Appendix B: AL Service Subsidy Sources, Eligibility Criteria & Availability). Income-eligibility criteria may be as low as 138% of the Federal Poverty Level (FPL, $17,774 per year or $1,481 per individual in 2021) or as high as 300% of the FPL ($38,640 per year or $3,220 per month) for the Community Living Fund. Note that "patch" funds provided through the San Francisco Department of Public Health (DPH) reportedly do not have an income test since they are intended to address the difference between cost and the individual's ability to pay. Except for DPH's "patch" funding, which is more focused on behavioral health needs, Medi-Cal subsidized AL residents are generally required to meet the state's Nursing Facility Level of Care (NFLOC) criteria or other specified criteria having to do with being relocated from or being at risk of nursing home placement. Subsidies or provider reimbursement rates also vary by program, resident need and individual providers.

The following are other noteworthy considerations for each of these service subsidy sources obtained through interviews, cited reports and program websites.

Assisted Living Waiver Program (ALWP)

Besides the planned increase of 7,000 slots to address the size of the current waiting list, it is unclear to what extent the ALWP is likely to grow by the time the proposed project is developed. Further, there are no plans to implement geographic market adjustments to address low provider participation rates in more costly markets like San Francisco. Another provider-reported barrier to participation is the long period of time required to become an ALW-certified provider. According to one contracted RCFE provider, it can take between three to four months and a year to complete the enrollment process, with the time required dependent on current DHCS leadership. Historically, new contracted providers had to have six months operating experience and then expect another three to four months for application review and approval.

That said, it is reasonable to assume that once approved as a contracted provider, the project would be able to move-in AL Waiver eligible applicants at a modest pace, particularly if they are being relocated or diverted from Laguna Honda Hospital, other skilled nursing facilities, or acute care hospitals. When asked about the approximately 12 to 15 patients per month that Laguna Honda Hospital discharges to the community, facility representatives estimated that three to five of those mostly Medi-Cal eligible individuals would be better served in an RCFE setting with a higher service capacity. According to Star Nursing, one of the two Care Coordination Agencies serving San Francisco, any RCFE beds the project made available for ALWP clients could easily be filled despite the large waiting list. The owner noted that it is much easier and faster to place applicants who are moving from a skilled nursing or hospital setting than from other settings. Specifically, new applicants for the ALWP waiting list who are living at home or in another community-based setting can expect to wait over two years to get placed. Transitions from skilled nursing facility or hospital settings have historically been prioritized with a 60-day prior stay requirement. More recently, such transitions for Adult Protective Service cases can reportedly be moved within a month with a shorter 24-hour prior stay in a skilled nursing or hospital setting.

Department of Public Health (DPH)

Primarily intended for individuals with behavioral needs, as well as complex medical needs, DPH provides "patch" subsidies for clients in RCFEs and smaller Adult Residential Facilities (ARFs). This would include individuals with Alzheimer's or other dementia's who have behavioral needs. As reported previously,[10] this program provides subsidies for more ARF and RCFE residents in San Francisco than all the other currently available subsidies combined. In March 2021, the program served 440 clients in licensed facilities located in San Francisco County plus 264 clients in facilities outside the County. Prior reports suggest that about 40 percent of the San Francisco clients are in RCFEs, with just over a third of those clients (34 percent) being subsidized at enhanced rates of up to $110 per day (or $3,344 per month). To fill the gap between what an RCFE provider would normally charge and what a resident can afford with their own resources and other available subsidies, DPH may also provide a "patch" payment when transitioning clients from institutional settings.

Program of All-Inclusive Care for the Elderly (PACE)

Being committed to maintaining members in their own homes as long as possible, PACE programs contract with AL providers as an alternative when clients need more assistance than available through family caregivers and other community-based service providers. This is particularly the case for people who have overnight care needs, such as due to Alzheimer's or related dementias, toileting assistance and transfer needs. Based on earlier reports and recent interviews, RCFE providers in San Francisco receive subsidies for approximately 120 PACE participants. On Lok Lifeways tends to maintain RCFE

[10] LTCC (2019) "Supporting Affordable Assisted Living in San Francisco"

utilization at about 8 to 10 percent of its enrolled participants. The Institute on Aging, which operates two PACE centers under On Lok's delegated authority, tends to have a slightly higher RCFE utilization – about 12 percent of its members. Flat or tiered RCFE reimbursement rates for PACE vary by contracted provider, ranging from about $2,500 to $4,000 per month to cover the service-related portion of monthly costs that the individual is unable to pay. Most On Lok Lifeways-supported RCFE residents (95 percent) are in higher service levels due to a combination of behavioral support and chronic health care needs.

Community Living Fund (CLF)

With funding from the City and County of San Francisco, this program provides subsidies for a small number of AL clients who have either transitioned out of a nursing facility or were living in the community and at risk of institutionalization. CLF provides subsidies for about 30 AL clients via the Institute on Aging (IOA), which is the lead contractor for the program. Such subsidies would be available for eligible individuals who may either be on the waiting list for the AL Waiver program or be financially ineligible for the AL Waiver program due to having income above 133 percent Federal Poverty Level. Previously reported monthly subsidies from CLF ranged from $737 to $5,854, with rates reportedly higher in larger RCFEs. During the last half of 2020, average RCFE service subsidies were about $3,600 per participant per month. Considering that CLF funding is reportedly at capacity with RCFE placements being restricted due to rising costs, increasing the size of the CLF program would help provide access for Medi-Cal beneficiaries who may be on the AL Waiver waiting list and for individuals with insufficient financial resources to afford AL who are not Medi-Cal eligible.

CalAIM and Future RCFE Subsidies

One of the more promising and unfolding developments for improving access to assisted living for Medi-Cal beneficiaries involves statewide reforms that should ultimately provide more comprehensive service coordination and a more integrated system for long-term services and supports. Current plans for California's Advancing and Innovating Medi-Cal (CalAIM) initiative specify that individuals eligible for long-term care services will be required to enroll in one of San Francisco's two managed care plans (MCPs) by January 1, 2013. At that time, MCPs will assume responsibility for Medi-Cal institutional long-term care costs including skilled nursing, intermediate care and subacute facility care. Considering that MCPs will be bearing more financial risk as payment shifts to a capitation rate for members, they will have the opportunity to manage that risk by offering less costly alternative support services that will be reimbursable as In Lieu of Services (ILOS). Among the preapproved ILOS options are payments for transitioning or diverting members from nursing facilities to RCFEs. Considering the experience of MCPs in counties with mandatory enrollment for dual-eligible and institutional long-term care carve-ins, this may include contracting with RCFEs and providing both short- and longer-term subsidies for members who are on the ALWP waiting list or are ineligible due to share of cost exclusion criteria. Note that these mechanisms are considered transitional, incremental steps towards a more comprehensive statewide managed long-term services and supports (MLTSS) benefit to be implemented by 2027. Such a benefit is intended to provide greater access to community-based LTSS than is currently available. As a result, San Francisco health plans will likely play a greater role in providing subsidies for Medi-Cal eligible RCFE residents beginning in less than two years.

Licensing and Regulatory Factors

The following provides an overview of key regulatory requirements and other considerations that will inform the programmatic and financial feasibility of both the licensed RCFE and housing with enhanced services models.

Service provision and coordination. In most cases, housing projects need to be licensed as an RCFE if they intend to directly provide, coordinate and/or contract for services that meet resident care and supervision needs. Licensing requirements have implications for the housing with enhanced services model considering the penalties associated with operating an unlicensed RCFE. Normally, facilities that accept or retain residents with care and supervision needs must be licensed even if the facility is only providing a room. However, such projects may be exempt from RCFE licensing if: (1) they meet federal statutory and programmatic definitions for supportive housing for the elderly, disabled or low-income people *and* (2) they help residents access supportive services directly or through a service coordinator without contracting for or providing those services.[11] This exception would preclude the project from having formalized "program agreements" or subcontracting with service providers.

Limited nursing services. RCFEs may accept and retain residents with a range of health conditions for which assistance may be provided under specified conditions by facility staff or other third-party service providers, such as home health or hospice agencies. The list of restricted health conditions that may be provided or arranged

[11] See Title 22, Division 6, Chapter 8, Section 87107 (a) (9).

include but are not limited to oxygen administration, catheter care, diabetic care, assistance with incontinence and wound care. Providers may be granted exceptions for retaining residents with restricted conditions under certain programmatic conditions. Other restricted health conditions do not require an exception request, such as incontinence or diabetic care that is manageable, as well as end-of-life care if the provider has a Hospice Care Waiver.

Dementia care. RCFEs may accept residents with dementia under a range of training, staffing, and programmatic conditions. Non-ambulatory fire clearance is required for units occupied by residents who are unable to evacuate with assistance. In addition, licensing rules specify other secured storage and design requirements in such RCFEs.

Residency criteria. RCFEs may not admit or retain residents with a range of *prohibited* health conditions, such as stage 3 or 4 pressure injuries, gastronomy tubes and tracheotomies, as well as being fully dependent on others for performing all activities of daily living. That said, exceptions to these prohibited health conditions may be granted under specified conditions that may involve licensing agency review, a Hospice Care Waiver or third-party service provision. Delayed egress devices may also be used under certain conditions to help manage wandering behaviors. Other significant restrictions worth noting for the proposed project include residents needing 24-hour skilled nursing or intermediate care and needing care and supervision due to ongoing behavior needs caused by a mental disorder that would be upsetting to other residents.

Service capacity and variation. Licensing requirements specify a range of "basic" services that facilities must have the capacity to provide. These include but are not limited to providing "care and supervision" (which includes medication assistance), meals, assistance with activities of daily living, assistance with service coordination and arranging medical care, monitoring, and a planned activity program. However, the scope of services that ALFs may choose to or be able to provide can vary widely due to resource limitations, building design, company policy or other organizational factors. For example, the ability to assist residents with transferring to and from a wheelchair, toilet or bed may be limited by provider preference due to liability concerns about falls and injuries, staffing limitations or non-ambulatory fire clearance requirements.

AL Provider Eligibility for Medicaid Subsidies. In 2014, the Centers for Medicare and Medicaid Services (CMS) adopted new rules to clarify requirements for home and community-based settings considered eligible for Medicaid subsidies under several federal HCBS programs. These programs were created to address the historically institutional bias of Medicaid long-term care programs by providing more opportunities for beneficiaries to receive services in their own home or in community settings rather than institutions. Nursing homes and hospitals are among the excluded settings, and settings that are on the grounds of or immediately adjacent to a public institution (like Laguna Honda Hospital) are *presumed* to have disqualifying institutional characteristics. For the proposed project to be approved as a contracted Medicaid provider, the California Department of Health Care Services (DHCS) will first need to conduct a "heightened security review" to verify that it meets the new HCBS requirements and then submit their determination to CMS for review and approval.[12] Although these requirements can readily be met by licensed RCFEs, DHCS' formal determination can only be made and submitted to CMS once the project is operational and occupied by residents. Initial conversations with DHCS leadership suggest that the department would be open to conducting a pre-opening review of building design, operational plans and other materials in order to verify that specified plans are consistent with state and federal HCBS requirements.

Development Financing

Financing the development of affordable assisted living projects generally involves a complex and layered approach that can include a combination of lower interest debt, grants, tax credit equity, and donated land and/or funds. Available options for financing new AL residences are similar to those used for most affordable senior housing projects. To a lesser extent, these have included Low Income Housing Tax Credits (LIHTC), HUD HOME funds, Federal Home Loan Bank Affordable Housing Program Fund, HUD's Assisted Living Conversion Program, and tax-exempt bonds under Section 142(d). Other more traditional sources of debt capital for seniors housing with care projects have included Fannie Mae, Freddie Mac, the U.S. Department of Housing and Urban Development (HUD)/Federal Housing Administration (FHA), commercial banks, life insurance companies, and commercial finance

[12] CMS has strongly encouraged states to limit the growth of settings like the proposed project that are presumed to have institutional qualities. However, CMS also recognizes that "there may be some locations where the ability to construct additional settings in which Medicaid-funded HCBS would be provided may be significantly limited, such as heavily built-up urban areas." The "heightened scrutiny review" process seems intended to address this challenge. See www.medicaid.gov/medicaid/home-community-based-services/guidance/home-community-based-services-final-regulation/index.html

companies. New Markets Tax Credits are a less common option that can be worth considering for eligible projects.[13]

For purposes of evaluating the feasibility of the proposed project as a licensed RCFE, the following highlights basic information about one of the more common debt capital sources for construction and permanent financing available through loans that are insured by HUD, as well as the less common use of tax-exempt bond financing that would also be worth exploring. The following also includes rationale for pursuing LIHTC financing, which is one of the less common though possibly essential equity capital options for the proposed project. Alternative grant and loan financing may also be obtained through the California Department of Housing and Community Development, such as through the Multifamily Housing Program that makes low-interest, long-term deferred-payment permanent loans for eligible projects.

HUD/FHA

Section 232 is an FHA program that insures loans for new AL construction by for-profit, public, and not-for-profit sponsors, with HUD programs insuring loans that are originated and serviced by HUD-approved lenders. In fiscal year 2001, the Department insured Section 232/223(f) mortgages for 198 facilities totaling $1.3 billion. [14] Financing through this program has grown considerably as reported commitments were issued for 299 facilities in 2019 totaling $3.9 billion. [15] Underwriting criteria and terms for these long-term, non-recourse loans include up to 40-year (fully amortizing) maximum terms (plus construction period) and the lesser of:

- 80% stabilized value for nonprofits
- The amount that results in debt service coverage ratio of 1.45x based on the underwritten net operating income[16]
- 90% of FHA's allowable replacement cost
- 100% of FHA's allowable costs less grants, public loans and tax credits

Tax-Exempt Bonds

Multifamily tax-exempt 142(d) bonds may also be issued to fund construction-to-permanent loans for new assisted living projects that qualify as a "qualified rental project." These long-term, non-recourse loans may fund projects in combination with other sources, including LIHTC and Section 232 loans. Compared with Section 232 loans, the terms for tax-exempt bonds include slightly higher interest rates, lower debt coverage ratio (1.2x) requirements, similar amortization (35 to 40 years) and interest-only payments until after stabilization according to one potential lender. [17] Projects are also subject to the low-income set-aside requirements either using the "20% at 50%" standard or the "40% at 60%" standard.

Low Income Housing Tax Credits (LIHTC)

As the primary federal subsidy program for developing affordable housing, the LIHTC program should be a key option worth exploring for financing the proposed project. Despite there being several AL projects in other states that were initially financed using LIHTC programs, this option may be more difficult to secure in California due to lack of local precedence allocating tax credits to AL projects as rental properties. At first glance, the inclusion or exclusion of such projects is not addressed in the California Tax Credit Allocation Committee's (CTCAC) regulations or compliance manual. Nevertheless, future consultation with CTCAC staff should explore the possibility of adding RCFEs as a special needs housing type. As an example, New York state considers AL projects as eligible special needs housing projects "…as long as they do not provide daily medical and nursing services and all other services are optional." [18]

In general, assisted living can be viewed as a risky use of tax credits both due to regulatory confusion from the IRS about project eligibility and uncertainty over Medicaid funding availability.[19] Part of the regulatory confusion has to do with whether an AL project is considered a health care facility versus a rental property, as well as the provision of nursing services and optional services. Unlike states like New Jersey that specifically define ALFs as health care facilities, Medicaid-contracted RCFEs in California

[13] To be eligible for NMTCs, a project must be a "qualified active low-income community business" as determined by census tract location (https://www.ftb.ca.gov/tax-pros/law/legislation/2019-2020/AB3101-022120-and-031620.pdf)

[14] Scheutz, J (2003), "Affordable Assisted Living: Surveying the Possibilities," Joint Center for Housing Studies, Harvard University.

[15] National Investment Center for Seniors Housing & Care (2020), "NIC Investment Guide," Sixth Edition

[16] FHA is authorized to exceed the debt service coverage limits up to an amount resulting in a 1.11x debt service coverage ratio. Such exceptions are rare and only granted when a project has unique attributes that mitigate additional risks from a higher loan amount.

[17] Based on preliminary interviews with members of Oppenheimer's Senior Living Banking team.

[18] New York New York State Division of Housing and Community Renewal (2000), "Using the Low-Income Housing Tax Credit Program for Special Needs Housing."

[19] Scheutz, J, 2003.

should be considered residential settings. First, the California Department of Health Care Services makes the distinction that ALWP-contracted "*facilities are not regarded as healthcare facilities, but social-based facilities. Although the RCFE/ARF is a licensed facility, ALW residents are considered as living in their own home, not in a healthcare setting*.[20]" Second, the limited nature of nursing services provided in RCFEs (as summarized in the licensing considerations above) should address potential LIHTC concerns about the project providing ongoing, continuous nursing services. Note that RCFEs do not provide medical services and any skilled nursing services are either provided by third-party service providers or by qualified staff on an intermittent rather than on a frequent or continuous basis. Finally, residents may choose to receive services from other third-party providers or otherwise refuse available services. Therefore, AL services could arguably be considered optional.

Garden Place Assisted Living

- Wisconsin-based project comprised of 50 licensed assisted living and 12 independent living units.
- All but 5 of the units are designated as affordable through Wisconsin's LIHTC program.
- 27 of the AL units are designated for Medicaid residents.
- The $7.5 million project was financed with LIHTC equity ($5.2M) and conventional debt ($2.3M)

Source: Wisconsin Coming Home Program, 2006, "Creating Affordable Assisted Living: A Coming Home Case Study"

Housing with Enhanced Services – Barriers, Opportunities and Other Considerations

The feasibility of a housing with enhanced services model was evaluated as an alternative to a licensed assisted living facility because of the challenges with securing adequate capital and service subsidies to develop and sustain an affordable licensed RCFE. This analysis assumes the target population for this model would be comparable with the RCFE model in terms of resident characteristics and level of service needs.

Service Provision in Affordable Senior Housing.

Many affordable senior housing projects employ resident service coordinators who connect residents with supportive services and facilitate access to benefits, entitlements, and community-based resources. Serving as an on-site information and referral resource, service coordinators help residents remain independent and self-sufficient by connecting them with community-based services and other income-related benefits.

The services for meeting the Instrumental Activities of Daily Living (IADL) or ADL needs of residents are then delivered by third-party service providers. In San Francisco, services are available from a variety of programs and funding sources including but not limited to DPH, CLF, and PACE, often stitched together in a patchwork-type configuration with each resident potentially receiving services from several different agencies. For summary information about the home and community-based services available in San Francisco, along with program-eligibility criteria and availability information, see Appendices B and C, pages 54 and 55.

Considering how services and eligibility criteria can differ and overlap between programs, resident service coordination in affordable housing properties can be complex. Nevertheless, San Francisco's rich service environment could support the delivery of services comparable to what is found in licensed assisted living facilities. The resident services coordinator role, working with outside case management and service agencies, would be critical to ensuring resident needs are met in a housing with enhanced services project with an assisted living level of care.

Despite San Francisco's rich service environment, some of the programs have caps on the availability of funds and/or number of slots (See Appendix D: Housing with Enhanced Services - HCBS Program Eligibility Criteria & Availability).

[20] See Basic Requirements for the ALW program specified at www.dchs.org for provider enrollment, as well as the program's Medicaid home and community-based waiver application.

Specifically, the HCBA waiver program, MSSP, and the Community Living Fund are all at full capacity with waiting lists. The Assisted Living Waiver Program, which funds services provided by contracted home health agencies for publicly subsidized housing residents, has no participating agencies in San Francisco County. Therefore, this program component is currently not an option for local residents who want to remain in the City. By comparison, the In-Home Supportive Services (IHSS) program is one of the most extensively funded and utilized programs, with no cap on the number of individuals served and 13,579 persons in San Francisco aged 65-plus receiving services through the program[21].

Eligibility criteria for most of the HCBS programs limits access to individuals at the lowest income levels, i.e. $1,481 per month or $17,775 per year in 2021. Therefore, ensuring residents of a housing with enhanced services property have access to publicly subsidized services will require careful consideration to income-eligibility restrictions and rent levels, as well as the extent to which needed services can be purchased by the Community Living Fund.

Some affordable senior housing properties have partnered with PACE, which allows for the provision of a nursing home level of care to residents who are PACE members. For example, BRIDGE Housing and the Institute on Aging worked together to develop the Coronet in San Francisco in which 50 of the 150 units have been set aside for PACE clients. Located on the first floor of the property is a PACE center, which provides a range of services to PACE members.

Essential Components for Affordable AL in a Housing with Enhanced Services Setting

This feasibility study reviewed and collected information about the most progressive supportive housing models for older adults in the US. As summarized in Program Review A of this report, the projects have evolved considerably in response to the aging in place of residents. However, even the most robust housing with service programs do not typically serve the older, more frail population found in licensed assisted living facilities (see the resident age and acuity comparison table in Program Review A).

Building on the existing and evolving innovations in the affordable senior housing field, an enhanced model of housing with services will be essential for addressing the reported need for a "step-down" option to nursing home care that can serve individuals who might otherwise be in a licensed RCFE. Following is a summary of essential components of such a model, along with potential implementation barriers:

1. **Frailty Preference for All Units**. To serve a resident population that would otherwise be found in licensed assisted living facilities, an affordable housing with enhanced services project would need to have the ability to screen and prioritize potential residents based on level of frailty. By securing approval from HUD for 61 of the 92 units to be occupied by frail elders, Presentation Senior Housing Community [22] serves as a precedent for establishing a "frailty" preference. To qualify for the frailty preference at this HUD 202 property, applicants must be:

   a. currently enrolled in a Community-Based Adult Services (CBAS) program; or

   b. currently living in a skilled nursing or residential facility and have been accepted for service at a CBAS program; or

   c. chronically needing assistance with two or more activities of daily living as assessed by a social service professional; or

   d. receiving or eligible for at least 60 hours per month of in-home supportive services as assessed by a social service professional.

   At this project, applicants must acknowledge whether they meet the qualifications for the frailty preference and if so, must provide written verification of frailty by a social services professional.

   Initial consultation with legal counsel specializing in affordable housing and fair housing laws suggest that the precedent set by the Presentation Community would likely enable the proposed project to secure approval for a similar frailty preference. Although there is not a known precedence for applying a frailty preference for all units in an affordable senior housing property, such a scenario was considered worth pursuing as a viable option, in consultation with HUD.

2. **Rental Subsidies for All Units**. Another critical factor in an affordable housing with enhanced services project designed to accommodate the target population is the availability of rental subsidies for all units so that Medi-Cal eligible individuals could reside at the property. As stated previously, coordinating services to meet the higher level of care envisioned for the project residents

[21] As of December 2020, per www.cdss.ca.gov/inforesources/ihss/program-data

[22] Located at 301 Ellis Street in San Francisco and operated by Mercy Housing of California.

requires being able to access the publicly-funded services available in the County, most of which have an income-eligibility criteria of $17,775 per year.

Following is a summary of the rental subsidies that may be available to the project:

- ***Project Rental Assistance Contracts (PRACs).*** In addition to providing capital funding for affordable senior housing projects, the HUD 202 program also provides rental assistance in the form of Project Rental Assistance Contracts (PRACs) to subsidize the operating costs of 202 properties. Through this program, residents pay 30 percent of their adjusted income in rent, with PRACs providing the difference between rental revenue and HUD-approved operating costs. As with HUD 202 capital funds, funding allocations for PRACs have been limited in recent years. As a result, it is not known how many (if any) PRAC subsidies the proposed project would be able to access. It is assumed that the project would apply for PRAC subsidies for all units. However, any subsidies not available through PRACs would need to be provided by locally-based rent-subsidy programs.
- ***Housing Choice Vouchers.*** HUD's Housing Choice Voucher program, commonly known as Section 8, subsidizes the rents paid directly by tenants. Under this program, landlords accept 30 percent of a household's income as the full rental payment, with HUD paying properties for the difference between that amount and the fair market rent for the area. This program can be either project-based (i.e. specified number of vouchers are applied to a particular property) or household based (i.e. an individual or family is able to use the voucher at any property willing to accept Section 8.

  Normally administered by the San Francisco Housing Authority (SFHA), the City has been responsible for the agency over the past several years because of defaults by SFHA on obligations with HUD. As a result, no new project-based vouchers are currently available through SFHA. However, since SFHA has recently resolved its default status with HUD, staff with MOHCD expect that new project-based vouchers may become available again in the near future. MOHCD staff estimated the maximum number of subsidies which the proposed project would likely receive to be 25, although there is no guarantee at this time that any project-based subsidies would be available to the project.
- ***Scattered Site Housing and Rental Subsidy Administration***. Financed by San Francisco City and County general funds through the Community Living Fund, this program provides housing options for individuals in skilled nursing facilities in San Francisco, including Laguna Honda Hospital, or who are at imminent risk for nursing home or institutional placement. The maximum income eligibility requirement for this program is 300 percent of the federal poverty limit, or $36,180 in San Francisco.

  As part of the Scattered Site Housing program, corporate or master leases are executed for a "set-aside" number of units at properties scattered throughout San Francisco for a preference population and priority access. HUD's fair-market rents are used as a benchmark for the set-aside units, with program participants paying 50 percent of their income in rent. According to the program manager with the Human Services Agency's Office of Community Partnerships, the Scattered Site Program was serving 110 consumers but can serve up to 115 or 120, with most clients of the program former residents of Laguna Honda. It was suggested that an estimated ten percent of the available slots (i.e. 11 or 12) could potentially be allocated to the project if it were able to meet the complex needs of individuals transitioning from Laguna Honda.
- ***Senior Operating Subsidies (SOS)***. This program was established to provide project-based rent subsidies to new senior affordable housing developments funded by the City to maintain rents that are affordable to extremely low-income residents (with incomes at or below 30 percent of the AMI), with the targeted households having incomes of 15 to 25 percent of the AMI. The SOS program is administered by DAS and utilizes grant agreements that have terms of no less than 15 years with operators of new senior affordable housing developments. The program is relatively small at this time, with $5 million in seed money and only one participating property.

3. **A "Clustered Care" Model for IHSS Workers[23].**

   The clustering or bundling of IHSS hours at a single location would allow IHSS workers to provide care to

[23] See Program Review B: IHSS Service Capacity and Contract Mode Eligibility for an overview of this program.

multiple residents throughout the day. This would enable more efficient use of authorized hours and the ability to meet unscheduled needs on demand. Ideally, the clustering of IHSS hours would also allow for 24/7 staffing, and as a result the capacity to respond to the nighttime needs of residents.

The proposed service model would likely utilize San Francisco's IHSS contract mode provider, Homebridge, and builds on this organization's prior experience with clustering IHSS workers through the Building Specific Care Team (BSCT) program. The BSCT model was implemented in 2018 to serve formerly homeless consumers living in congregate settings. Trained professional caregivers staff the BSCT model, working in teams of between eight and 14 under the guidance of a supervisor who provides further support such as real-time scheduling. One of the primary benefits of the BSCT model is the ability of the small care teams to provide flexible, on-demand care.[24]

Despite the inherent advantages of this model, several potential barriers exist for building-wide implementation at the proposed project. First, eligible residents may prefer and choose[25] to receive IHSS from an independent provider (IP) either through the IHSS Public Authority[26] or more often, a friend or family member, rather than via contract mode. The large majority (62 percent) of IHSS independent providers in San Francisco are clients' relatives, which may be strongly preferred and have family household income implications. Second, residents may not be eligible for contract mode[27] if they are able to independently direct their IHSS services and/or are not at significant risk for fraud, abuse or neglect.

Although residents could be presented with the advantages of utilizing the contract mode of service delivery, it not known how many would choose to work with Homebridge rather than an independent provider. This would be an important factor as a large proportion of residents would need to choose the contract mode to maximize the model's effectiveness. There is also uncertainty about how many residents would meet the service level criteria for Homebridge, as noted above.

Another potential barrier for a clustered model of IHSS involves obtaining approval from the California Department of Social Services (CDSS) to allow for the bundling of clients' authorized hours. There have been reported concerns about the ability to pool IHSS hours because of the use of Medicaid funding for the IHSS program. However, a review of existing programs in other states and California provides precedence for using Medicaid funds to pay for care in clustered settings (see Program Review C: Precedence for Clustered IHSS Model, pg. 43). One possibility worth exploring is whether a Medicaid waiver would be needed to address concerns with pooling or clustering hours at specific locations.

Consistent with RCFE regulations related to operating an unlicensed facility, the project would not be able to maintain a formalized "program agreement" or subcontract with third service providers, including Homebridge.

4. **Funding for Resident Service Coordinators** in HUD 202 properties is available either through HUD's Multifamily Housing Service Coordinator grant program when "no other funding is available" or through the property's HUD-approved operating budget where the position would be supported through rental assistance funds.[28] However, with a higher level of care than is typically seen at a HUD 202 building anticipated at the proposed project, more service coordinators per resident would be needed contingent on additional funding approval from HUD.
5. **Funding for a Wellness Nurse**. A wellness nurse will be an essential component for implementing a housing with enhanced services model that is able to support a level of care comparable to that found in a licensed assisted living facility. The SASH and IWISH programs utilize a half-time nurse for every 100 to 115 residents, with funding provided by HUD for the IWISH demonstration project[29] (see Program Review A: Leading Models of Housing with Enhanced Services, page 38). Although this funding has been extended for IWISH sites, the cost of wellness nurses to non-demonstration sites is not covered by HUD. Therefore, it will be important to identify a source of funding for

[24] Per information provided by Krista Blyth-Gaeta, San Francisco's In-Home Supportive Services (IHSS) Program Director

[25] IHSS recipients have the right to choose their service providers under the "free choice of provider" right of Medicaid beneficiaries

[26] Assists clients who want autonomy and independence in managing their care and do not have a pre-designated friend or family member to provide the care.

[27] Under the contract mode, Homebridge assists IHSS beneficiaries with services coordination, caregiver management, and care management if needed, and performs the hiring, training, scheduling, and oversight of all contract mode IHSS workers.

[28] www.hud.gov/program_offices/housing/mfh/scp/otherfunding

[29] Leading Age LTSS Center @ UMass Boston, (2019), "Exploring Financing Options for services in Affordable Senior Housing Communities" www.ltsscenter.org

the wellness nurse position. Because of the level of frailty envisioned for the project, a full-time nurse is recommended.

As noted in Program Review A, funding for on-site health and wellness-related positions at affordable senior housing properties can be provided by healthcare organizations. Funding provided by two health plans in California provide the precedence for similar positions at the proposed project.

Two Medi-Cal managed care health plans serve residents of San Francisco, with the San Francisco Health Plan (SFHP) serving 80 percent of the City's Medi-Cal managed care enrollees. As noted previously, the SFHP is expected to assume responsibility for the long-term care costs of dual eligible residents who will be required to enroll by January 2023.

Because the SFHP will be responsible for long-term care benefits in the coming years and because of the successful experience of other health plans in partnering with senior housing organizations, it is thought that the SFHP might have interest in a partnership with the proposed project. The project could provide the plan with a community-based option for members who might otherwise need a skilled level of care, and in turn provide the needed funding for the wellness nurse position at the project. The Chief Medical Officer for the SFHP expressed interest in a possible pilot model to explore the options available in a residential setting, and acknowledged the need for the plan to acquire housing expertise and understand the drivers for moves to different settings. Such a collaboration could be mutually beneficial for the plan and the proposed project.

6. **Meal Service Coordination**. Residents at higher acuity levels typically need assistance with shopping and the preparation of meals. As a result, licensed assisted living facilities are required to provide three meals a day plus snacks for residents. The apartments at affordable senior housing properties typically include full kitchens, with high-functioning residents preparing their own meals. Residents who are more frail typically receive assistance with shopping and meal preparation through their IHSS provider, available family caregivers or other community service providers.

If the proposed project were serving a resident population comparable to that of a licensed RCFE, most residents would likely need assistance with shopping and meal preparation. Furthermore, if IHSS hours can be bundled to gain efficiencies and more effectively meet resident needs, it might be possible to provide some form of congregate meal service at the property. Having a co-located Community-Based Adult Services (CBAS) or Adult Day Program equipped with a commercial kitchen at the property could provide project residents with access to at least one meal per day. Additional congregate meals could also be prepared using bundled IHSS hours with shared or after-hours access to the commercial kitchen. Another option might be to utilize the kitchen for a senior nutrition site, from which residents of the property could also access meals. Many of the recommendations outlined above assume a frailty level for all residents similar to that seen in a licensed assisted living facility. If some reason the presumed level of acuity is not attainable, some of the recommendations may not be operationally viable due to a lack of sufficient economies of scale.

Furthermore, if some of the components of the housing with enhanced services model are not able to be implemented (particularly the clustered care approach to IHSS), partnerships with On Lok, as well as the Institute on Aging, could be explored as an alternative approach to coordinating a higher level of care. Selected units could be set-aside for PACE clients, with the possible co-location of a PACE center at the site. On-Lok, the primary PACE provider in San Francisco, has expressed interested in a potential partnership with the project and reportedly has a need for additional affordable housing units.

Financial Feasibility Analysis: Licensed Assisted Living Model

This financial feasibility analysis was conducted to demonstrate how an affordable, licensed model of assisted living would perform financially, and to determine the operating and capital subsidies that would likely be needed for its development. The operating assumptions were based on current dollars, inflated to 2024 to match the development costs that were provided by a Cahill Guzman Construction Group.

Considering the urban location of the proposed project, higher development costs in the San Francisco market and preliminary design work, the development team agreed that examining the feasibility of a larger 95-unit project would be a sensible size to consider for achieving more economies of scale than a typical affordable AL project. And although the market analysis identified significant demand and limited supply for memory care-specialized assisted living, this evaluation does not assume that the proposed project will include a separate, secured memory care program due to the much higher operating costs of such programs and the limited availability of adequate public subsidies.

The following are a few building and programmatic assumptions that informed this analysis:

- **Target population**: Considering market feasibility study findings, as well as service subsidy limitations, a mixed income population would also address the needs of "middle-market" individuals who do not qualify for Medi-Cal and lack the resources to afford higher cost projects in San Francisco. As a mixed income project, having more market rate units should generate more net income for securing needed financing and ensuring a financially sustainable project.
- **Building**: The housing component will consist of 95 private studio apartments, as well as other common areas available to residents and visitors. Although future scenarios could explore alternative size and unit configurations, this initial analysis assumes studio apartments (e.g. private sleeping area and living area, full bathroom, kitchenette, etc.) that are more likely to appeal to both private-pay residents and comply with the requirements of affordable housing financing options.
- **Services**: A wide range of services will be provided primarily by residence personnel to meet varying levels of need and in accordance with state licensing requirements for Residential Care Facilities for the Elderly. [30] These include basic services that most residents will need (e.g. meals, housekeeping, laundry, maintenance, activities, medications, etc.), as well as assistance with personal care (e.g. bathing, dressing, personal hygiene, mobility, toileting and eating), health-related care (e.g. assessments, treatments, condition monitoring, coordinating physician visits, acute care episodes, etc.), and other specialized care to address memory loss and mental health care needs.
- **Personnel**: The project will employ a team of staff in accordance with both state licensing requirements and industry practice for managing day-to-day operations and meeting resident service needs. Personnel may be grouped into several functional areas. Administrative staff will include the residence's Executive Director, as well as other management and support staff (e.g. office management, reception, etc.). Resident care staff will include nurses and other qualified caregivers for meeting both scheduled and unscheduled service needs 24 hours a day, including awake nighttime staff on duty. Food services staff will include a manager, cooks, dietary aides and servers. Other key positions will include social workers, housekeepers, maintenance workers and a driver. (For staffing levels and compensation details, see the Labor Expense assumptions in this section).

Revenue Assumptions

The revenue projections for the proposed project are based on the results of the market analyses, the rates charged at facilities located in the primary market area, prior and current research about service subsidies and lease-up and vacancy rates typical of similar projects. A blended annual inflation rate for all payment sources was calculated as a weighted average of estimated past inflation rates and the proportion of residents by payer source. The following summarizes the various revenue assumptions incorporated in this analysis.

Market Rate (aka Private-Pay)

The market analysis assumed $6,000 per month (with a base rate of $5,500 plus $500 for the lowest level of care)

[30] See Manual of Policies and Procedures, Community Care Licensing Division, Residential Care Facilities For The Elderly, Title 22, Division 6, Chapter 8, www.ccld.ca.gov

for market-rate assisted living units. Based on this rate structure, the market study found there to be a need in 2021 for 270 market-rate units.

The monthly rates adopted for this analysis were set just below the average base monthly rates for private bedroom or studio units as reported by the 17 larger RCFEs in San Francisco. Specifically, the average base monthly rates (which typically exclude service level charges) for these RCFEs were $6,635. Most providers were charging for additional service levels that averaged almost $800 per month and ranged from $465 to $1,250 per month. One provider reported an all-inclusive $9,840 monthly rate. Service level charges for the proposed project were set at $600 per month.

The analysis assumes that 45 percent of the units will be occupied by private-pay residents who have the financial resources to pay for monthly rental and service costs. This may include a number of "middle market" residents who may be receiving financial support from family members and/or other available benefits from a private long-term care insurance policy, the Veteran's Aid and Attendance program or other local subsidies.

Service Subsidies for Affordable Units

Project revenue estimates for residents eligible for available public subsidies include the estimated amounts from sources as specified below plus the residents' share of room, board and other costs covered by the current SSI/SSP rate.[31] Although the resident's share of cost may be higher for some residents (e.g. residents qualifying for CLF subsidies who do not qualify for Medi-Cal), it is assumed that total revenues per resident would remain the same since service subsidies would be adjusted accordingly. Note that the service subsidy amounts noted below do not include the SSI/SSP rate used in the financial analysis for estimating total revenues per program participant.

Assisted Living Waiver

- Subsidy amount assumptions are based on daily reported rates as of January 2021.[32] The distribution of residents by tiers was based on CDHS-reported statewide figures for the program for the five years preceding its 2019 waiver renewal application.[33]
- Projections do not include additional reimbursement that may be available for "Rehabilitation Hours" ($27 per hour for up to 16 hours a day) for residents with behavioral concerns whether due to dementia or chronic mental health needs.
- A five percent annual inflation rate was initially assumed for ALWP subsidies based on seven-year average rate increases since 2014. Annual reimbursement rates were higher since 2017 (average 9 percent) after several years of no rate increases.[34]

PACE

- Subject to individual project-specific rate negotiations, revenue assumptions were based on interviews with leadership at On Lok, Inc. both in terms of monthly subsidies and distribution across three service levels, as well as interviews with two larger RCFE providers contracted to serve PACE members. In the absence of actual program data, the lowest level of payment was set at $3,000 per month plus $500 for each of two additional service levels. Based on provider interviews, it was assumed that the project might also be eligible to receive additional "patch" subsidies from DPH for a small number of PACE clients at the highest service level who have more complex behavioral and health care needs. Examining the proposed rate structure and distribution of residents across service levels, the average estimated RCFE expenditure per PACE client is $3,714 per month.
- In the absence of historical RCFE subsidy information for PACE members, a conservative three percent annual inflation rate was initially assumed.

Community Living Fund (CLF)

- As with PACE participants, subsidy amounts are understood to be provider specific in terms of monthly contracted rates and resident specific in terms of the individual resident's financial resources and service needs. Subsidy level assumptions for this program were partly informed by reported expenditures for assisted living (RCFE / board & care) purchased services during the last six months of 2020 per RCFE client (i.e. $585,240 / 27 clients / 6 months = $3,613). Additionally, expenditures per client increased by an average rate of nine percent every six months since December 2018. Note that these figures were used as

[31] Effective January 1, 2021, the Non-Medical Out of Home Care Payment Standard includes Room and board ($525.37), Care and supervision ($554 maximum) or $1,079.37, as well as a $138 personal and incidental needs allowance for the resident.

[32] See: www.dhcs.ca.gov/services/ltc/Pages/AssistedLivingWaiver.aspx

[33] California Department of Health Care Services, 2019, Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver, Appendix J

[34] Chen, O; Jordan, S; Lim, S; Lou, Z; Segal, K, 2019, "Evaluating California's Assisted Living Waiver Program Report," California Advocates for Nursing Home Reform

a reference point for potential subsidies rather than a representation of the average cost of RCFE-purchased services per resident.

- For feasibility purposes, this analysis assumed *four* service levels structured more closely to the market rate clients. It also assumes that a few individuals with more complex behavioral or health care needs would be eligible for additional "patch" subsidies from DPH. Examining the proposed rate structure and distribution of residents across service levels, estimated RCFE expenditures per CLF client is $3,962 per month. This figure is 9.7 percent higher than the figure noted above for the last six months of 2020.[35]
- Recognizing that CLF provides subsidies for a relatively small number of RCFE residents in San Francisco compared to other programs, this analysis assumes that the City and County of San Francisco might choose to increase the size of the CLF program and potentially serve twice as many RCFE residents. Unlike the number of ALWP and PACE subsidized clients, which San Francisco does not control, interviews and policy considerations suggest that the City could choose to allocate additional funds as recommended by the Assisted Living Workgroup to increase access to new affordable AL beds.
- A four percent annual inflation rate was initially assumed for CLF subsidies, which have increased at a higher rate in recent years. Comparing CLF expenditures for purchased RCFE services per client per month during the last six months of 2018, 2019 and 2020, expenditures seemed to increase by about 19 percent year over year.

Department of Public Health

- This analysis assumes that "patch" funding from DPH might play a smaller role in subsidizing service costs for the proposed project. This was based on target population considerations for the proposed project and assumptions about how CLF subsidies might play a larger role in the proposed project. This was also based on interviews with DPH staff, which identified potential competing demand concerns related to planned investments in residential care supply and subsidies that will be needed for individuals with complex mental health and behavioral needs. As a result, the analysis assumes that just a handful of PACE and CLF subsidized residents might need and qualify for "patch" subsidies at the Specialty Care rate.

Vacancy and Lease-up Rates

A seven percent vacancy rate was used in the financial analysis based on operator experience with affordable AL projects and under supply in the target market. Industry lenders typically require a vacancy rate ranging from seven to nine percent and as determined by local market conditions.

An 18-month lease-up period was assumed for the proposed project considering the size of the number of units to fill and local market conditions. It was assumed that 15 percent of units would be filled during the first month and that occupancy would increase by just over one unit per week. Note that AL resident turnover rates are significantly higher (median: 54 percent per year) and lengths of stay are much shorter (median: 22 months)[36] than in affordable housing projects for older adults. New market rate AL projects can take 24 months to reach stable occupancy[37].

Annual Inflation Rates

A 4.1 percent weighted average inflation rate was calculated based on the assumed proportion of units by payer source and initial inflation rates described above.

[35] Department of Disability and Aging Services, "Community Living Fund (CLF), Program for Case Management and Purchase of Resources and Services, Six-Month Report (July-December 2020)," April 7, 2021.

[36] American Seniors Housing Association (2019) "The State of Seniors Housing," Tables 8.1 and 8.2

[37] NIC (2020) "Investment Guide (2020), Sixth Edition.

Non-Labor Expense Assumptions

Detailed non-labor expense projections were developed for the proposed project based on cost data from several sources. First, per-unit expenses from smaller, affordable ALFs managed or co-owned by the project consultant in less urban settings were adjusted to levels reported for the highest quartile or decile among larger ALFs participating in a national survey of seniors housing providers in the US [38]. These were further adjusted for local market conditions using budget information provided by a larger local affordable RCFE, as well as suggested figures provided by a local consultant who has operated investor-owned and non-profit owned senior living communities in the Bay area. Note that non-labor expenses can vary widely according to market location, building, provider practices and target market characteristics.

A few noteworthy assumptions include:

- **Utilities**: Consistent with industry practice, basic cable will be provided and included in the monthly rates for all units, as well as all utilities except phone.
- **Repair and replacement reserve**: $500 per unit per year to meet lender requirements for funding needed facility repairs and renovation in future years.
- **Management fee**: Five percent of gross revenues; assumes a third-party management company with expertise in assisted living, per lender requirement and owner preference. The selection of a management company with experience managing affordable projects in California is thought to be essential considering the complexity of subsidies.
- **Licensing fees**: For RCFEs licensed for 75 to 100 units, $3,469 initially and $1,734 annually.
- **Accounting**: For software related expenses, which will vary by operator.
- **Linen and bedding**: Assumes most residents will bring own linens with some provided for residents without their own linens.
- **Professional/referral fees**: AL residents/families in larger California markets often choose to work with professional placement agencies and online services to help identify the most suitable location. Associated fees are charged back to facilities and are typically 80 to -100 percent of the first month's fees.

A three percent inflation factor was built into the analysis for all non-labor expenses.

Personnel Cost Assumptions

Wages used in the analysis were obtained from a local RCFE consultant who has operated investor-owned and non-profit owned senior living communities in the Bay area. A wage survey of competitive facilities was attempted with limited and insufficient provider responses. Positions and staffing levels were based on industry practice and the project consultant's experience with operating affordable projects of varying sizes and states including California. Overall and department-specific staffing levels were in line with nationally reported rates for assisted living communities.[39] The following summarizes staffing levels and compensation for the proposed project:

Full-Time Employees (FTEs)* and Wages/Salaries for 95-unit Affordable Assisted Living

Position	Wage/Salary	FTEs
Administration		
Executive Director	$127,628	1.0
Assistant Executive Director	$86,528	1.0
Business Office Manager	$75,712	1.0
Receptionists	$18.7	1.4
Outreach & Move-In Coord.	$75,712	1.0
Life Enrichment / Activities		
Director & Assistants	$73,548 /18.7	2.0
Driver	$23.9	0.5
Environmental Services		
Maintenance Director & Assist.	$82,202 / 19.8	2.0
Housekeepers	$17.2	2.0
Food & Dietary Services		
Director & Cooks	$62,732 / 18.7	3.8
Dietary aides	$17.7	2.8
Health Care & Social Services		
Nurses (LVNs)	$29.1	1.8
Resident Care Coordinator	$35.4	1.0
Staffing Coordinator	$29.1	0.8
Med Techs	$19.8	7.0
Care Partners	$18.2	17.5
Social worker	$31.2	1.0
Total FTEs		**47.6**

* Prior to replacement time for paid time off.

Benefits and Inflation Factor. Replacement time for selected non-salary positions (e.g. direct, caregivers, nurse, dietary, housekeeper) was included in the analysis based on 10 paid-time-off (PTO) days per year. In addition, a

[38] American Seniors Housing Association (2020) "The State of Seniors Housing," Table 9.15 Assisted Living Residences with Memory Care – per Occupied Unit/Bed – Property Size > 80 Units

[39] American Seniors Housing Association (2019), "The State of Seniors Housing," Tables 11.1 & 11.2

factor of 30 percent was used to calculate other benefits, such as health insurance, worker's compensation, and payroll taxes. An annual inflation factor of four percent was assumed for personnel costs that have recently been increasing at higher rates.

Development Costs

An initial construction cost estimate of $51.2 million was provided by Cahill Guzman Construction Group and includes a 3-year escalation rate. With the addition of $7.7 million for construction, design and bidding contingencies, total estimated construction costs are $58.9 million as shown in the table below. Assuming 77,913 total square feet and 95 studio apartments,[40] construction costs for the proposed project are $758 per square foot ($621,619 per unit). Building on a preliminary development budget prepared by Mercy Housing California, this analysis includes another $12.2 million for soft costs, $3.9 million for reserve requirements and $2.2 million for developer costs. Total development costs are estimated at $77.1 million -- $989.5 per square foot ($811,510 per unit).

Preliminary Estimate of Development Costs

Acquisition	$ 15,000
Construction (Hard Costs)	58,863,802
Soft Costs (Architecture, Financing, Legal, etc.)	12,217,123
Reserves (Operating, lease-up & debt service)	3,797,499
Developer Fees	2,200,000
Total	**$ 77,093,424**

Sources of Funds

The capital funds for the proposed project will be drawn from a variety of sources. Because the project will be developed to serve a mixed-income population, the project is projected to generate sufficient revenues to support some debt.

Debt Capital

As noted in the Development Financing subsection for the Licensed RCFE Model section of this report, HUD-insured Section 232/223(f) mortgages are among the most common financing options for new assisted living projects. Since this would be for a new construction project, the maximum 40-year loan term would apply plus the construction period. This analysis assumes a loan that results in a debt service coverage ratio of 1.45x based on the set Operating Income (NOI) upon stabilization.[41] A 3.5 percent interest rate was used based on consultation with a HUD 232-specialized mortgage broker. Understanding that the project could also qualify for secondary debt, this analysis assumed gap financing with a 20-year loan term and a debt coverage ratio of 1.20x based on the stabilized NOI.

It is worth noting that the project could avoid having to secure a secondary loan in the event the HUD lender is able to secure authorization from FHA for a higher debt coverage ratio. This would be in consideration that the project adds needed affordable AL units to the market area, as well as other unique project attributes.

Equity Capital

As noted previously in this report, the Low-Income Housing Tax Credit (LIHTC) program is the most used source of equity for affordable housing projects. In the event the licensed version of the proposed project would qualify for LIHTC financing, this analysis assumed that all but 95 percent of total development costs would be eligible for four percent credits and that 80 percent of the units would be LIHTC eligible.

To evaluate potential demand in San Francisco for LIHTC-financed AL units, additional market analyses were conducted that involved estimating the number of age, income and needs-eligible homeowner households at different Area Median Income (AMI) thresholds. These estimates indicated 316 such households at the 50 percent AMI threshold; 525 households at 60 percent AMI and 896 households at 80 percent AMI in 2021. After subtracting

[40] Assumes 330 square foot studio apartments that include private, fully accessible showers and kitchenettes both to appeal to market-rate residents and to conform with financing requirements for affordable housing projects

[41] Loan sizing may also be determined by project valuation, which could be lower if calculated according to the project's Net Operating Income versus local market valuation considerations.

the number of such households assumed to already be living in existing RCFEs and assuming that 15 percent of the remaining households would choose to move into the proposed project, there is strong demand for serving at least 33 households below the 50 percent AMI threshold; 55 households below the 60 percent AMI threshold and 95 households below the 80 percent AMI threshold.

The analysis also assumes that about a third of the $50 million in forgivable loan funds for the proposed project that are potentially available from the City and County of San Francisco's Mayor's Office of Housing and Community Development could be used to provide equity funding for the assisted living portion of the project.

Sources	**Amounts**
FHA 232 Loan	$ 19,704,878
Gap Financing	2,204,915
4% Low-Income Housing Tax Credits	17,545,568
City Funding	16,666,667
Total	**56,122,028**
Less Total Development Costs	77,093,424
Project Gap	**$ (20,971,396)**

Considering the large size of the funding gap, the discussion section below explores several potential alternatives to be considered for reducing this gap.

Projected Revenues and Expenses at Stabilization

Financial projections indicate that the project will be operationally self-sustaining once it reaches stable occupancy in Year 2. Specifically, the project could generate enough revenues to cover total operating expenses when it reaches 65% occupancy by month 11 and could break even to also cover debt payments at 85% occupancy by month 15. During Year 1, lease-up reserves will be needed to cover operating deficits and mortgage payments totaling $2.3M. Stabilized occupancy will lead to more sustainable financial results in subsequent years with the net operating income projected at just over $1.2M for Year 2 of operations and $1.4M for Year 3 of operations.

Operating Proforma at Stabilization (Year 3)

Revenues	
AL Rent and Service Revenues	$ 8,122,983
Less Vacancy	- 568,609
Net Revenue	**$ 7,554,374**
Operating Expenses	
Personnel	$ 3,841,241
Administrative	270,595
Food Services	338,191
Housekeeping & Laundry	49,777
Resident Care	139,836
Activities	34,361
Marketing	130,921
Utilities	416,295
Maintenance	246,485
Vehicle	10,573
Insurance	95,153
Management	377,719
Other Expenses	186,238
Total Operating Expenses	$ 6,137,384
Net Operating Income	1,416,990
Less Estimated Debt Service	- 1,114,960
Cash Flow after Debt	**$ 302,030**
DCR	1.27

Discussion

Since emerging in the early 1990's as a more desirable and less costly alternative to nursing home care, developing affordable assisted living has been limited by the lack of adequate public financing options for subsidizing building and operating costs. Developing such a project in San Francisco is especially challenging due to the incomparably high construction costs and relatively small Medi-Cal subsidies for assisted living. Nevertheless, this financial analysis has examined potential financing sources that could be creatively combined, if not easily, to address considerable development barriers.

The financial analysis conducted for the proposed project considered: a) various state and local subsidy options currently available in San Francisco, b) local supply and demand factors, c) development financing options used by other affordable assisted living projects in other states, d) preliminary estimated development costs, and e) local operating costs financing options. Detailed profit and loss projections based on the assumptions outlined above (the base scenario) are included in the appendix to the report. Alternative scenarios were also modeled to show the impact modifications to key assumptions would have on the financial performance of the project. The amount of debt a project can support can be estimated from the projected net operating income of the project in conjunction with estimated terms for a particular type of financing vehicle. The amount of any funding gap can then be determined by subtracting the estimated amount of the loan from the estimated development costs.

The projected funding gap for the project as a licensed RCFE may vary widely depending mostly on its ability to secure non-debt capital financing through Low-Income Tax Credits or other sources. As shown in the table below, loan terms and payer mix assumptions are the other key drivers of financial performance. The impact of these variables on the financial viability of the project is illustrated by comparing the projected capital funding gap for the various scenarios modeled below.

The base scenario (detailed in Appendix E of this report) has a projected funding gap of $21 million. This gap would be twice as large without LIHTC financing (Scenario 2). Securing approval for more favorable loan terms and a slightly lower interest rate for a HUD 232 loan might also be feasible considering the need for new affordable AL units in San Francisco and other helpful factors. This would increase the amount of the allowable debt and reduce the cost of debt, thereby reducing the funding gap to $13.6 million (Scenario 3). Increasing the number of market rate, LIHTC-eligible units from 45 to 55 units would result in an increased net operating income for the project, thereby

increasing the project's ability to carry more debt while reducing the projected funding gap (Scenario 4). Combining these two scenarios -- more favorable loan terms and more LIHTC eligible market rate units – could reduce the gap to $10.4 million (Scenario 5). Finally, increasing average private-pay monthly rates by about 9% increase the projected NOI by $490,554 and reduce the funding gap by $1.6 million (Scenario 6).

Projected Funding Gap with Alternative Financing and Market Rate Unit Assumptions

Scenarios	Projected Funding Gap
1. Base: assumes LIHTC Financing; HUD 232 loan @ 1.45 DCR & secondary debt; 45 market rate units	(20,971,396)
2. Base without LIHTC Financing	(38,516,964)
3. Base with HUD 232 loan @ 1.11 DCR; 3.25% interest rate	(16,909,219)
4. Base with 55 market rate units	(14,974,523)
5. LIHTC financing with 55 market rate units; HUD 232 loan @ 1.11 DCR; 3.25% interest rate	(10,413,290)
6. Scenario 5 with increases to Base Private-Pay and Service Level Rates	(1,629,246)

Advancing the proposed project will likely be contingent on a range of internal and external factors. First, the development of licensed affordable AL projects in other states has historically involved project sponsors and funding partners who are: a) committed to addressing a local community need through innovation; b) actively engaged in advocacy efforts with state and local policymakers; c) willing and able to sustain predevelopment efforts for a much longer time than is typically required by market-rate projects; and d) able to stitch together complex and unconventional financing structures. In this case, securing LIHTC financing, negotiating more favorable service subsidies from health plans and local funding sources, and securing more favorable loan terms will take considerable time and effort. Second, engaging an operator with experience developing and managing affordable AL projects will be essential, preferably in California. Third, future design efforts should explore alternative apartment and building configurations that might help reduce the per-unit development costs.

Financial Feasibility Analysis: Housing with Enhanced Services Assisted Living Model

A financial feasibility analysis was conducted to demonstrate how a housing with enhanced services model of affordable assisted living would perform financially, and to provide an estimate of the operating and capital subsidies that would be needed if this model were pursued. As with the preceding licensed AL analysis, operating assumptions were based on current dollars, inflated to 2024 to match the development costs that were provided by Cahill Guzman Construction Group. Many of the assumptions were based on the experience of Mercy Housing California, who would likely be the operator of the project if a housing with enhanced services model were pursued.

The financial analysis was based on the following key assumptions:

- **Target population**: It is assumed that the housing with enhanced services model would have a similar level of frailty as is seen in licensed assisted living facilities. Thus, the financial feasibility analysis assumes that all project units will be occupied by very low-income individuals who qualify for Medi-Cal, so that residents are able to access the array of community-based services available in the area. It is further assumed that all residents at the project will have some level of need at the time of move-in, meeting the criteria established for a frailty preference.
- **Building**: The housing component of the project will consist of 95 apartments, with approximately 60 percent studio units and 40 percent one-bedroom units.
- **Services**: A wide range of services will be provided by a variety of community-based service agencies, with service coordination and wellness services provided by on-site resident service coordinators and a wellness nurse. As discussed earlier in this report, it is assumed that a clustered approach to IHSS hours through Homebridge will be utilized in order to maximize efficiencies and provide the ability to meet the unscheduled and nighttime needs of residents.
- **Personnel**: The project will employ a team of staff members similar to that seen in other affordable senior housing projects, including property management staff, front desk clerks, maintenance personnel, and janitorial staff. A higher staff-to-resident ratio of resident service coordinators and housing support specialist staff will be provided than is typical for affordable senior housing properties, due to the frailty preference that will be in place for all of the units. In addition, it is assumed that an on-site wellness nurse / health navigator position will be funded through an outside source, such as the San Francisco Health Plan, as discussed earlier in this report.

Revenue Assumptions

The revenue projections for the proposed project assume that all residents will be at the lowest income levels in order to access service programs that require Medi-Cal-eligibility (a maximum of $17,775 per year or $1,481 per month). The actual income levels of residents may be even lower than this maximum amount, as the combined federal and state SSI payments in California for aged or disabled individuals living independently is currently $954.72 per month. Because of the low-income levels assumed for the project, it is assumed that residents will pay 30 percent of their adjusted income in rent, or approximately $300 per month. The remaining rental revenue will be provided by subsidy sources.

As stated earlier in this report, the HUD 202 program includes rental assistance in the form of Project Rental Assistance Contracts (PRACs) to subsidize the operating costs of 202-financed properties. With the 202 program, residents pay 30 percent of their adjusted income in rent, with the PRACs providing the difference between tenant-paid rental revenue and HUD-approved expenses.

It is assumed that application to HUD for PRAC funding will be made for all units, although the allocation of funds would not be known in advance. Any gap in subsidies (i.e. not covered by PRACs) would need to be provided locally by the City or County. As noted earlier, City staff estimated that subsidies for approximately 11 or 12 units might be available for the project through the Scattered Site Program, with HUD's Housing Choice Voucher program (administered by the San Francisco Housing Authority) an additional possible source of subsidies for up to 25 units. Finally, expanding the recently created Senior Operating Subsidies (SOS) program could provide another source of rental subsidies for the project.

In addition to rental revenue, miscellaneous revenue from laundry equipment usage was also included in the

financial projections, based on the experience of Mercy Housing California.

Vacancy and Lease-up Rates

A vacancy rate of five percent was assumed in the financial analysis. In addition, a lease-up period of six months with 20 percent of units occupied the first month was assumed. This lease-up period is slightly longer than what might be expected for a typical affordable senior housing project of this size due to the potential added complexity of the move-in process with a frailty preference applied to all units.

Annual Inflation Rates

An inflation rate of 3.5 percent for all revenue was assumed in the analysis, to match the annual inflation factor projected for both non-labor and personnel costs at the project.

Non-Labor Expense Assumptions

Detailed non-labor expense projections were developed for the proposed project, based on Mercy Housing California's operating experience for similar properties. A few noteworthy assumptions include:

- **Utilities**: It is assumed that all utilities (i.e. electricity, water, sewer, trash, and cable TV for the common areas) will be paid by the project.
- **Repair and replacement reserve**: A repair and replacement reserve of $500 per unit per year (in current dollars) to fund needed facility repairs and renovation in future years was included in the financial projections.
- **Resident services**: Additional funds were allocated for resident services than would be typical for an affordable senior housing property due to the higher level of frailty expected for the project.
- **Management fees**: A management fee of $72 per unit per month in current dollars was included to provide ongoing oversight of the project. In addition, an asset management fee of $53,550 per year was included, with $24,280 allocated as an operating expense and $29,270 shown "below the bottom line" after all other operating expenses have been paid, per MOHCD guidelines.

A 3.5 percent inflation factor was built into the analysis for all non-labor costs based on Mercy Housing California's experience.

Personnel Cost Assumptions

The personnel costs assumed in the analysis, including both wages and the number of full-time employees by position, were based on the experience of Mercy Housing California. As stated previously, higher levels of resident service coordinator and housing support specialist staff were budgeted as compared to typical affordable senior housing properties due to the more frail resident population anticipated for the project.

Following is a summary of the staffing levels projected for the proposed project:

Full-Time Employees (FTEs)* for Housing with Enhanced Services Project

Position	Hrly Wage	FTEs
Senior Property Manager	$40.9	1.0
Assistant Property Manager	$22.0	3.0
Assistant Manager – Front Desk	$22.0	1.0
Community Coordinator	$22.0	1.0
Front Desk Clerk	$17.8	2.5
Housing Support Specialist	$43.3	1.0
Resident Service Manager	$34.6	1.0
Resident Service Coordinators	$26.4	1.6
Maintenance Director	$30.0	1.0
Maintenance Technician	$23.0	2.0
Janitorial / Cleaning Staff	$18.5	2.0
Total FTEs		**15.1**

* Prior to replacement time for paid time off.

Benefits and Inflation Factor. Personnel benefits were assumed to be 35.1 percent of wages, with an annual inflation factor for personnel costs of 3.5 percent, based on the experience of Mercy Housing California.

DEVELOPMENT COSTS

An initial construction cost estimate of $58,863,802, escalated to 2024 by five percent annually, was provided by Cahill Guzman Construction Group, as noted in the

Financial Feasibility Analysis: Licensed Assisted Living Model section of this report. The total development costs for 95 units of housing with enhanced services is estimated to be $74.3 million, or $482,036 per unit. Although the construction cost estimate was developed assuming a licensed assisted living facility, it is thought to also be applicable for the housing with enhanced services model at this preliminary phase based on a comparison of total development costs for comparable affordable housing projects recently completed or planned in San Francisco.

A breakdown of the total development costs estimated for the project is as follows, based on a preliminary development budget prepared by Mercy Housing California:

Preliminary Estimate of Development Costs

Acquisition	$ 15,000
Construction (Hard Costs)	58,863,802
Soft Costs (Architecture, Financing, Legal, etc.)	12,217,123
Reserves (Lease-up & Operating)	997,527
Developer Fees	2,200,000
Total	**$ 74,293,452**

Sources of Funds

Development funds for the housing with enhanced services model of the proposed project will be drawn from a variety of sources. Because the project will be developed to serve a very low-income population with rental subsidies required for all units, the project will not be able to support any debt. As a result, the needed funds will be drawn from programs designed to support the capital costs of affordable housing projects.

HUD Section 202 Program. As the primary federal source of capital grants for developing supportive housing projects for low-income older adults, HUD's 202 program was first established in 1959. No new funding was allocated to the program between 2011 and 2020. In 2020, $51 million in 202 funds was awarded to 18 projects[42], with $150 million in additional funding announced by HUD in January 2021[43] and an additional $90 million available for the next Section 202 Notice of Funding Opportunity (NOFA). [44] Although these recent funding allocations are encouraging, the available amounts are minimal considering the unmet need for affordable senior housing nationwide.

Due to the uncertainty about the future availability, timing, and competitive nature of HUD 202 funding, it is assumed that only ten percent of the capital costs for the project would be sourced from this program.

Low-Income Housing Tax Credits (LIHTC). Compared with the less common use for financing new licensed AL projects, the LIHTC program remains "the largest annual federal expenditure for new affordable housing for older adults with low incomes" according to a report developed by Leading Age and the National Housing Trust. Recent developments in California's LIHTC program should provide favorable scoring and award conditions for the housing with enhanced services model, considering the target population, site location and other factors. Specifically, the California Tax Credit Allocation Committee established a goal in 2020 of allocating 15 percent of total housing credits to projects designated for older adults. Points are awarded to projects that include features and amenities that would benefit older residents, including resident services coordination, accessible design features, and proximity to services such as public transportation and healthcare. [45]

It is assumed that 30 percent of the project's development costs will be obtained through four percent low-income housing tax credits.

Other Capital Funding Sources assumed in the feasibility analysis for the housing with enhanced service model include an estimated $20 million from California's Multifamily Housing Program and $1.2 million from the Federal Home Loan Bank's Affordable Housing Program. This assume that the City would provide the remaining funding ($23.3 million) needed for the project.

The proposed sources of funds are summarized below:

Sources	Amounts
4% Low-Income Housing Tax Credits	22,288,036
HUD 202 Program	7,429,345
Multifamily Housing Program	20,000,000
FHLB's Affordable Housing Program	1,200,000
City Funding	23,376,071
Total	**74,293,452**

Financial Feasibility Results

The financial projections developed for the housing with services model show a net revenue of $2,504,337, with total expenses of $2,474,042, resulting in a net operating income of $30,295 in Year 2 (the first year of stabilized occupancy). After the portion of the asset management fees projected below the bottom line ($30,294 in Year 2) are paid, no cash flow will be generated by the project. If the property were not to perform as projected, the asset management fee would thus be at risk, and as stated previously, the project has no capacity to support debt.

Following is a summary of the profit and loss projections for the housing with services model in Year 2 of operations:

Operating Proforma at Stabilization (Year 3)
Revenues

[42] HUD.gov press release, Feb. 27, 2020
[43] HUD Section 202 FY2020 NOFA, Reference FR-64-N-52
[44] HUD.gov FR-6400-N-52, January 2021
[45] Leading Age & National Housing Trust (2020), "Affordable Senior Housing: A Scan of Housing Credit Allocation Plans."

Rent Revenue	$2,629,113
Misc. Revenue	7,031
Gross Revenue	**2,636,144**
Less Vacancy Factor	131,807
Net Revenue	**2,504,337**
OPERATING EXPENSES	
Personnel	
Administrative & General	470,806
Building & Grounds	184,499
Housekeeping and Laundry	88,313
Total Salaries and Wages	**743,618**
Plus Benefits	260,958
Total Personnel	**1,004,576**
Non-Labor Expenses	
Administrative Expense	119,817
Housekeeping and Laundry	14,090
Resident Services	298,361
Marketing	3,443
Utilities	449,765
Maintenance	218,572
Vehicle Expense	1,377
Insurance	240,980
Management Fees	120,198
Other Expenses	2,864
Total Non-Labor Expenses	**1,469,467**
Total Operating Expenses	**2,474,042**
Net Operating Income (NOI)	30,295
Less Estim. Debt Service Payments	0
Cash Flow after Debt	**30,295**
Less Asset Management Fees	30,294
Cash Flow after Asset Mngt Fees	**0**

Note: Totals may not sum due to rounding

Detailed profit and loss projections for the first ten years of operation are included in Appendix F of this report. The negative cash flow of -$456,337 shown in year 1 would be covered by a lease-up reserve, which has been capitalized as part of the development budget. Also included in the development budget is an operating reserve of $541,191.

DISCUSSION

The housing with services model is projected to break even beginning in month six, based on the assumption that rental subsidies have been secured for all units to match operating expenses. If PRAC subsidies through the HUD 202 program are not available for all units, local rental subsidies would need to be provided for those units not subsidized by PRACs.

Because the project would be unable to support debt, capital subsidies would also need to be provided by the City, with the amount of the capital needed contingent upon the availability of funding from other sources, such as from the LIHTC and HUD 202 programs. The amount of this subsidy is currently estimated at $23.4 million (in 2024 dollars).

In addition, the successful implementation of the housing with services model would be contingent on a number of other factors in order to replicate the level of care provided in a licensed assisted facility. These factors, which have been discussed in detail earlier in the report, are as follows:

- Approval by HUD to apply a frailty preference to all units in order to serve individuals at an assisted living level of care.
- Approval by CDSS to utilize a "clustered" staffing model for IHSS workers in order to gain efficiencies in service provision and meet the unscheduled and nighttime needs of residents.
- Enough residents choosing to utilize Homebridge as their IHSS provider over a family member or friend so economies of scale could be achieved with the proposed clustered care model of staffing.
- Funding for a wellness nurse / health navigator provided by the San Francisco Health Plan (or another source).

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PROGRAM REVIEWS AND APPENDICES

Program Review A: Leading Models of Housing with Enhanced Services

Models in Other States

Because of the aging of the population served in affordable senior housing properties, and the corresponding increase in frailty and care needs, there has been growing interest in developing models to support the aging-in-place of these residents. This interest has been fueled in part by the lack of affordable assisted living and the documented desire of most individuals to remain at home as they age.[46] As a result, several national initiatives have been exploring options to provide services to support the increasingly older and frail residents of affordable senior housing properties. For example, LeadingAge [47] has partnered with the University of Massachusetts Boston to create the LeadingAge LTSS Center @UMassBoston, which is committed to serving as a national catalyst for the development, adoption and support of innovative affordable housing solutions that enable older adults with low and modest incomes to age safely and successfully in their homes and communities.[48]

Additionally, 13 leading multi-state, non-profit affordable housing providers formed the non-profit Stewards of Affordable Housing of the Future (SAHF) in 2003 to collaborate around shared objectives, one of which is to "improve the effectiveness of service-enriched housing."[49] Through this initiative, SAHF and its members utilize indicators, test and evaluate business models, collect data, and measure outcomes.

These high-level collaborations, in addition to innovations pursued by individual affordable housing organizations, have resulted in a variety of different housing with service models that have been implemented in various locations. Following is a summary of a sample of these models:

Support and Services at Home (SASH). The SASH program was launched in Vermont in 2011 to provide services for residents of affordable housing communities throughout the state. In this program, full-time services coordinators and part-time wellness nurses are assigned to panels of approximately 100 older adults, most of whom live in affordable housing properties. The SASH program provides each participant with a functional and cognitive assessment, a customized healthy-aging plan, ongoing care and service coordination, wellness nurse visits, and care transition assistance. The program's multi-disciplinary team meetings focus on high-risk residents, with community-wide healthy aging plans developed based on aggregated information from the assessments of all participants. Assistance with ADLs and IADLs is available to SASH participants who qualify through the State's Choices for Care 1115 Medicaid waiver program. The development of SASH included the utilization of CMS funds through a demonstration program to pay for care coordination and wellness nurse staff members, with the participation of case managers and home health nurses in team meetings funded through Medicaid.

Reported outcomes of the SASH program included higher overall functional status and less difficulty managing medications for program participants compared to a control group. Additionally, some of the SASH panels had significantly slower per-beneficiary growth in Medicare expenditures resulting from hospital stays, emergency room visits, and physician specialists.[50]

Integrated Wellness in Supportive Housing (IWISH). Building on the success of the SASH program, HUD funded a three-year demonstration[51] at 40 HUD-assisted properties in seven states to document the implementation of the IWISH program and measure the impact of the program on residents' housing stability and healthcare utilization. As with the SASH model, in the IWISH program a full-time resident wellness director coordinates health and wellness programming for the property and connects residents to supportive services in the community, while a wellness nurse monitors residents' health and wellness and facilitates access to primary and preventative healthcare.

In the IWISH program, HUD provides funding for the resident wellness directors and wellness nurses. Key components of the program include in-depth resident assessments and the development of resident-specific healthy aging plans; community-wide healthy-aging plans to identify appropriate partnerships and programming for the community; an emphasis on developing partnerships with healthcare and other

[46] www.aarp.org/research/topics/community/info-2018/2018-home-community-preference.html
[47] LeadingAge represents more than 5,000 non-profit aging services providers nationally.
[48] www.ltsscenter.org
[49] www.sahfnet.org
[50] https://www.brookings.edu/wp-content/uploads/2018/03/es_20180315_housing-as-a-hub_final.pdf
[51] From October 2017 through September 2020, with a comprehensive analysis and report of the demonstration to be completed in 2022.

providers to better coordinate health and wellness services for residents and transitional care following hospitalizations; and supplemental funding to support evidence-based programming and other activities to support aging in place.[52] If the evaluation of the program, which is currently underway, demonstrates effectiveness, it is hoped that HUD will make additional funding available for wellness directors and wellness nurses in HUD-assisted properties.[53]

Housing with Healthcare Partnerships. Many senior affordable housing properties are exploring the opportunities and benefits of ongoing partnerships with healthcare organizations. Typically the healthcare entity in a housing-health partnership is the funding source for the programming made available to residents at the housing property, with possible funding strategies including: 1) the provision of funds required by non-profit hospitals to satisfy community benefit requirements; 2) billing for services provided such as primary care, physical or occupational therapy, or mental health treatment; 3) creating field-placement opportunities for health-related professional training programs; and 4) the reduction of costly services and/or penalties assessed by CMS for hospital readmissions.[54]

Although these partnerships can take many forms, the goal of each is typically to support the ability of residents to successfully age in place in an affordable senior housing property. Following is a sample of innovative housing and healthcare partnerships that have been implemented in affordable housing communities nationwide[55]:

- In Baltimore, Maryland, the Greater Baltimore Medical Center (GBMC) provides a nurse practitioner to host weekly clinics at multiple affordable housing communities operated by the Catholic Charities of Baltimore. GBMC believes that providing access to this nurse practitioner offers an opportunity to intervene before health complications reach a crisis level; provides residents with guidance for appropriate care; and shows residents the importance of complying with existing medications or self-care directives to reduce emergency department visits, hospitalizations, and re-hospitalizations.
- In Harrisburg, Pennsylvania, PinnacleHealth found that a 150-unit housing property operated by Presbyterian Senior Living had a high rate of emergency room visits and hospital utilization. As a result, PinnacleHealth began to provide a weekly, half-day clinic at the housing property, staffed by a physician, nurse navigator and social worker with the goal of helping residents better manage multiple chronic conditions and more appropriately navigate the healthcare system. The clinic physician does not replace the residents' primary care physicians but reconnects residents to the healthcare system and supplements their primary care. The first year, the number of emergency room visits by residents were decreased by half and hospitalizations were reduced by 70 percent.
- In Richmond, Virginia, the schools of nursing and pharmacy at Virginia Commonwealth University operate a weekly health clinic at Dominion Place, a 249-unit affordable senior housing site, to reduce unneeded emergency room visits. The clinic helps residents manage their healthcare needs and offers a venue for students to complete their required rotations. The clinic is staffed by a team of students and supervisors from the schools of nursing, pharmacy, medicine, social work and gerontology. The goal is to reconnect residents to the healthcare system and supplement the primary care residents receive from their own physicians (if a resident does not have a primary care physician, the clinic will help them find one).
- In Northeast Ohio, a continuing care retirement community (CCRC) operates the Personal Health Partners program in three affordable senior housing properties as part of its mission to support the communities it serves. The Personal Health Program provides nurse-staffed clinics two-to-four days a week at each housing property to empower residents to make sound, health-related decisions by providing and coordinating education, support,

[52] https://www.huduser.gov/portal/sites/default/files/pdf/IWISH_FirstInterimReport.pdf

[53] A two-year extension of funding for IWISH was granted after the demonstration concluded, with additional funding included in HUD's budget for 2021 (https://www.hud.gov/sites/dfiles/SPM/documents/26_FY21CJ_Section202v2.pdf)

[54] http://www.ltsscenter.org/resource-library/Housing_Health_Partnership_Guide.pdf, page 19.

[55] Ibid, page 20-23.

referrals and services. A fitness instructor and spiritual coordinator also support the program.

Mercy Housing's Program to Support Aging-in-Place

Despite the prevalence of innovative models such as those summarized above, interviews with industry leaders acknowledge the lack of models able to serve a comparable population and provide a similar level of services as found in licensed assisted living facilities. As one interviewee observed, "Lots of people see the need, but no one's cracked the nut yet." Another said, "everyone is struggling to figure out how to support a higher need population." Nevertheless, Mercy Housing was mentioned by several interviewees as being on the forefront of the movement to provide enhanced services and support aging in place in affordable senior housing properties. And Mercy Housing staff report ongoing efforts to refine their program to provide the needed supports for increasingly older and more frail residents.

In addition to providing services in the areas of housing stability and community participation, Mercy Housing's enhanced health and wellness model for seniors includes a full range of services and supports offered on the housing site either directly by Mercy Housing resident services staff or through strong partnerships with local health service organizations. The essential services included in the enhanced health and wellness model have been selected to be responsive to the needs of older adults wishing to "age in place". They further address the critical factors associated with averting and delaying institutionalization such as continuously monitoring cognitive, functional, and other risk factors; providing wellness services; teaching chronic disease management strategies; and actively coordinating transitions to and from the hospital.

Mercy Housing's "enhanced services" model builds on the traditional resident service coordinator role and utilizes a comprehensive assessment process for developing individualized resident service plans. Resident service coordinators monitor each resident's needs, daily if needed, then adapt the resident's service plan as appropriate in response to changing needs.

In addition, residents are triaged by level of risk during the assessment process, which allows part-time wellness nurses to focus on the highest-risk residents. These nurses also provide wellness-based education, outreach and some medication management to residents, and at times communicate with residents' physicians on their behalf. The focus of Mercy Housing's enhanced services model is to prioritize health and wellness programming.

Even with the models developed by Mercy Housing and other affordable housing providers to support the aging in place of residents in affordable senior housing properties, the frailty level of most residents is much lower than in a licensed assisted living facility. This is mostly due to the lower minimum age requirements for affordable senior housing properties (usually 55 or 62 years), as well as the common expectation among housing providers that individuals be independent and relatively high-functioning at the time of move-in. As a result, older, more frail residents are typically replaced with younger, more independent residents as units turn over. Increasing care needs may be found in older affordable senior housing properties where residents have lived for sometimes decades, but the average care needs even in these older buildings are significantly lower than in licensed assisted living facilities, where residents typically move because they have long-term care needs.

The following table provides a comparison of the acuity levels at three affordable senior housing properties and at assisted living facilities in California (on average)[56]. Of the three senior housing properties, one building has a younger and lower-acuity resident population, one has a moderate level of acuity, and a third could be characterized as a high-acuity affordable senior housing property where older residents have aged-in-place and have increased care needs. Not surprisingly, the proportion of residents aged 85 years and older is associated with a building's level of acuity in terms of the proportion of residents needing assistance with personal care needs. Compared to the highest acuity affordable senior housing property, RCFE's tend to serve a much higher proportion of residents aged 85 years and older who are more likely to need assistance with multiple activities of daily living:

[56] NCHS (2018)

% Residents Age 85+ and Resident Acuity Level
In Affordable Senior Housing and CA RCFE's

	Affordable Senior Housing Acuity			CA RCFEs
	Low	Medium	High	
Age 85+	3%	20%	39%	55%
Need Bathing Assist	6%	12%	41%	57%
Need Dressing Assist	5%	12%	25%	48%
Need Toileting Assist	0%	2%	24%	44%
Average ADL Needs	0.2	0.4	1.2	3.1

Source: Data from sample low-acuity, medium-acuity and high-acuity affordable senior properties was provided by Mercy Housing California; RCFE data from NCHS, 2018

Program Review B: IHSS Service Capacity and Contract Mode Eligibility

California's Medi-Cal funded In-Home Supportive Services (IHSS) program provides services to qualifying individuals so they can safely remain at home. Authorized services can include housecleaning, meal preparation, laundry, grocery shopping, personal care services such as bathing, grooming, and bowel and bladder care, accompaniment to medical appointments, and protective supervision for the mentally impaired.

The provision of IHSS-funded services is essential for individuals to age in place in affordable senior housing properties. Average authorized hours per IHSS recipient in San Francisco is 105.1 per month (3.5 hours per day), with the average number of authorized hours for those aged 85-plus being 125.7 per month (4.1 hours per day). Severely impaired IHSS recipients average 159.6 hours per month (5.25 hours per day)[57], with the maximum allowable hours for a severely impaired person 283 hours per month, or 9.3 hours per day.[58]

Although a significant resource for individuals with IADL and ADL needs, even the maximum number of IHSS hours can be insufficient to meet the unscheduled needs of individuals with the level of frailty seen in licensed assisted living facilities. That is, as the acuity level in a resident population increases, so does the frequency of both scheduled and unscheduled service needs. With higher acuity, more residents need assistance with ADLs that are difficult to schedule, such as toileting and transferring assistance. Furthermore, with increased age, greater numbers of residents experience cognitive impairment, [59] which may require oversight, supervision and/or redirection on an as-needed basis.

In some affordable senior housing properties, a family member (often also the resident's authorized IHSS worker) may stay with a resident for long hours and sometimes overnight to meet the resident's scheduled and unscheduled needs. [60] This is reportedly more common among racial and ethnic minority families. Residents without family caregivers available to provide this level of assistance are less able to secure 24/7 support.

The contract mode of IHSS is designed for consumers who cannot independently direct their IHSS services and/or are at significant risk for fraud, abuse or neglect. To be eligible for IHSS services through the contract mode, consumers must meet one or more of the following service level criteria:

- **Supported Services**, with basic service coordination and caregiver management. Clients at this service level require intervention and support to accept and thrive in services and have only domestic and/or simple personal care needs that pose limited-to-no-risk of housing instability and/or health and safety concerns.
- **Intensive Services**, with full-service coordination and caregiver management. Clients at this level require significant intervention and support to accept and thrive in services and/or remain stably housed; paramedical and/or complex personal care training that does not address imminent health and/or safety concerns; and heaving cleaning and/or significant intervention and support in maintaining a safe and habitable home environment.
- **Critical Services**, with full-service coordination, care management and caregiver management. Clients at the critical services level require assistance with basic needs that if not met pose an imminent, possibly life-threatening level of risk; paramedical and/or complex personal care training that addresses imminent health and/or safety concerns; a high degree of coordination due to being discharged from Laguna Honda or another skilled nursing facility; protective supervision; or a high degree of coordination due to medical acuity.

[57] In December 2020, https://www.cdss.ca.gov/inforesources/ihss/program-data

[58] https://lao.ca.gov/handouts/socservices/2021/2021-22-Budget-IHSS-022621.pdf

[59] An estimated 31.3 percent of individuals aged 85 and older have a moderate degree of cognitive impairment, with 28.6 percent found to have mild impairment and 19.6 percent having severe cognitive impairment (https://pubmed.ncbi.nlm.nih.gov/2233632/)

[60] In San Francisco, 62.1% of IHSS providers are relatives, and 34.7 of IHSS recipients have a live-in caregiver (Program Data (ca.gov))

Program Review C: Precedence for Clustered IHSS Model

To address concerns about pooling IHSS hours for clients at supportive housing projects including the proposed project, the following are three well-established examples of such programs:

The Assisted Living Services Program in Connecticut[61]

This program provides supportive services, personalized assistance, and health care to residents of state-funded congregate housing facilities, federally funded HUD facilities, and four affordable AL demonstration sites. Clients are assessed by an Access Agency to determine their level of need, and based on that assessment, clients are approved for a Services Package Level. There are four Services Package Levels, with each level based on the weekly number of personal service hours needed plus nursing visits as needed. Each service level corresponds to a bundled rate funded by Medicaid.

Personal services include hands-on assistance with activities of daily living, including but not limited to dressing, bathing, grooming, using the toilet, transferring, walking and eating. The personal services and nursing visits are provided by licensed Assisted Living Services Agencies (ALSAs), with the ALSAs bundling the payments for all residents to provide staffing coverage to those residents receiving services through the program.

In the assisted living services program, caregivers do not track their time by resident but services are documented with the understanding that the time needed to provide those services matches the number of authorized hours. Billing is conducted for each resident based on a daily rate, according to the assessed tier.

The Assisted Living Program (ALP) in New Jersey[62]

Established in 1997, the ALP provides comprehensive assisted living services for residents in publicly subsidized housing settings. Through certified ALP providers, nurses, social workers and home health aides provide individualized services for residents with health and mobility challenges. ALP services include 12 to 16 hours, seven days a week, of on-site staff; assistance with bathing, grooming and dressing; overnight access to a RN; housekeeping and laundry services; meal preparation; medication administration; and care plan management.

ALP providers receive a flat rate of $57 per day per participating resident from Medicaid managed care regardless of the resident's care needs. Through the program, home health aides are able to provide resident services in smaller and more frequent increments of time throughout the day and on demand than would be the case with traditional home care. Revenue from the program is bundled to maximize staff availability, but billing is done on a per-resident, per-day basis.

California's Assisted Living Waiver Program (ALWP) [63]

Since its inception as a pilot project in 2006, the ALWP has included an option for using Medi-Cal funds to provide assisted living eligible residents of publicly subsidized housing settings. ALWP services are provided by home health agency staff, including 24-hour awake staff; assistance with ADLs and IADLs; health-related services; recreational activities; meals; housekeeping; and laundry. In addition, a Care Coordinator works with enrolled residents to ensure needs are being effectively met as specified in an individualized service plan.

Payment rates for the ALWP are based on a five-tiered system comprised of daily rates ranging from $71 to $200 per participant per day, according to the level of care required as assessed by a care coordination agency. ALWP-approved home health agencies bill Medi-Cal for all residents served through the program, with funds received used to pay for the cost of providing care. According to the only home health agency in the State serving as an ALWP provider in publicly subsidized housing, staff work from resident care plans and are not limited to minimum increments of time as is the case with traditional home care.[64]

[61] Information about this program was provided by the Connecticut Department of Social Services, Division of Health Services and through Affordable Senior Housing Plus Services case studies developed by LeadingAge and The Lewin Group.

[62] "Analysis of the Portable Assisted Living Services Model", by Capital Impact Partners, March 2019; NJ Assisted Living Program Statewide Initiative 2019-2021, by Capital Impact Partners; and communication with a NJ ALP provider.

[63] Description of Publicly Subsidized Housing available at www.dhcs.ca.gov; Communication with Libertana, the only home health agency in CA providing ALW services in publicly subsidized housing.

[64] Per the ALWP Program Manager with Libertana

Program Review D: California Managed Care Health Plan Investments in Supportive Housing

As part of California's Coordinated Care Initiative for improving medical and long-term care integration for dually eligible enrollees, the Inland Empire Health Plan and the San Mateo Health Plan have partnered with affordable senior housing properties.

The Inland Empire Health Plan (IEHP) partners with HumanGood to provide a variety of services to residents at Mt. Rubidoux Manor, [65] a 188-unit affordable apartment community for older adults located in Riverside, California. This partnership includes having between six and 10 set-aside units with rents subsidized by the health plan for dual-eligible IEHP members who meet specific criteria.[66]

Additionally, IEHP provides a health navigator position at the property three days a week to perform case management functions and help residents understand and access their health benefits. The health navigator uses a health appraisal to determine resident needs and level of social isolation, and then links residents to IEHP departments and community-based organizations based on the results of that assessment. This position also helps members understand and navigate the health care system, and facilitates continuity of care by: (a) helping residents schedule appointments with a range of providers; (b) making referrals to health education programs to assist with chronic disease management; (c) addressing behavioral health concerns through linkage with IEHP's behavioral health department and support groups; and (d) addressing social determinants of health by connecting residents to local community resources and IEHP programs. The health navigator position also promotes wellness by providing culturally-appropriate health information to residents, and assists residents with the self-management of chronic illnesses and medication adherence. Finally, the health navigator identifies individual and community needs and coordinates weekly check-ins with the property's resident services coordinator.

The IEHP also supports the involvement at Mt. Rubidoux of the Independent Living and Diversity Services (ILDS) team of the plan's Community Health Department. The ILDS team developed a partnership with La Sierra University's internship program, which allows bachelor-level interns to serve their intern hours (14 hours a week) at Mt. Rubidoux Manor. This partnership created a resident wellness program that offers services to residents to reduce rates of social isolation, address depression, and improve mental health. This partnership also collaborates with the health navigator and the property's resident services coordinator to organize and facilitate educational groups.

The dual components of one-on-one interaction of the health navigator with residents and the group programming developed by the ILDS team allows the IEHP to take a comprehensive approach to helping residents address factors within their environment that may impact their health.

The San Mateo Health Plan also partners with selected senior housing properties, with the plan receiving preference for units and providing funding for on-site services. The SMHP provides on-site care management at one senior property as does the health navigator position utilized by the Inland Empire Health Plan. In these partnerships, the members occupying set-aside units pay for the rent, with the health plan contributing service dollars to the property[67].

In a partnership with HumanGood, 18 apartments have been set-aside for residents who are eligible for Medi-Cal LTSS, eligible for IHSS, at risk of or currently living in a skilled nursing facility, or in possession of a certification from a medical professional who will manage their long-term care and direct service coordination. The San Mateo Health Plan has agreements with two HumanGood properties, with reported benefits including improved health outcomes and a reduction in medical costs[68].

The San Mateo Health Plan also partners with The Villa at San Mateo, a 55-plus apartment community located in San Mateo. According to the housing provider, 12 of the 135 units at this property are subsidized by the San Mateo Health Plan, with the health plan paying market rents for the units and choosing the occupants for those units. Housing-related services and case management are provided by outside agencies.

[65] Based on interviews with and information provided by partner members and a case study developed by the LTSS Center @UMass Boston

[66] No residents of the set-aside units pay more than 40 percent of their income in rent.

[67] Per Maya Altman, CEO of the San Mateo Health Plan

[68] Per information provided by HumanGood

Appendix A: Demand Analyses

The following summarizes an analysis of demographic and supply data to determine the current and projected need for assisted living and memory care for three segments of San Francisco's senior population: 1) Households who meet California's Medi-Cal income-eligibility criteria, 2) Households with incomes greater than the Medi-Cal income threshold but who likely couldn't afford to pay privately for assisted living or memory care, and 3) Households who likely could afford to pay market-based rates for assisted living and memory care services. The demographic data used for this analysis was obtained from Claritas, Inc., a national supplier of demographic information, and is based on 2010 Census data, with current year estimates and five-year projections developed by Claritas.

Summary Results

Following are estimates of the total market potential for assisted living and memory care for San Francisco based on the demand analyses conducted:

Total Market Potential (in Households) for Assisted Living and Memory Care in San Francisco

Population Segment	Assisted Living		Memory Care	
	2021	2026	2021	2026
Medi-Cal-Eligible	1,694	1,616	2,415	2,314
Middle-Market ("Gap")	2,798	3,057	3,006	3,285
Private-Pay	1,798	2,362	2,326	2,998
Total	6,290	7,034	7,747	8,744

The market potential shown above consists of all households in San Francisco who would likely be appropriate for assisted living or memory care based on age, income and level of need. Note that the five-year projections suggest a five percent decline in the number of lower-income Medi-Cal eligible households, a nine percent increase in "middle market" households and a 47 percent increase in private-pay households.

Applying a market penetration rate of 15 percent to the total market potential shows an estimated and projected market demand for the following numbers of additional assisted living and memory care beds in San Francisco:

Demand for Additional Assisted Living and Memory Care Units in San Francisco

Population Segment	Assisted Living		Memory Care	
	2021	2026	2021	2026
Medi-Cal-Eligible	254	242	362	347
Middle-Market ("Gap")	420	459	529	567
Private-Pay	270	354	401	492
Total Units	944	1,055	1,291	1,406

Monthly AL Rates in San Francisco

Based on comparable market-rate information obtained for 17 of the larger (16+ beds) assisted living facilities, the following provides summary estimates that informed demand and financial analyses assumptions. In addition to charging a base monthly rate that varied by unit type, most providers charge for additional services based on the resident's level of need.

Private-Pay Monthly Rates for Private Bedroom or Studio Apartment Units in San Francisco RCFEs, 2021

		Average	Median	Range
Base Monthly Rate		6,635	6,318	4,900 - 9,840
Base + Service Rates	Low	7,048	6,663	5,802 – 9,840
	Medium	8,274	8,051	6,400 – 9,840
	High	9,433	9,605	7,226 - 11,250
Monthly Charge per Service Level		797	763	465 - 1200

Market Demand Assumptions

The market need for these population segments was based on the following income brackets, as explained in more detail later:

For Assisted Living:

Medi-Cal Eligible:	Incomes < $17,775 per year
Middle (Gap) Market:	Renters with incomes between $17,775 and $85,000 per year Homeowners with incomes between $17,775 and $35,000 per year
Private-Pay Market:	Renters with incomes greater than $85,000 per year Homeowners with incomes greater than $35,000 per year

For Dedicated Memory Care:

Medi-Cal Eligible:	Incomes < $17,775 per year
Middle (Gap) Market:	Renters with incomes between $17,775 and $105,000 per year Homeowners with incomes between $17,775 and $35,000 per year
Private-Pay Market:	Renters with incomes greater than $105,000 per year Homeowners with incomes greater than $35,000 per year

Medi-Cal Eligible Assisted Living

The analysis to determine the strength of the market for households who would meet the Medi-Cal income-eligibility criteria for assisted living was based on the following factors:

Primary Market Area. As stated earlier in this report, the geographic area to be served by the proposed project is defined as the City and County of San Francisco.

Age. The average age of assisted living residents is 86.9 years[69] and most residents (93 percent) are older than age 75 years at move-in.[70] Consistent with typical assisted living market analyses, this report evaluated market demand based on a minimum age of 75 years.

Income. Individuals in California who are aged, blind or disabled may qualify for Medi-Cal if they have incomes no greater than 138 percent of the federal poverty limit (FPL)[71] and meet the maximum asset requirement of no more than $2,000 for a single person or $3,000 for a couple.[72] In 2021, 138 percent of the federal poverty limit for a single person is $17,775 annually,[73] which was the maximum income used in the demand analysis to define Medi-Cal-eligible households.

Frailty Factor. Residents of assisted living facilities typically require assistance with Instrumental Activities of Daily Living (IADLs), such as housecleaning, preparing meals, shopping, or managing money, and/or Activities of Daily Living (ADLs) such as bathing, dressing, grooming, ambulation, or toileting. Typically, criteria that estimate the incidence of persons who need assistance with at least one or two ADLs are used to determine the number of age and income qualified households in a market area that would be appropriate to move to an assisted living facility.

To determine the number of individuals who have difficulty with varying numbers of ADLs, a factor to estimate need was applied to the population in the primary market area. This factor was derived from research based on the 2004/2005 National Long-Term Care Survey, which was designed to study changes over time in the health and functional status of Americans aged 65-plus. The survey was administered by the U.S. Census Bureau and utilized a large, nationally representative sample that included both elders in the community and those residing in institutions[74]. As part of this study, the percentage of seniors in various age brackets reporting difficulty with personal care activities was determined (the ADLs included in the study were bathing, dressing, eating, getting in/out of

69 www.ahcancal.org/ncal/resources/Pages/ResidentProfile.aspx

70 "2009 Overview of Assisted Living", sponsored by AAHSA, ASHA, NIC, ALFA and NCAL.

71 "Eligibility-and-Enrollment-Plan," available at www.dhcs.ca.gov,

72 "MediCal General Property Limitations," available at: www.dhcs.ca.gov

73 "2021 Federal Poverty Levels," Letter No 21-01, California Department of Health Care Services

74 As per the National Long-Term Care Survey home page at www.nltcs.aas.duke.edu/.

bed and chairs, walking, getting outside, and using the toilet).

Because most of the programs that would provide service funding for a licensed assisted living facility (i.e. RCFE) have eligibility criteria that include a nursing facility level of care, such as the Assisted Living Waiver Program or PACE, a need criterion of two or more ADLs was assumed for the Medi-Cal-eligible demand analysis. Following are estimates from the National Long-Term Care Survey of the number of non-institutionalized people aged 75-plus who have difficulty with two or more activities of daily living:[75]

Percentage of Individuals Who Have Difficulty With 2+ ADL Needs

Ages 75 – 84	11.9%
Ages 85+	23.9%

Source: 2004/2005 National Long-Term Care Survey

Competitive Units. There are currently an estimated 210 Medi-Cal-eligible individuals residing in RCFEs with more than 15 beds in San Francisco, based on information gathered directly from facilities. Interviews indicated multiple funding sources including PACE, the Community Living Fund, the Department of Public Health, hospital foundations and in one facility, the Health Plan of San Mateo. This number is slightly less than that shown in publicly available data, as is summarized below for the most recent years for which the data was available:

Estimated Medi-Cal Eligible or Publicly Subsidized Residents in RCFEs

Funding Source*	# of Est. Residents
SF Dept. of Public Health	146
PACE	120
Total	293

*DPH estimates are from 2018; CLF estimates are from 2020; PACE estimates are from project interviews with On Lok and Institute on Aging leadership

The 293 Medi-Cal-eligible or publicly subsidized individuals residing in RCFEs shown above is likely greater than the current estimate of 210 residents, which do not include residents in smaller (<16 bed) RCFEs or individuals receiving CLF or DPH subsidies who may not necessarily be Medi-Cal eligible.

For the purposes of the demand analysis, the estimated 210 current Medi-Cal-eligible RCFE residents were deducted from the age, income and need-eligible households in the primary market area.

Market Penetration Rates. The market penetration rate for a proposed project is the percentage of age, income, and need-eligible households in the primary market area that would need to move to the project to achieve full occupancy. Market penetration rates of up to 15 percent are generally considered acceptable for assisted living residences.

Secondary Market Factor. Typically, a portion of residents at an assisted living facility move to the facility from outside the primary market area (also referred to as a secondary market). A secondary market was not included in this demand analysis in order to provide an estimate of the market demand for San Francisco only.

[75] www.nltcs.aas.duke.edu/; The 2004/2005 National Long-Term Care Survey did not break out the need for 2 ADL needs; therefore, the 2-plus ADL need factor was estimated by averaging the need for 1+ ADLs (15.2% for ages 75-79 and 29.9% for ages 85+) and the need for 3+ ADLs (8.5% for ages 75-79 and 17.8% for ages 85+), resulting in a need estimate of 11.9% for ages 75 to 79 and 23.85% for ages 85-plus.

Estimates of Market Need. Following are estimates of market need for assisted living based on the assumptions outlined above for Medi-Cal-eligible individuals:

Demand Analysis - Medi-Cal Eligible Assisted Living

	2021	2026
Age and Income Qualified Households:		
Homeowners and Renters with Incomes <$17,775		
Ages 75 to 84	6,246	6,204
Ages 85-plus	4,878	4,571
Total	**11,124**	**10,776**
Age, Income and Health-Qualified Households:		
Ages 75 to 84	740	735
Ages 85-plus	1,163	1,090
Total	**1,904**	**1,826**
Less Medi-Cal eligible RCFE residents	*- 210*	*- 210*
Total Market Potential	**1,694**	**1,616**
Market Demand:		
With a 15% market penetration rate	**254 units**	**242 units**

Data Source: Claritas, Inc.

Note: Totals may not sum as shown due to rounding

This analysis shows the total market potential in San Francisco to be 1,694 in 2021 and 1,616 in 2026, representing an estimate of the current and projected number of Medi-Cal-eligible households that would need the services provided in a RCFE. This total market potential translates into a current demand for an additional 254 Medi-Cal-eligible RCFE beds in the County, with a need of 242 additional beds projected for 2026.

Middle-Market Assisted Living

Many individuals have income that exceeds that allowed under Medi-Cal but is insufficient to pay privately for assisted living. To determine the extent of this middle (or gap) market, an analysis of the income that would typically be required to pay the fees of a RCFE was conducted.

To determine the income that would be needed to afford to pay privately for assisted living, an estimated starting rate of $6,000 per month ($5,500 base plus $500 for additional services) was assumed based on the lower end of private unit, market-rate RCFEs in San Francisco with more than 15 beds as noted in the previously. Assisted living residents can typically spend up to 85 percent of their income on facility-based fees, with the remaining 15 percent available to cover other costs. Based on this assumption, a starting rate of $6,000 per month at an RCFE would require an annual income of $84,706.

However, because assisted living is typically a need-based rather than a life-style decision, individuals are often willing to spend the equity in their homes and/or draw down other assets in order to pay the fees at assisted living facilities.[76] This is thought to be particularly pertinent in San Francisco because of the high home values in the area.

Thus, it may be conservatively assumed that homeowners could supplement their income with the proceeds from the sale of a home, with the net proceeds estimated at 90 percent of the sale price and a three percent income stream generated from the proceeds. Based on this assumption, homeowners would require an estimated annual income of $46,919, as compared to the $84,706 minimum annual income needed by renters, as is shown below[77]:

[76] This is consistent with research conducted by the National Investment Center for Seniors Housing that has shown that the approximately two-thirds of residents of assisted living communities had annual incomes below $25,000 ("Income Confirmation Study of Assisted Living Residents and the Age 75+ Population; A Follow-Up Study to the NIC National Survey of Assisted Living Residents", prepared by ProMatura Group, LLC for the National Investment Center for the Seniors Housing and Care Industries).

[77] Taxes are not incorporated into this analysis because of the medical deduction typically available to assisted living residents.

Required Income Calculation for Market-Rate Assisted Living

	2021 (Estimates)
Starting Monthly Rate	$6,000
% of Income Needed	85.0%
Annual Required Income (Renters)	**$84,706**
Median Home Price	$1,399,513
Net Proceeds (at 90%)	$1,259,562
Annual Income Stream @ 3.0%	$37,787
Annual Required Income (Home Owners)	**$46,919**

Source: Claritas, Inc.

Because of the high value of homes in San Francisco, it may be further assumed that homeowners needing assisted living would also likely be willing to draw down some of the equity from the sale of a home and/or other assets to pay facility-based fees. Therefore, San Francisco homeowners aged 75-plus with incomes between $35,000 and $46,919 were also assumed to be able to pay privately for assisted living. Thus, the private-pay market for assisted living would be comprised of renters with incomes greater than $84,706 per year and homeowners with incomes greater than $35,000 per year (for the purposes of the demand analyses, the minimum required income for renters to pay privately was rounded up to $85,000 annually).

The middle, or gap, market for assisted living in San Francisco would thus be comprised of households that fall between the Medi-Cal eligibility income criteria of $17,775 annually and the minimum income needed to pay privately ($85,000 for renters and $35,000 for homeowners).

Primary Market Area. As with the Medi-Cal-eligible analysis, the primary market area assumed for the middle-market is comprised of the County of San Francisco, with no secondary market factor incorporated into the analysis.

Age. A minimum age of 75 years was also assumed in the middle-market demand analysis., as was the case for the prior analysis.

Frailty Factor. Private-pay demand analyses for assisted living are typically based on one or more ADL need. Therefore, a need factor to estimate the incidence of individuals with this level of need was incorporated into the demand analysis, based on the results of the 2004 / 2005 National Long-Term Care Survey referenced earlier in the report. This study found that 15.2 percent of the population aged 75-79 and 29.9 percent of those aged 85-plus needed assistance with one or more ADL[78].

Competitive Units. As it is not possible to know the actual incomes of current residents of RCFEs in San Francisco, for the purposes of the demand analysis, no estimates are included for the number of residents who fall within the middle-market income criteria (i.e. between $17,775 and $35,000 annually for homeowners and $17,775 and $85,000 per year for renters)[79].

Estimates of Market Need. Following are estimates of the need for middle-market (gap) assisted living in San Francisco, incorporating the factors outlined above:

[78] www.nltcs.aas.duke.edu/

[79] Based on interviews and reported program eligibility data, as well as considering other available resources, there may be an unreported number of RCFE residents in these income categories who are being subsidized by the Community Living Fund, Department of Public Health "patch" funding, family members, or other programs.

Demand Analysis - Middle-Market ("Gap") Assisted Living

	2021	2026
Age and Income Qualified Households:		
Ages 75 to 84	8,512	9,541
Ages 85-plus	5,030	5,374
Total	**13,542**	**14.915**
Age, Income and Health-Qualified Households:		
Ages 75 to 84	1.294	1,450
Ages 85-plus	1,504	1,607
Total	**2,798**	**3,057**
Less estimated RCFE middle-market residents	Info. NA	Info. NA
Total Market Potential	**2,798**	**3,057**
Market Demand:		
With 15% market penetration	420 units	459 units

Data Source: Claritas, Inc.

Note: Totals may not sum as shown due to rounding

As shown above, the total market potential for the middle (or gap) market in San Francisco for assisted living is 2,798 in 2021 and 3,057 in 2026. Assuming a 15 percent market penetration rate, results show an estimated demand for 420 additional RCFE units in 2021 and 459 additional units in 2026.

Private-Pay Assisted Living

The analysis to estimate the demand for market-rate assisted living was based on the following factors:

Primary Market Area. As with the prior analyses, the primary market area assumed for the private-pay analysis is comprised of the County of San Francisco, with no secondary market factor incorporated into the analysis.

Age. As with the Medi-Cal-eligible and middle-market analyses, a minimum age of 75 years was assumed in the private-pay demand analysis.

Income. As outlined above, the market for private-pay assisted living would be comprised of renters with incomes greater than $85,000 per year and homeowners with incomes greater than $35,000 per year.

Frailty Factor. As with the middle-market analysis, a need factor of one or more ADL was assumed in the market-rate analysis.

Competitive Units. [80] The number of market-rate competitive units was based on the current number of RCFEs with more than 15 beds, less the number of beds estimated to be occupied by Medi-Cal-eligible residents. There are currently 1,392 RCFE beds in 24 facilities with more than 15 beds, with an estimated 1,182 of those units serving private-pay residents.

Estimates of Market Need. Following are estimates of the need for market-rate assisted living in San Francisco, incorporating the factors outlined above:

Demand Analysis - Market-Rate Assisted Living

	2021	2026
Age and Income Qualified Households:		
Ages 75 to 84	11,275	13,770
Ages 85-plus	4,235	4,850
Total	**15,509**	**18,620**
Age, Income and Health-Qualified Households:		
Ages 75 to 84	1,714	2,093
Ages 85-plus	1,266	1,450
Total	**2,980**	**3,543**
Less private-pay RCFE residents	- 1,182	- 1,182
Total Market Potential	**1,798**	**2,362**
Market Demand:		
With a 15% market penetration	270 units	354 units

Data Source: Claritas, Inc.

Note: Totals may not sum as shown due to rounding

As shown above, there is a total market potential (age, income and need-qualified households) for market-rate assisted living of 1,798 in 2021 and 2,362 in 2026. This market potential results in an estimated demand for 270 additional RCFE units in 2021 and 354 additional units in 2026, assuming a 15 percent market penetration rate.

[80] For estimating competitive units, the analysis adjusted the number of AL beds in several of the larger RCFEs that serve multiple levels of care and reported having a large number of their licensed beds occupied by more independent residents not receiving assisted living services.

Memory Care Demand Analyses

A demand analysis similar to that outlined above for assisted living was conducted to estimate and project need in the primary market area for specialized care for persons with Alzheimer's disease or other dementias. Following is an overview of the factors included in this analysis:

Primary Market Area. As with the assisted living analyses, the primary market area for the memory care demand analyses was assumed to be the County of San Francisco, with no secondary market factor incorporated.

Age. A minimum age of 75 years was assumed for the memory care analyses, based on national data on assisted living facilities[81].

Frailty Factor. Significant research has been conducted to estimate the prevalence of Alzheimer's disease and other dementias in the general population. The study "Estimated Prevalence of Alzheimer's Disease in the United States[82]" presents prevalence estimates by age and degree of impairment (mild, moderate and severe), as is shown below:

Alzheimer's Disease Prevalence by Age and Degree of Impairment

	Mild	Moderate	Severe
Ages 65-74	14.3%	4.6%	0.3%
Ages 75-84	27.0%	14.3%	5.6%
Ages 85+	28.6%	31.2%	19.6%

Source: Evans, Denis A.,et al, Harvard Medical School, "Estimated Prevalence of Alzheimer's Disease in the United States".

Individuals with mild cognitive impairment can typically still live at home with some assistance or in a non-specialized assisted living facility. Individuals with moderate impairment, on the other hand, may require the services provided at a dedicated memory care facility and those with severe dementia may potentially be best served in a nursing facility. The demand analyses to estimate the need for specialized memory care thus assume the prevalence factors for a moderate level of impairment to estimate the need for this level of care in the primary market area.

Income. As with assisted living, the income criteria for memory care is comprised of three main categories: 1) those who qualify for Medi-Cal 2) those who have too much income to be Medi-Cal eligible but not enough income to pay privately, and 3) those who can afford to pay the market rates at RCFE-licensed memory care facilities.

As stated previously, the maximum income criteria to be eligible for Medi-Cal is $17,775 annually. The income ranges appropriate for middle-market memory care and private-pay memory care were based on the memory care facilities currently located in San Francisco.

To determine the minimum income that would be needed to pay privately for dedicated memory care in a RCFE in San Francisco, a starting rate of $7,500 per month was assumed based on the lower end of market-rate memory care facilities in San Francisco with more than 15 beds. As is the case with assisted living, private-pay memory care residents can typically spend up to 85 percent of their income on facility-based fees, with the remaining 15 percent available to cover other costs. Based on this assumption, a starting rate of $7,500 per month would require an annual income of $105,882.

If, however, it is assumed as was the case with the assisted living analysis, that homeowners could supplement their income with the proceeds from the sale of a home, homeowners would require an estimated annual income of $68,095, as compared to the $105,882 minimum annual income needed by renters, as is shown below:[83]

[81] "2009 Overview of Assisted Living", sponsored by AAHSA, ASHA, NIC, ALFA and NCAL.

[82] Evans, Denis A., "Estimated Prevalence of Alzheimer's Disease in the United States", The Milbank Quarterly, Vol. 68, No. 2 (1990), pp. 267-298.

[83] Taxes are not incorporated into this analysis because of the medical deduction typically available to memory care residents.

Required Income Calculation for Market-Rate Memory Care

	2021 (Estimates)
Starting Monthly Rate	$7,500 / month
% of Income Needed	85.0%
Annual Required Income (Renters)	**$105,882**
Median Home Price	$1,399,513
Net Proceeds (at 90%)	$1,259,562
Annual Income Stream @ 3.0%	$37,787
Annual Required Income (Homeowners)	**$68,095**

Source: Claritas, Inc.

Considering the high home values in San Francisco, it may be further assumed that family members of homeowners needing memory care would likely be willing to draw down some of the equity from the sale of a home. Therefore, homeowners aged 75-plus with incomes between $35,000 and $68,095 were also included in the demand analysis. The private-pay market for memory care would thus be defined as renter households with incomes greater than $105,882 per year (rounded down to $105,000 for the demand analysis) and homeowners with incomes greater than $35,000 per year.

Households that have too much income to qualify for Medi-Cal or too little income to pay privately for memory care would comprise the middle (or gap) market. This gap market thus includes renter households with incomes greater than the $17,775 income limit for Medi-Cal but less than $105,000 per year and homeowners with incomes greater than $17,775 but less than 35,000 per year.

Competitive Units. There are reportedly no dedicated memory care units in San Francisco serving Medi-Cal-eligible or middle-market individuals with memory impairment and an estimated 388 market-rate memory care units in RCFEs.

Market Need for Medi-Cal-Eligible Memory Care

Following are estimates of the need for Medi-Cal-eligible memory care (MC) in San Francisco, incorporating the factors outlined above:

Demand Analysis - Medi-Cal Eligible Memory Care

	2021	2026
Age and Income Qualified Households:		
Ages 75 to 84	6,246	6,204
Ages 85-plus	4,878	4,571
Total	**11,124**	**10,776**
Age, Income and Health-Qualified Households:		
Ages 75 to 84	893	887
Ages 85-plus	1,522	1,426
Total	**2,415**	**2,314**
Less Medi-Cal eligible RCFE residents	Info. NA	Info. NA
Total Market Potential	**2,415**	**2,314**
Market Demand:		
With 15% market penetration	362 units	347 units

Data Source: Claritas, Inc.

Note: Totals may not sum as shown due to rounding

As shown above, the total market potential for Medi-Cal eligible dedicated memory care in San Francisco is 2,415 in 2021 and 2,314 in 2026. This market potential results in an estimated demand for 362 Medi-Cal eligible memory care beds in 2021 and 347 memory care beds in 2026, assuming a 15 percent market penetration rate.

Market Need for Middle-Market (Gap) Memory Care

The analysis to determine the estimated demand for dedicated memory care (MC) for the middle-market is summarized below:

Demand Analysis - Middle-Market ("Gap") Memory Care

	2021	2026
Age and Income Qualified Households:		
Ages 75 to 84	9,316	10,454
Ages 85-plus	5,365	5,738
Total	**14,682**	**16,192**
Age, Income and Health-Qualified Households:		
Ages 75 to 84	1,332	1,495
Ages 85-plus	1,674	1,790
Total	**3,006**	**3,285**
Less estimated RCFE middle-market residents in dedicated MC beds	Info. NA	Info. NA
Total Market Potential	**3,006**	**3,285**
Market Demand:		
With 15% market penetration	519 units	567 units

Data Source: Claritas, Inc.

Note: Totals may not sum as shown due to rounding

As shown above, the total market potential for the middle-market (or gap population) for dedicated memory care in San Francisco is 3,006 in 2021 and 3,285 in 2026. This market potential results in an estimated demand for 519 middle-market memory care beds in 2021 and 567 middle-market memory care beds in 2026, assuming a 15 percent market penetration rate.

Market Need for Private-Pay Memory Care

The analysis to determine the estimated demand for market-rate memory care is summarized below:

Demand Analysis - Market-Rate Memory Care

	2021	2026
Age and Income Qualified Households:		
Ages 75 to 84	10,470	12,857
Ages 85-plus	3,899	4,486
Total	**14,370**	**17,343**
Age, Income and Health-Qualified Households:		
Ages 75 to 84	1,497	1,839
Ages 85-plus	1,217	1,400
Total	**2,714**	**3,238**
Less estimated private-pay RCFE MC residents	388	388
Total Market Potential	**2,326**	**2,850**
Market Demand:		
With 15% market penetration	401 units	492 units

Data Source: Claritas, Inc.

Note: Totals may not sum as shown due to rounding

As shown above, the total market potential for market-rate memory care in San Francisco is 2,326 in 2021 and 2,850 in 2026. This market potential results in an estimated demand for 401 market-rate memory care beds in 2021 and 492 market-rate memory care beds in 2026, assuming a 15 percent market penetration rate.

Appendix B: AL Service Subsidy Sources, Eligibility Criteria & Availability

Subsidy Source	*Financial Eligibility*	*Functional Eligibility*	*Subsidy Information*	*Availability*
Assisted Living Waiver	Medi–Cal eligible (138% of the Federal Poverty Level for individual)[84]	Nursing Facility level of care (NFLOC); moderate - severe cognitive impairment; need assist with 2+ ADLs; Relocating from or at risk of institutionalization	5 Tiers of daily rates ranging from $78 - $200 Additional reimbursement for Rehabilitation Services available at $27 per hour for up to 16 hours per day	Available in 15 counties Capped with just over 5,400 enrolled statewide[85] and over 4,000 on waiting list as of April '21
PACE	Medi-Cal eligible or able to pay monthly Medi-Cal premium payment	NFLOC	On Lok contracts with providers for 3 levels of care Specific contract rates are unpublished and vary by provider	About 12,000 members served by 20 PACE organizations available in 22 counties
Community Living Fund	300% of the Federal Poverty Level for Individual	Need service / resource to prevent institutionalization; Need assist with 2+ ADLs; NFLOC; or Emotional / cognitive impairment with need for assist with 3+ IADLs	Provides monthly subsidies to fill gap. Purchased AL service expenses were about $3,613 per 27 clients for last 6 months of 2020 (or $585,240 total)[86]	344 total clients served in San Francisco in Jul to Dec 2020, less than 8% in RCFEs
Department of Public Health	None specified since intended as a patch between cost and ability to pay	Behavioral health needs; multiple complex characteristics (e.g., mental health, substance use, medically compromised)	3 levels with daily rate "patches" ranging from $35 to $125	Served almost 800 clients per month in RCFEs and ARFs both in and around San Francisco between July 2020 and April 2021

Sources: www.cdss.ca.gov; www.aging.ca.gov; www.dhcs.ca.gov; www.calpace.org; Chapman & Evanson, 2020, "Long-Term Services and Supports in Medi-Cal," California Health Care Foundation; key informant interviews

[84] Excludes individuals with Medi-Cal benefits that include a share of cost, as well as those enrolled in another Medi-Cal Managed Care Plans

[85] Information was requested but not readily available from the California Department of Health Services about the current number of ALW participants in San Francisco and applicants on the waiting list

[86] Department of Disability and Aging Services, Six-month Community Living Fund report dated April 7, 2021

Appendix C: Housing with Enhanced Services – Services Provided or Purchased by Benefit Program

	In-Home Supportive Services (IHSS)	*Community-Based Adult Services (CBAS)*	*PACE & Day Health Center*	*HCBA Waiver*	*MSSP*	*Community Living Fund*	*AL Waiver*
Meals - shopping, preparation, etc.[87]	✓	✓	✓			✓	✓
Housekeeping	✓		✓			✓	✓
Personal Care (ADLs)	✓	✓	✓	✓		✓	✓
Medication Assistance	✓	✓	✓			✓	✓
Socialization / life enrichment / companionship	✓	✓	✓			✓	✓
Social services / coordination		✓	✓	✓	✓	✓	✓
Case management		✓	✓	✓	✓	✓	
Skilled nursing		✓	✓	✓		✓	✓
Health care management & coordination		✓	✓	✓	✓	✓	✓
Dementia-related care, supports	✓	✓	✓		✓	✓	✓
Mental health		✓	✓			✓	
Transportation	✓	✓	✓			✓	✓

Notes:

IHSS: services delivered at client's residence; CBAS and PACE Day Health Center services provided at center, generally available Monday through Friday; AL Waiver services provided by Home Care Agency at publicly subsidized housing settings.

[87] To supplement existing home delivered grocery and meal services.

Appendix D: Housing with Enhanced Services - HCBS Program Eligibility Criteria & Availability

	Financial Eligibility	*Functional Eligibility*	*Other Criteria*	*Availability*
IHSS	Medi–Cal eligible (138% of the Federal Poverty Level for individual)[88]	Must have a medical need for care services and be at risk of institutionalization (nursing home care) without program assistance	Age 65+ or disabled, or blind; living at home (RCFE excluded)	Not capped; 600k+ recipients statewide
CBAS	Medi-Cal eligible	Nursing Facility level of care (NFLOC); moderate - severe cognitive impairment; need assist with 2+ ADLs	Older or disabled age 18+ Medi-Cal Managed Care enrolled	Not capped; 38k enrollees across 27 counties
PACE	Medi-Cal eligible or able to pay monthly Medi-Cal premium payment	NFLOC	Age 55+	About 12,000 members served by 20 PACE organizations available in 22 counties
HCBA Waiver	Medi-Cal eligible	NFLOC	Lives in a hospital or NF or at risk of institutionalization within 30 days	Very limited, capped with waiting list; @ 5.9k enrollees across 50 counties
MSSP	Medi-Cal eligible	NFLOC Disabled	Age 65+	Very limited, capped with waiting list; @11.4k enrollment cap across 46 counties
Community Living Fund	300% of Federal Poverty Level for Individual	Need service / resource to prevent institutionalization; 2+ ADL needs; NFLOC; or Emotional / cognitive impairment with 3+ IADL needs	Age 18+; lives in a hospital or NF or at risk of institutionalization; willing / able to live in community	344 clients served in San Francisco in Jul – Dec 2020
AL Waiver	Medi-Cal eligible[89]	NFLOC; Relocating from or at risk of institutionalization	Available for residents of publicly subsidized housing (PSH).	Very limited, capped with 5,400 enrolled and long waiting list; available in 15 counties

Sources: www.cdss.ca.gov; www.aging.ca.gov; www.dhcs.ca.gov; www.calpace.org; Chapman & Evanson, 2020, "Long-Term Services and Supports in Medi-Cal," California Health Care Foundation

[88] As of April, 2021, $1,481 per month for individuals

[89] Excludes individuals with Medi-Cal benefits that include a share of cost, as well as those enrolled in another Medi-Cal Managed Care Plans

Appendix E: Profit and Loss Projections – Licensed Assisted Living Model

		Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Revenue											
Private-Pay	Studio Units (Priv)	1,760,531	4,042,750	4,489,069	4,673,121	4,864,719	5,064,173	5,271,804	5,487,948	5,712,954	5,947,185
Private-Pay	Studio Units (ALW)	281,229	645,794	717,089	746,490	777,096	808,957	842,124	876,651	912,594	950,010
Private-Pay	Studio Units (PACE)	408,524	938,103	1,041,669	1,084,378	1,128,837	1,175,120	1,223,300	1,273,455	1,325,667	1,380,019
Private-Pay	Other » Studio CLF	735,402	1,688,720	1,875,155	1,952,036	2,032,070	2,115,384	2,202,115	2,292,402	2,386,390	2,484,232
Gross Revenue		**3,185,686**	**7,315,366**	**8,122,983**	**8,456,025**	**8,802,722**	**9,163,634**	**9,539,343**	**9,930,456**	**10,337,604**	**10,761,446**
Less Vacancy Factor		0	330,980	568,609	591,922	616,191	641,454	667,754	695,132	723,632	753,301
Net Revenue		**3,185,686**	**6,984,387**	**7,554,374**	**7,864,103**	**8,186,532**	**8,522,179**	**8,871,589**	**9,235,324**	**9,613,972**	**10,008,145**
Operating Expenses - Personnel											
Administrative & General											
Executive Director		143,565	149,308	155,280	161,491	167,951	174,669	181,656	188,922	196,479	204,338
Assistant Executive Director		97,332	101,226	105,275	109,486	113,865	118,420	123,156	128,083	133,206	138,534
Outreach & Move-In Coordinator		85,166	88,572	92,115	95,800	99,632	103,617	107,762	112,072	116,555	121,217
Other »	Business Office Manager	85,166	88,572	92,115	95,800	99,632	103,617	107,762	112,072	116,555	121,217
Other »	Receptionists	43,800	59,786	66,323	68,976	71,735	74,604	77,588	80,692	83,920	87,276
Subtotal - Administrative & General		**455,028**	**487,464**	**511,108**	**531,552**	**552,814**	**574,927**	**597,924**	**621,841**	**646,715**	**672,583**
Building & Grounds											
Maintenance Director		92,466	96,164	100,011	104,011	108,172	112,499	116,999	121,678	126,546	131,607
Maintenance Workers		46,233	48,082	50,005	52,006	54,086	56,249	58,499	60,839	63,273	65,804
Subtotal - Building & Grounds		**138,698**	**144,246**	**150,016**	**156,017**	**162,258**	**168,748**	**175,498**	**182,518**	**189,818**	**197,411**
Dietary											
Food Service Director		70,566	73,389	76,324	79,377	82,552	85,854	89,288	92,860	96,574	100,437
Cooks		62,027	128,771	142,849	148,563	154,506	160,686	167,114	173,798	180,750	187,980
Dietary Aides		70,535	121,617	134,913	140,310	145,922	151,759	157,830	164,143	170,708	177,537
Subtotal - Dietary		**203,127**	**323,776**	**354,087**	**368,250**	**382,980**	**398,300**	**414,232**	**430,801**	**448,033**	**465,954**
Housekeeping and Laundry											
Housekeeping Staff		46,391	105,393	116,915	121,592	126,456	131,514	136,775	142,246	147,935	153,853
Subtotal - Housekeeping and Laundry		**46,391**	**105,393**	**116,915**	**121,592**	**126,456**	**131,514**	**136,775**	**142,246**	**147,935**	**153,853**
Resident Services											
LPNs		71,539	128,771	142,849	148,563	154,506	160,686	167,114	173,798	180,750	187,980
Resident Assistants		401,011	802,021	889,709	925,297	962,309	1,000,802	1,040,834	1,082,467	1,125,766	1,170,796
Other »	Med Tech	211,153	348,306	386,388	401,843	417,917	434,634	452,019	470,100	488,904	508,460
Other »	Resident Care Coordinator	44,813	80,664	89,483	93,063	96,785	100,657	104,683	108,870	113,225	117,754
Other »	Staffing Coordinator	54,506	56,686	58,954	61,312	63,764	66,315	68,968	71,726	74,595	77,579
Subtotal - Resident Services		**783,022**	**1,416,449**	**1,567,384**	**1,630,079**	**1,695,282**	**1,763,093**	**1,833,617**	**1,906,962**	**1,983,240**	**2,062,570**
Activities											
Activity Director		89,096	92,660	96,367	100,221	104,230	108,399	112,735	117,245	121,935	126,812
Van Driver		30,136	31,341	32,595	33,898	35,254	36,665	38,131	39,656	41,243	42,892
Other Activites Staff		43,800	45,551	47,374	49,268	51,239	53,289	55,420	57,637	59,943	62,340
Subtotal - Activities		**163,031**	**169,553**	**176,335**	**183,388**	**190,724**	**198,353**	**206,287**	**214,538**	**223,120**	**232,045**
Other											
Other »	Social Worker	39,541	71,174	78,956	82,114	85,399	88,815	92,367	96,062	99,904	103,901
Subtotal - Other		**39,541**	**71,174**	**78,956**	**82,114**	**85,399**	**88,815**	**92,367**	**96,062**	**99,904**	**103,901**
Total Salaries and Wages		**1,828,840**	**2,718,054**	**2,954,801**	**3,072,993**	**3,195,913**	**3,323,749**	**3,456,699**	**3,594,967**	**3,738,766**	**3,888,316**
Plus Benefits		548,652	815,416	886,440	921,898	958,774	997,125	1,037,010	1,078,490	1,121,630	1,166,495
Total Personnel Costs		**2,377,491**	**3,533,471**	**3,841,241**	**3,994,891**	**4,154,686**	**4,320,874**	**4,493,709**	**4,673,457**	**4,860,395**	**5,054,811**

Appendix D: Profit and Loss Projections – Licensed Assisted Living Model

Expenses (Non-Pesonnel)	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Administrative Expense										
Telephone / Internet	27,406	28,228	29,075	29,947	30,845	31,771	32,724	33,705	34,717	35,758
License or Permit	22,737	23,420	24,122	24,846	25,591	26,359	27,150	27,964	28,803	29,667
Legal	24,914	25,662	26,431	27,224	28,041	28,882	29,749	30,641	31,561	32,507
Audit	9,966	10,265	10,573	10,890	11,216	11,553	11,900	12,257	12,624	13,003
Accounting	19,931	20,529	21,145	21,780	22,433	23,106	23,799	24,513	25,248	26,006
Office Supplies	16,194	16,680	17,180	17,696	18,227	18,774	19,337	19,917	20,514	21,130
Computer / Technology	19,931	20,529	21,145	21,780	22,433	23,106	23,799	24,513	25,248	26,006
Conference / Travel	1,246	1,283	1,322	1,361	1,402	1,444	1,487	1,532	1,578	1,625
Mileage Remibursement	3,737	3,849	3,965	4,084	4,206	4,332	4,462	4,596	4,734	4,876
Personnel Recruiting / Advertising	13,080	13,472	13,877	14,293	14,722	15,163	15,618	16,087	16,569	17,066
Printing / Duplicating / Forms	3,737	3,849	3,965	4,084	4,206	4,332	4,462	4,596	4,734	4,876
Inservice Training / Education	17,440	17,963	18,502	19,057	19,629	20,218	20,824	21,449	22,092	22,755
Dues / Memberships	4,983	5,132	5,286	5,445	5,608	5,776	5,950	6,128	6,312	6,501
Postage / Delivery	6,229	6,415	6,608	6,806	7,010	7,221	7,437	7,660	7,890	8,127
Equipment	8,720	8,982	9,251	9,529	9,814	10,109	10,412	10,724	11,046	11,378
Pre-Employment Screening	21,800	22,454	23,128	23,821	24,536	25,272	26,030	26,811	27,615	28,444
Other » Bank fees	7,474	7,698	7,929	8,167	8,412	8,665	8,925	9,192	9,468	9,752
Other » Staff appreciation	3,114	3,208	3,304	3,403	3,505	3,610	3,719	3,830	3,945	4,063
Other » Payroll/processing/consulting	19,931	20,529	21,145	21,780	22,433	23,106	23,799	24,513	25,248	26,006
Other » Uniforms/Name Badges	2,491	2,566	2,643	2,722	2,804	2,888	2,975	3,064	3,156	3,251
Subtotal - Administrative Expense	**255,062**	**262,714**	**270,595**	**278,713**	**287,075**	**295,687**	**304,558**	**313,694**	**323,105**	**332,798**
Dietary / Kitchen										
Raw Food [per elder / per day]	144,946	296,931	317,799	327,333	337,153	347,267	357,685	368,416	379,468	390,852
Supplies [per elder]	561	1,148	1,229	1,266	1,304	1,343	1,383	1,425	1,468	1,512
Equipment	11,211	11,548	11,894	12,251	12,619	12,997	13,387	13,789	14,202	14,628
Dietary Consultant	3,114	3,208	3,304	3,403	3,505	3,610	3,719	3,830	3,945	4,063
Other » Smallwares Linens/Kitchen	3,737	3,849	3,965	4,084	4,206	4,332	4,462	4,596	4,734	4,876
Subtotal - Dietary / Kitchen	**163,570**	**316,684**	**338,191**	**348,336**	**358,786**	**369,550**	**380,636**	**392,056**	**403,817**	**415,932**
Housekeeping and Laundry										
Housekeeping Supplies	18,499	37,896	40,559	41,776	43,029	44,320	45,650	47,019	48,430	49,883
Laundry Supplies [per elder]	2,803	5,742	6,145	6,330	6,520	6,715	6,917	7,124	7,338	7,558
Linen and Bedding [per elder]	1,401	2,871	3,073	3,165	3,260	3,358	3,458	3,562	3,669	3,779
Subtotal - Housekeeping and Laundry	**22,703**	**46,508**	**49,777**	**51,270**	**52,808**	**54,393**	**56,024**	**57,705**	**59,436**	**61,219**
Resident Care										
Care Supplies [per elder]	20,180	41,341	44,246	45,574	46,941	48,349	49,800	51,294	52,832	54,417
Medications [per elder]	561	1,148	1,229	1,266	1,304	1,343	1,383	1,425	1,468	1,512
Contracted Svcs / Temp Personnel	62,285	64,154	66,079	68,061	70,103	72,206	74,372	76,603	78,901	81,268
Equipment	16,194	16,680	17,180	17,696	18,227	18,774	19,337	19,917	20,514	21,130
Other » Professional Audit/ Medical Services	6,229	6,415	6,608	6,806	7,010	7,221	7,437	7,660	7,890	8,127
Other » Resident Testing / Vaccinations	498	513	529	544	561	578	595	613	631	650
Other » Pendants/wanderguard	3,737	3,849	3,965	4,084	4,206	4,332	4,462	4,596	4,734	4,876
Subtotal - Resident Care	**109,685**	**134,101**	**139,836**	**144,031**	**148,352**	**152,802**	**157,386**	**162,108**	**166,971**	**171,980**
Activities										
Activity Supplies	6,229	6,415	6,608	6,806	7,010	7,221	7,437	7,660	7,890	8,127
Entertainment	22,423	23,095	23,788	24,502	25,237	25,994	26,774	27,577	28,404	29,257
Other » Decorations, Food, Holidays	3,737	3,849	3,965	4,084	4,206	4,332	4,462	4,596	4,734	4,876
Subtotal - Activities	**32,388**	**33,360**	**34,361**	**35,392**	**36,453**	**37,547**	**38,673**	**39,834**	**41,029**	**42,260**

Appendix D: Profit and Loss Projections – Licensed Assisted Living Model

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Marketing										
Advertising	24,914	25,662	26,431	27,224	28,041	28,882	29,749	30,641	31,561	32,507
Printing	4,983	5,132	5,286	5,445	5,608	5,776	5,950	6,128	6,312	6,501
Professional Referral Fees	76,069	78,351	80,701	83,122	85,616	88,184	90,830	93,555	96,362	99,252
Other » Events, meals	17,440	17,963	18,502	19,057	19,629	20,218	20,824	21,449	22,092	22,755
Subtotal - Marketing	**123,406**	**127,108**	**130,921**	**134,849**	**138,894**	**143,061**	**147,353**	**151,773**	**156,327**	**161,016**
Utilities										
Electricity	149,485	153,970	158,589	163,346	168,247	173,294	178,493	183,848	189,363	195,044
Water / Sewer	80,971	83,400	85,902	88,479	91,134	93,868	96,684	99,584	102,572	105,649
Gas	37,371	38,492	39,647	40,837	42,062	43,324	44,623	45,962	47,341	48,761
Garbage Removal	80,971	83,400	85,902	88,479	91,134	93,868	96,684	99,584	102,572	105,649
Cable TV	43,600	44,908	46,255	47,643	49,072	50,544	52,060	53,622	55,231	56,888
Subtotal - Utilities	**392,398**	**404,170**	**416,295**	**428,784**	**441,648**	**454,897**	**468,544**	**482,600**	**497,078**	**511,991**
Maintenance										
Maintenance and Repairs	105,885	109,062	112,334	115,704	119,175	122,750	126,433	130,225	134,132	138,156
Grounds	29,897	30,794	31,718	32,669	33,649	34,659	35,699	36,770	37,873	39,009
Alarm Monitoring	6,229	6,415	6,608	6,806	7,010	7,221	7,437	7,660	7,890	8,127
Pest Control	4,983	5,132	5,286	5,445	5,608	5,776	5,950	6,128	6,312	6,501
Life Safety Maintenance	6,229	6,415	6,608	6,806	7,010	7,221	7,437	7,660	7,890	8,127
Elevator	2,295	2,364	2,434	2,508	2,583	2,660	2,740	2,822	2,907	2,994
Other Contracted Services	18,686	19,246	19,824	20,418	21,031	21,662	22,312	22,981	23,670	24,381
Repair and Replacement Reserve	51,905	53,462	55,066	56,717	58,419	60,172	61,977	63,836	65,751	67,724
Other » Windows Washing/Siding	6,229	6,415	6,608	6,806	7,010	7,221	7,437	7,660	7,890	8,127
Subtotal - Maintenance	**232,336**	**239,306**	**246,485**	**253,879**	**261,496**	**269,341**	**277,421**	**285,744**	**294,316**	**303,145**
Vehicle Expense										
Gas/Oil	6,229	6,415	6,608	6,806	7,010	7,221	7,437	7,660	7,890	8,127
Vehicle Lease/Purchase Payment	0	0	0	0	0	0	0	0	0	0
Vehicle Maintenance	3,737	3,849	3,965	4,084	4,206	4,332	4,462	4,596	4,734	4,876
Subtotal - Vehicle Expense	**9,966**	**10,265**	**10,573**	**10,890**	**11,216**	**11,553**	**11,900**	**12,257**	**12,624**	**13,003**
Insurance										
Other » Liability and Property Ins	85,954	88,533	91,188	93,924	96,742	99,644	102,633	105,712	108,884	112,150
Other » Auto	3,737	3,849	3,965	4,084	4,206	4,332	4,462	4,596	4,734	4,876
Subtotal - Insurance	**89,691**	**92,382**	**95,153**	**98,008**	**100,948**	**103,976**	**107,096**	**110,309**	**113,618**	**117,026**
Corporate / Management Fees										
Management / Corporate Fee [% rev]	362,842	362,875	377,719	393,205	409,327	426,109	443,579	461,766	480,699	500,407
Subtotal - Corporate / Management Fees	**362,842**	**362,875**	**377,719**	**393,205**	**409,327**	**426,109**	**443,579**	**461,766**	**480,699**	**500,407**
Other Expenses										
Property Taxes	0	0	0	0	0	0	0	0	0	0
Other » Mortgage Ins. Premium	175,547	180,813	186,238	191,825	197,580	203,507	209,612	215,901	222,378	229,049
Subtotal - Other Expenses	**175,547**	**180,813**	**186,238**	**191,825**	**197,580**	**203,507**	**209,612**	**215,901**	**222,378**	**229,049**
Total Expenses	**4,347,085**	**5,743,756**	**6,137,384**	**6,364,073**	**6,599,269**	**6,843,297**	**7,096,491**	**7,359,203**	**7,631,793**	**7,914,638**
Net Operating Income (NOI)	**(1,161,398)**	**1,240,631**	**1,416,990**	**1,500,031**	**1,587,262**	**1,678,883**	**1,775,097**	**1,876,121**	**1,982,179**	**2,093,507**
Less Estimated Debt Service Payments	1,114,960	1,114,960	1,114,960	1,114,960	1,114,960	1,114,960	1,114,960	1,114,960	1,114,960	1,114,960
Cash Flow after Debt	**(2,276,359)**	**125,670**	**302,030**	**385,070**	**472,302**	**563,922**	**660,137**	**761,161**	**867,219**	**978,546**

Appendix F: Profit and Loss Projections – Housing with Enhanced Services Model

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Occupancy										
% Occupied (before vacancy)	n/a	100%	100%	100%	100%	100%	100%	100%	100%	100%
% Occupied (after vacancy)	n/a	95%	95%	95%	95%	95%	95%	95%	95%	95%
# Units Occupied	n/a	91	91	91	91	91	91	91	91	91
Revenue										
Rent Revenue	2,032,164	2,629,113	2,721,132	2,816,371	2,914,944	3,016,967	3,122,561	3,231,851	3,344,966	3,462,039
Misc Revenue	5,435	7,031	7,278	7,532	7,796	8,069	8,351	8,643	8,946	9,259
Service Revenue	0	0	0	0	0	0	0	0	0	0
Gross Revenue	**2,037,599**	**2,636,144**	**2,728,409**	**2,823,903**	**2,922,740**	**3,025,036**	**3,130,912**	**3,240,494**	**3,353,911**	**3,471,298**
Less Vacancy Factor	74,287	131,807	136,420	141,195	146,137	151,252	156,546	162,025	167,696	173,565
Net Revenue	**1,963,312**	**2,504,337**	**2,591,989**	**2,682,708**	**2,776,603**	**2,873,784**	**2,974,367**	**3,078,469**	**3,186,216**	**3,297,733**
Personnel										
Administrative & General										
Assistant Property Management Positions	254,207	263,104	272,313	281,844	291,708	301,918	312,485	323,422	334,742	346,458
Desk Clerk	102,335	105,916	109,623	113,460	117,431	121,541	125,795	130,198	134,755	139,472
Senior Property Manager	94,241	97,539	100,953	104,487	108,144	111,929	115,846	119,901	124,097	128,441
Senior Property Manager Bonus	4,102	4,246	4,394	4,548	4,707	4,872	5,043	5,219	5,402	5,591
Subtotal - Administrative & General	**454,885**	**470,806**	**487,284**	**504,339**	**521,991**	**540,260**	**559,170**	**578,740**	**598,996**	**619,961**
Building & Grounds										
Maintenance Director	69,184	71,605	74,112	76,706	79,390	82,169	85,045	88,021	91,102	94,291
Maintenance Technician	106,082	109,795	113,638	117,615	121,732	125,992	130,402	134,966	139,690	144,579
Payroll Bonus	2,994	3,098	3,207	3,319	3,435	3,555	3,680	3,809	3,942	4,080
Subtotal - Building & Grounds	**178,260**	**184,499**	**190,956**	**197,640**	**204,557**	**211,717**	**219,127**	**226,796**	**234,734**	**242,950**
Housekeeping and Laundry										
Housekeeping Staff	85,327	88,313	91,404	94,603	97,915	101,342	104,889	108,560	112,359	116,292
Subtotal - Housekeeping and Laundry	**85,327**	**88,313**	**91,404**	**94,603**	**97,915**	**101,342**	**104,889**	**108,560**	**112,359**	**116,292**
Total Salaries and Wages	**718,471**	**743,618**	**769,644**	**796,582**	**824,462**	**853,319**	**883,185**	**914,096**	**946,090**	**979,203**
Plus Benefits	252,133	260,958	270,091	279,545	289,329	299,455	309,936	320,784	332,011	343,632
Total Personnel Costs	**970,604**	**1,004,576**	**1,039,736**	**1,076,127**	**1,113,791**	**1,152,774**	**1,193,121**	**1,234,880**	**1,278,101**	**1,322,834**
Expenses										
Administrative Expense										
Telephone / Internet	26,383	27,306	28,262	29,251	30,275	31,335	32,432	33,567	34,741	35,957
Pagers / Cell Phones	1,104	1,143	1,183	1,224	1,267	1,312	1,357	1,405	1,454	1,505
License or Permit	0	0	0	0	0	0	0	0	0	0
Legal	17,296	17,901	18,528	19,176	19,848	20,542	21,261	22,005	22,776	23,573

Appendix E: Profit and Loss Projections – Housing with Enhanced Services Model

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Audit	12,480	12,917	13,369	13,836	14,321	14,822	15,341	15,878	16,433	17,009
Accounting	15,799	16,352	16,925	17,517	18,130	18,765	19,421	20,101	20,805	21,533
Office Supplies	2,111	2,185	2,261	2,340	2,422	2,507	2,595	2,685	2,779	2,877
Computer / Technology	3,047	3,153	3,264	3,378	3,496	3,619	3,745	3,876	4,012	4,152
Conference / Travel	2,222	2,300	2,380	2,463	2,550	2,639	2,731	2,827	2,926	3,028
Mileage Remibursement	1,264	1,308	1,354	1,401	1,450	1,501	1,554	1,608	1,664	1,723
Personnel Recruiting / Advertising	0	0	0	0	0	0	0	0	0	0
Printing / Duplicating / Forms	3,326	3,443	3,563	3,688	3,817	3,950	4,089	4,232	4,380	4,533
Inservice Training / Education	6,094	6,307	6,528	6,756	6,992	7,237	7,490	7,753	8,024	8,305
Dues / Memberships	9,207	9,529	9,863	10,208	10,565	10,935	11,317	11,714	12,124	12,548
Postage / Delivery	559	578	599	620	641	664	687	711	736	762
Equipment	0	0	0	0	0	0	0	0	0	0
Pre-Employment Screening	0	0	0	0	0	0	0	0	0	0
Other » Employee Recognition	3,100	3,208	3,321	3,437	3,557	3,682	3,811	3,944	4,082	4,225
Other » Misc. Admin.	11,775	12,187	12,613	13,055	13,512	13,985	14,474	14,981	15,505	16,048
Subtotal - Administrative Expense	**115,765**	**119,817**	**124,011**	**128,351**	**132,844**	**137,493**	**142,305**	**147,286**	**152,441**	**157,776**
Housekeeping and Laundry										
Contracted Svcs / Temp Personel	8,874	9,185	9,506	9,839	10,183	10,540	10,909	11,290	11,686	12,095
Janitorial Supplies	4,740	4,906	5,077	5,255	5,439	5,629	5,826	6,030	6,241	6,460
Other »	0	0	0	0	0	0	0	0	0	0
Other »	0	0	0	0	0	0	0	0	0	0
Subtotal - Housekeeping and Laundry	**13,614**	**14,090**	**14,584**	**15,094**	**15,622**	**16,169**	**16,735**	**17,321**	**17,927**	**18,554**
Marketing										
Collatoral, branding, signage	3,326	3,443	3,563	3,688	3,817	3,950	4,089	4,232	4,380	4,533
Other »	0	0	0	0	0	0	0	0	0	0
Other »	0	0	0	0	0	0	0	0	0	0
Subtotal - Marketing	**3,326**	**3,443**	**3,563**	**3,688**	**3,817**	**3,950**	**4,089**	**4,232**	**4,380**	**4,533**
Utilities										
Electricity	128,602	133,103	137,762	142,584	147,574	152,739	158,085	163,618	169,345	175,272
Water / Sewer	225,500	233,392	241,561	250,016	258,766	267,823	277,197	286,899	296,940	307,333
Gas	0	0	0	0	0	0	0	0	0	0
Garbage Removal	78,231	80,969	83,803	86,736	89,772	92,914	96,166	99,532	103,015	106,621
Cable TV	2,222	2,300	2,380	2,463	2,550	2,639	2,731	2,827	2,926	3,028
Subtotal - Utilities	**434,555**	**449,765**	**465,507**	**481,799**	**498,662**	**516,115**	**534,179**	**552,876**	**572,226**	**592,254**
Maintenance										
Maintenance and Repairs	11,274	11,669	12,077	12,500	12,938	13,390	13,859	14,344	14,846	15,366
Grounds	12,759	13,206	13,668	14,146	14,641	15,154	15,684	16,233	16,801	17,389
Pest Control	22,578	23,368	24,186	25,033	25,909	26,815	27,754	28,725	29,731	30,771
Life Safety Maintenance	15,340	15,877	16,433	17,008	17,603	18,219	18,857	19,517	20,200	20,907
HVAC	7,757	8,028	8,309	8,600	8,901	9,212	9,535	9,869	10,214	10,571

Appendix E: Profit and Loss Projections – Housing with Enhanced Services Model

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Elevator	31,040	32,126	33,250	34,414	35,619	36,865	38,156	39,491	40,873	42,304
Other Contracted Services	16,631	17,213	17,815	18,439	19,084	19,752	20,443	21,159	21,900	22,666
Repair and Replacement Reserve	52,664	54,507	56,415	58,390	60,433	62,548	64,738	67,003	69,349	71,776
Other » Paint / Décor	1,663	1,721	1,782	1,844	1,908	1,975	2,044	2,116	2,190	2,267
Other » Windows/Curtains	665	689	713	738	763	790	818	846	876	907
Other » Security Services	38,810	40,168	41,574	43,029	44,535	46,094	47,707	49,377	51,105	52,893
Other »	0	0	0	0	0	0	0	0	0	0
Subtotal - Maintenance	**211,181**	**218,572**	**226,222**	**234,140**	**242,335**	**250,816**	**259,595**	**268,681**	**278,085**	**287,817**
Vehicle Expense										
Vehicle Maintenance	1,330	1,377	1,425	1,475	1,527	1,580	1,635	1,693	1,752	1,813
Other »	0	0	0	0	0	0	0	0	0	0
Other »	0	0	0	0	0	0	0	0	0	0
Subtotal - Vehicle Expense	**1,330**	**1,377**	**1,425**	**1,475**	**1,527**	**1,580**	**1,635**	**1,693**	**1,752**	**1,813**
Insurance										
Property and Liability Insurance	232,831	240,980	249,414	258,144	267,179	276,530	286,208	296,226	306,594	317,324
Other »	0	0	0	0	0	0	0	0	0	0
Subtotal - Insurance	**232,831**	**240,980**	**249,414**	**258,144**	**267,179**	**276,530**	**286,208**	**296,226**	**306,594**	**317,324**
Corporate / Management Fees										
Management / Corporate Fee [% rev]	0	0	0	0	0	0	0	0	0	0
Management / Corporate Fee [flat fee]	91,004	94,189	97,485	100,897	104,429	108,084	111,867	115,782	119,834	124,029
Asset Management Fee	25,130	26,009	26,920	27,862	28,837	29,846	30,891	31,972	33,091	34,249
Other [% rev] »	0	0	0	0	0	0	0	0	0	0
Subtotal - Corporate / Management Fees	**116,133**	**120,198**	**124,405**	**128,759**	**133,266**	**137,930**	**142,758**	**147,754**	**152,925**	**158,278**
Other Expenses										
Interest Expense [excl mortgage interest]	0	0	0	0	0	0	0	0	0	0
Property Taxes	2,767	2,864	2,964	3,068	3,176	3,287	3,402	3,521	3,644	3,772
Subtotal - Other Expenses	**2,767**	**2,864**	**2,964**	**3,068**	**3,176**	**3,287**	**3,402**	**3,521**	**3,644**	**3,772**
Total Expenses	**2,390,379**	**2,474,042**	**2,560,634**	**2,650,256**	**2,743,015**	**2,839,020**	**2,938,386**	**3,041,230**	**3,147,673**	**3,257,841**
Net Operating Income (NOI)	**(427,067)**	**30,295**	**31,355**	**32,452**	**33,588**	**34,764**	**35,981**	**37,240**	**38,543**	**39,892**
Less Estimated Debt Service Payments	0	0	0	0	0	0	0	0	0	0
Cash Flow after Debt	**(427,067)**	**30,295**	**31,355**	**32,452**	**33,588**	**34,764**	**35,981**	**37,240**	**38,543**	**39,892**
Less Asset Management Fees	29,270	30,294	31,355	32,452	33,588	34,764	35,980	37,240	38,543	39,892
Cash Flow after Asset Management Fees	**(456,337)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**