36th SNF Cost Comparison and Industry Trends Report

COVID-19 CHALLENGES

By: Stephen Taylor, Matthew Wocken, and Seth Wilson

WEALTH ADVISORY | OUTSOURCING | AUDIT, TAX, AND CONSULTING

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Executive Summary

Executive Summary

For skilled nursing facility (SNF) operators, enduring the pressures of the COVID-19 pandemic involves a variety of factors: financial health leading into the pandemic, impact on operating revenues and expenses, and the amount of funding received through various Public Health Emergency (PHE) sources.

For many SNF stakeholders, the current business challenges are all-consuming — most notably, slow occupancy recapture and workforce challenges. And though PHE funding sources provided critical financial lifelines, they have a finite existence and a host of ever-evolving requirements.

In our 35th annual report, we anticipated "... the impact in 2020 will likely be masked by the operational and financial consequences of COVID-19." These themes are reflected in the data points within this year's report.

Methodology

This publication provides benchmarks and ratios calculated using annual SNF cost report data released by the Centers for Medicare and Medicaid Services (CMS) as of October 2021. Due to a pandemic-related Medicare cost report filing extension granted by CMS, the October 2021 data release was the earliest data release determined to have an adequate representation of 2020 filed cost reports.

Any cost reports that were not available for analysis in previous years' cost comparison reports have since been added, so amounts presented for 2016 – 2019 may differ from prior-year reports.

Each SNF's data was ranked numerically and stratified into percentiles. These summary statistics and our data perspectives are intended to provide a general understanding of financial and operational trends. This report is not intended to provide any conclusions about correlation and dependence within the data.

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Ratio Analysis

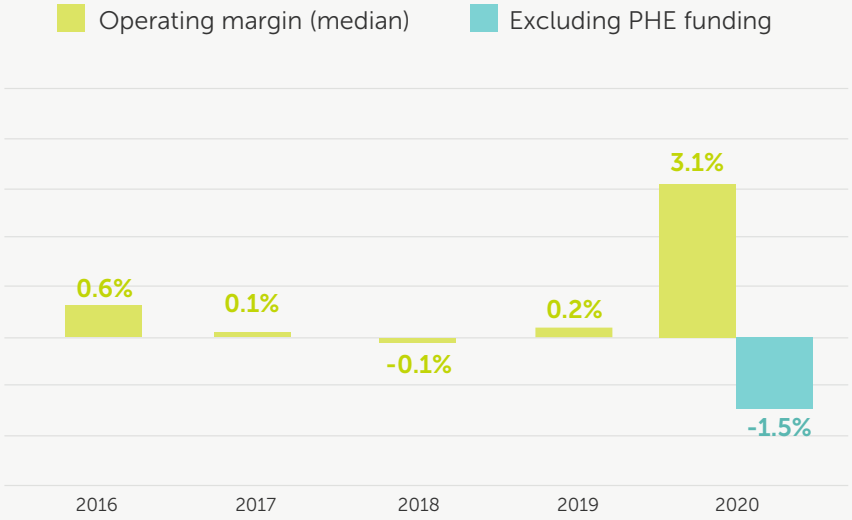
Operating margin

Utilizing the same methodology as in prior years, the median SNF operating margin for 2020 of 3.1% is significantly stronger than previous years: an increase of almost three percentage points compared to the previous dip and plateau — a result of providers recognizing PHE funds into income.

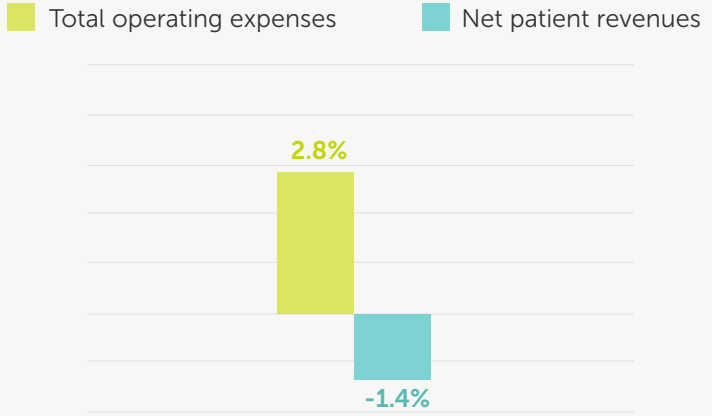
Unfortunately, the operational reality is masked by a variety of factors, most notably the benefit of PHE funds. By excluding the impact of PHE funds from the calculation, we see something more representative of the challenging operating environment: a median net operating margin of -1.5%.

With significant reductions in occupancy, it is no surprise that net patient revenues declined. What is interesting is how much the increase in operating expenses exceeded the decrease in net patient revenues.

Median Operating Margin



Median Change in Patient Revenues and Operating Expenses



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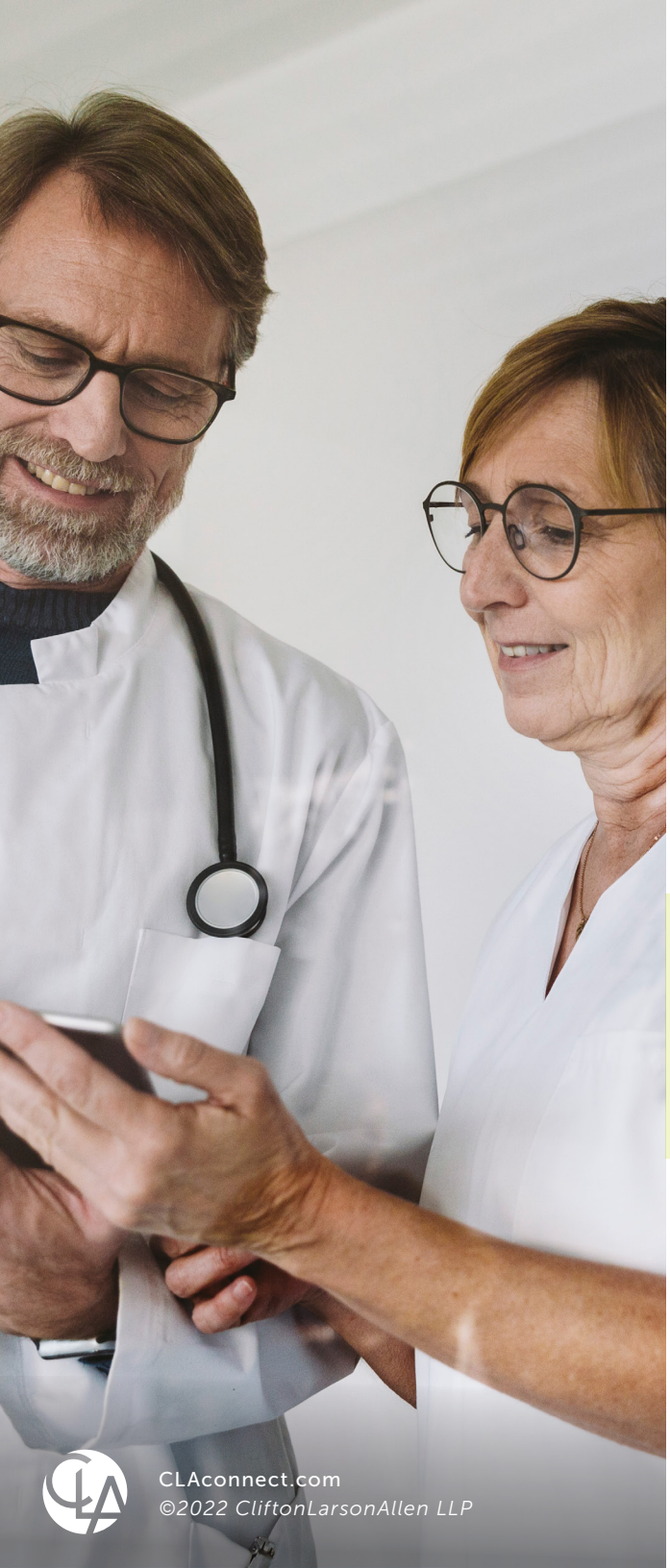

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RATIO ANALYSIS

PHE Funding

SNF operators may have participated in a variety of funding programs created by policymakers in 2020. Each funding source contains restrictive parameters of eligibility, restrictions on use and funding allocation, and time periods of use. Those restrictions created wide variability in the amount of funding received — and when it was recognized in the financial results of organizations. Matters are further complicated in instances when funds may need to be returned and by the fact that state-level funding varies from state to state.

- U.S. Department of Health and Human Services (HHS) Provider Relief Fund (PRF)
- Small Business Administration (SBA) Paycheck Protection Program (PPP)
- Accelerated and Advance Medicare Payment (AAMP)
- Medicare sequestration temporary suspension
- Temporary waiver of three-day hospital stay
- Employer payroll tax deferral
- Temporary 6.2% increase in Federal Medical Assistance Percentages (FMAP)

A common factor among these funding sources is their finite existence. The pressure on SNF operating revenues and cost structure is likely to outlast many of them.

COVID-19 continues to create many uncertainties for health care providers. If you've received federal or state funding, CLA can help you navigate the complex and continuously changing reporting requirements. ***Get Help***

Patient Driven Payment Model (PDPM)

At the onset of 2020, many SNF stakeholders were reviewing their January and February financial results with a sense of optimism. This was in response to the change in Medicare Part A case-mix methodology from RUG-IV to PDPM (Patient Driven Payment Model). In fact, the increase in median Medicare revenue per day in 2020 was approximately 7% when compared to 2019. As we have analyzed the data, there is certainly an impact of COVID factoring into this increase. This increase helped offset some of the lost revenue providers experienced with the decreases in occupancy.

However, the Centers for Medicare and Medicaid Services (CMS) continues to evaluate the "true" budget neutrality of the PDPM reimbursement methodology.

Occupancy

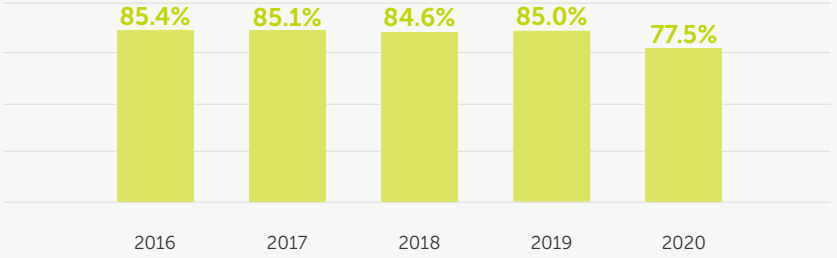
Occupancy is one of the strongest indicators of SNF financial performance. The declaration of a national emergency in March 2020 immediately impacted SNF occupancy. Hospitals paused non-emergent and elective procedures, and SNFs experienced isolation protocols, quarantine mandates, and potential COVID infections in residents.

Throughout 2020, occupancy continued to fall, bringing the average below 80% for the first time.

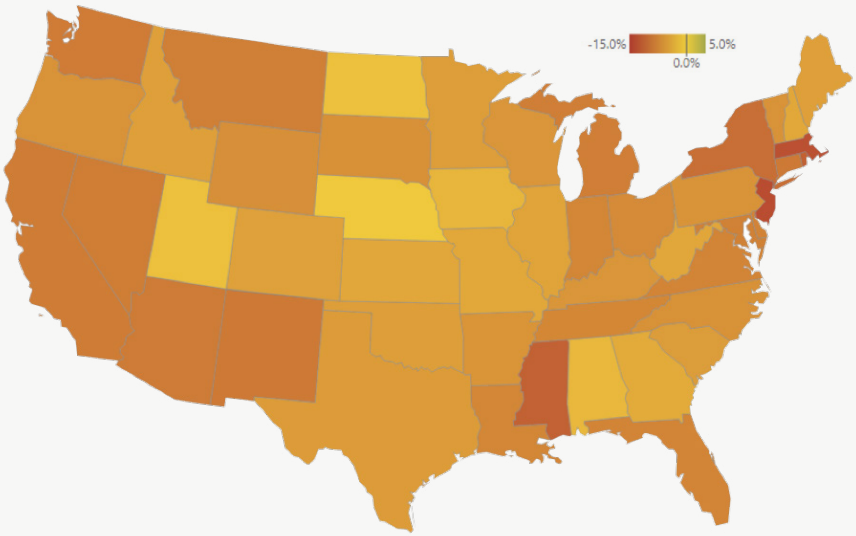
The causes for occupancy reductions exist nationwide, but each state has its own story and is seeing different levels of impact. Looking at the change in median occupancy from 2019 to 2020, we see northeastern states like Massachusetts and New York, which previously reported strong occupancy, were impacted the hardest with a decline of 10% or more. Meanwhile, states in the central part of the country had a lesser dip and/or quicker recovery, netting a decline closer to 5%.

It is important to note these visuals are presenting data aggregated at the state level. Within each state are regions or counties, and within each of those are facilities over- and underperforming. At this level, an effective attribute for grouping and benchmarking purposes is the CMS star rating.

Median Occupancy Rate



Change in Median Occupancy by State



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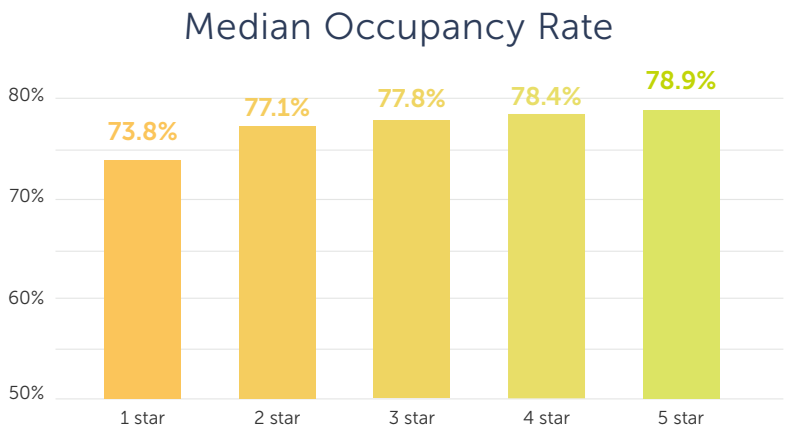
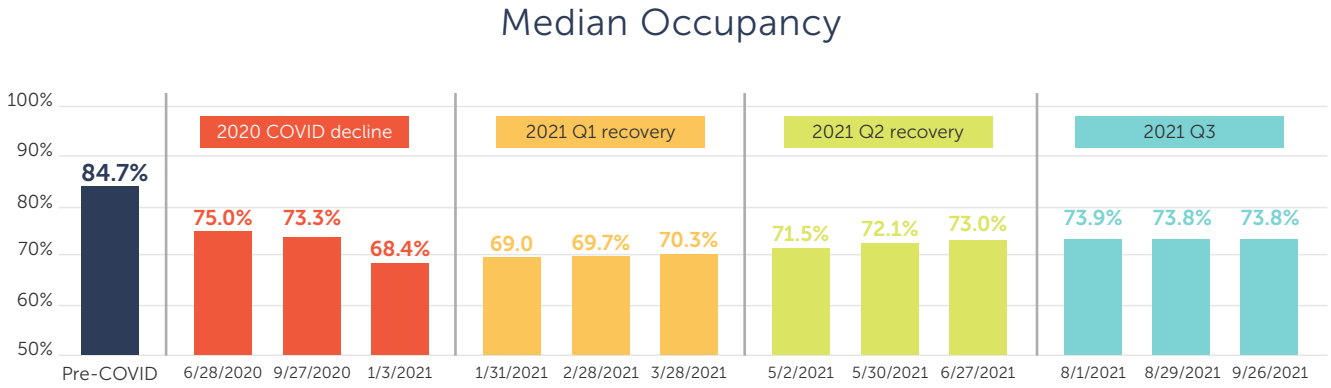
RATIO ANALYSIS

Looking at median occupancy by overall star rating reveals two immediate observations. First, there is a much greater difference in median occupancy for facilities with a 1-star overall rating compared to others. Second, though not a significant difference, the median occupancy is slightly higher as the overall star rating increases from 2 to 5.

There is variation within these groups and we are looking at the median for the entire group. Certainly, there are 1-star facilities with higher occupancy and 5-star facilities with lower occupancy. Still, star rating and how it relates to performance indicators is a key consideration.

Occupancy reached a low point at the end of calendar 2020 for many facilities, and the recapture of that lost occupancy remains critical for SNF stakeholders. While many facilities experienced their low point in the second half of 2020 and have been in recovery mode throughout 2021, the earliest we can hope to report a median occupancy rate above 80% is 2022. We are seeing a disproportionate recapture of occupancy among operators in markets, which is creating a wide gap between the haves and the have-nots. Three consistent themes arise: market(s) you operate in, quality, and staffing.





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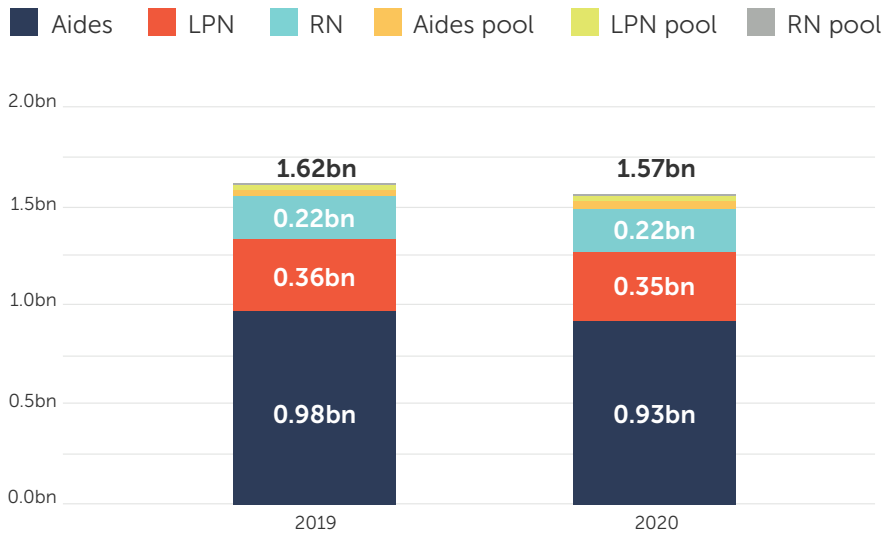
Workforce

During 2020 many operators experienced increased staffing costs due to "hero pay," overtime, and increased agency staffing utilization due to infection rates and quarantine protocols. As infection rates decreased in 2021, the clinical crisis shifted to a workforce crisis.

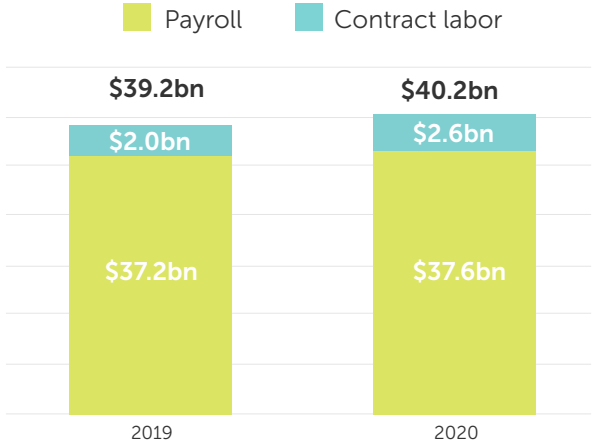
A study conducted by American Health Care Association (AHCA) highlighted the difficulties and lack of qualified candidates. The factors that drove the increase in cost in 2020 — shift differentials and agency staffing — persist in 2021. The reduction in availability of labor is accelerating the pace of rising labor costs. The study noted "58 percent of nursing homes limiting new admissions due to staffing shortages."

The tables to the right illustrate the workforce challenges on a macro level. Across the nation there were approximately ***50,000,000 fewer*** nursing hours paid in 2020 compared to 2019. However, even with this substantial decrease in total hours, the cost of those nursing positions ***increased by approximately $1B.***

Paid Nursing Hours



Direct Care Nursing Expense by Source



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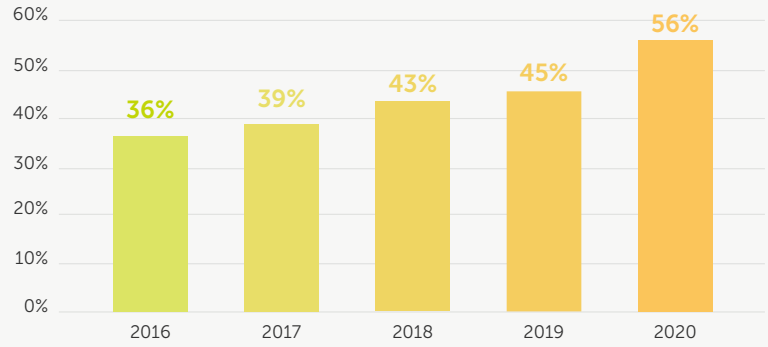
RATIO ANALYSIS

One way to measure nursing labor supply is to look at nursing pool utilization. 2020 was the first year we have seen more than 50% of facilities report utilization of nursing pool. Because some of these facilities used more and others used less, we also look at the amount of utilization for those that reported it. While more facilities reported utilization, the median utilization for those reporting remained close to 3%, while utilization for the upper quartile remained below 10%. Despite the challenge to attain direct employees rather than access contract labor, the data suggests facilities are having some success making the investment to attract and retain direct care staff.

It's interesting to observe how pool utilization relates to the overall star rating. Looking at the aggregate measure, the percentage of 1-star facilities using pool is 12% more than the percentage of 5-star facilities using pool. Even more interesting is that 1-star facilities reporting pool are reporting more than double the utilization reported by 5-star facilities.

Earlier we saw a lower median occupancy for 1-star facilities than other ratings. This could signal that lower occupancy leads to fewer resources available to attract and retain direct care staff that would support a higher rating and reduce pool utilization. Each facility has its own story.

Providers Reporting Hours Paid to Nursing Pool



	2016	2017	2018	2019	2020
25th	0.4%	0.5%	0.6%	0.7%	0.7%
50th	1.8%	2.2%	2.6%	3.2%	3.0%
75th	5.6%	6.8%	7.9%	8.9%	9.2%
Providers with pool	36%	39%	43%	45%	56%

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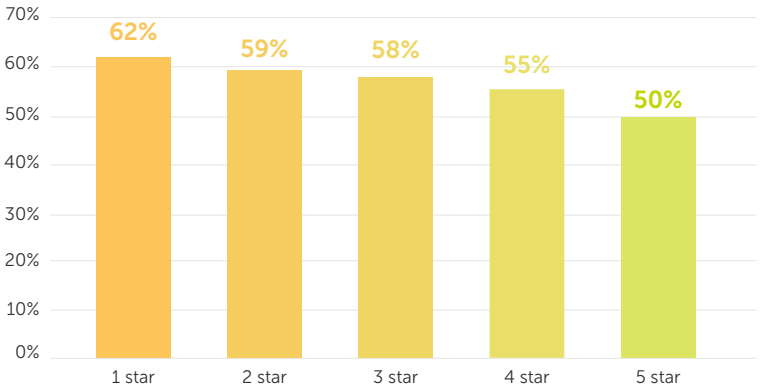
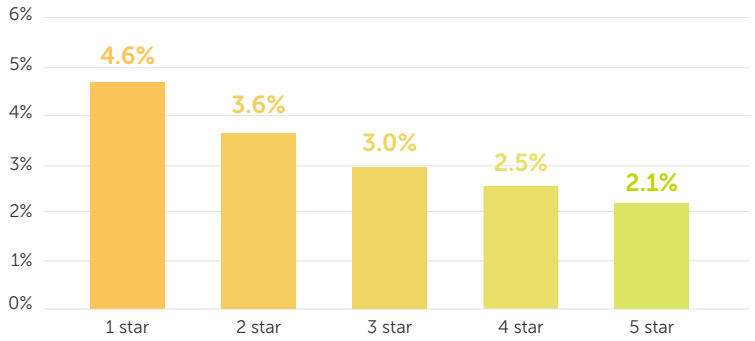
RATIO ANALYSIS

% of Providers Using Pool by Star Rating



Median Pool Utilization by Star Rating



We continue to hear clients share their challenges with workforce and how, in response, they continue to be pressured into increasing compensation. The table below shows an increase to average rates across the board through 2020, likely indicating a need for great advocacy for funding in addition to greater emphasis on scheduling and human resources.

Year	Nursing admin	RN	LPN	Aide	Social services	Plant	Housekeeping	Laundry	Dietary	Admin
2016	$34.57	$34.46	$26.08	$14.73	$19.71	$18.39	$10.98	$10.69	$12.50	$26.71
2017	$35.37	$35.55	$26.93	$15.37	$20.21	$18.83	$11.33	$11.11	$12.90	$27.45
2018	$36.05	$36.80	$27.81	$16.10	$20.92	$19.45	$11.73	$11.45	$13.26	$28.24
2019	$37.01	$37.78	$28.71	$16.88	$21.57	$20.00	$12.14	$11.85	$13.79	$28.83
2020	$38.82	$39.65	$30.36	$18.18	$22.50	$20.83	$13.00	$12.63	$14.57	$30.06

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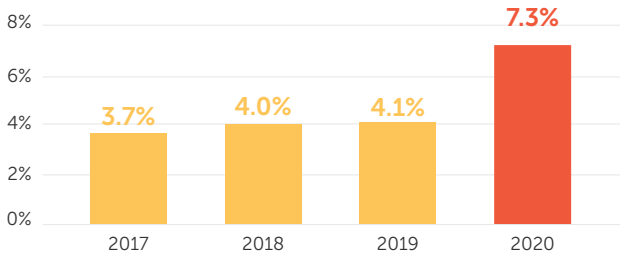
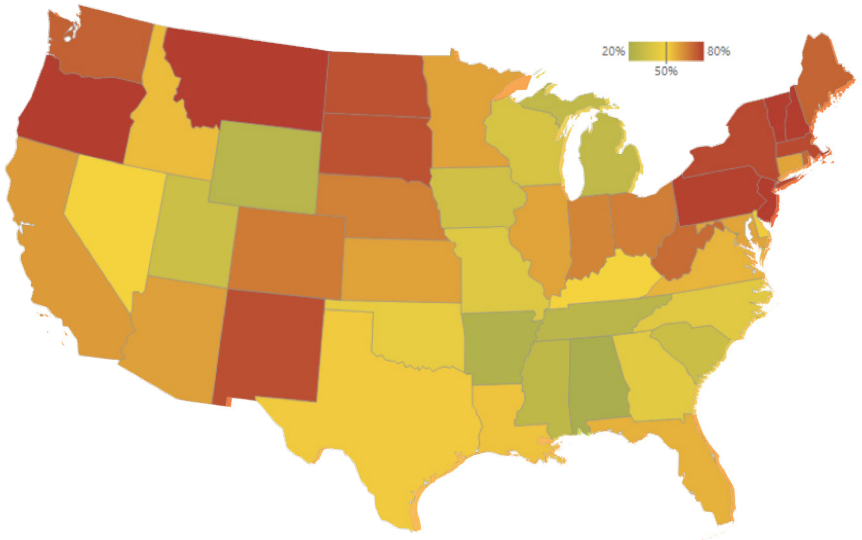
RATIO ANALYSIS

Median Increase in Total Nursing Average Hourly Wage

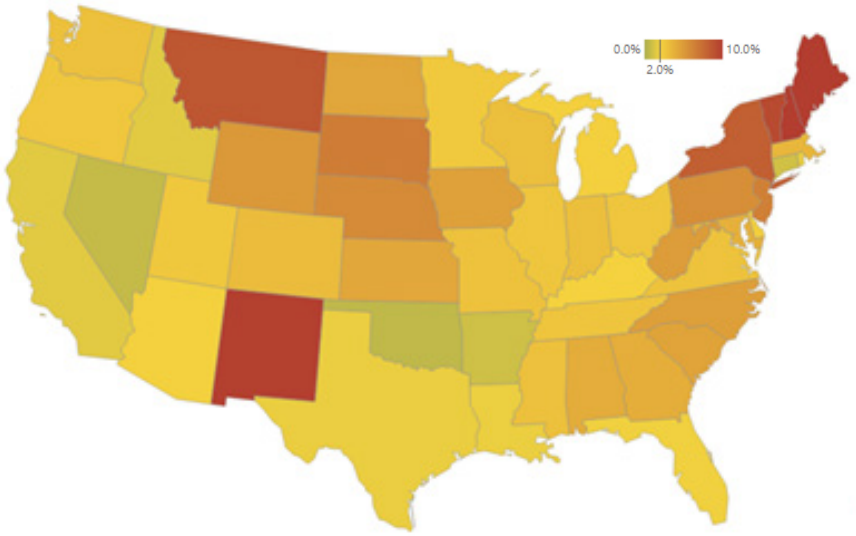


In response to the workforce challenges facing the industry, the average hourly wages paid to the nursing department ***increased 7.3% in 2020.*** "Hero pay" to staff, overtime due to staff shortages, shift differentials, and other premium pay factors caused the larger than historical increases in the average hourly wages. This theme continued through 2021. Many operators are realizing the squeeze of operating in a fee-for-service environment may require a greater focus on their strategic path forward.

Providers Reporting Hours Paid to Nursing Pool in 2020



Median Pool Utilization in 2020



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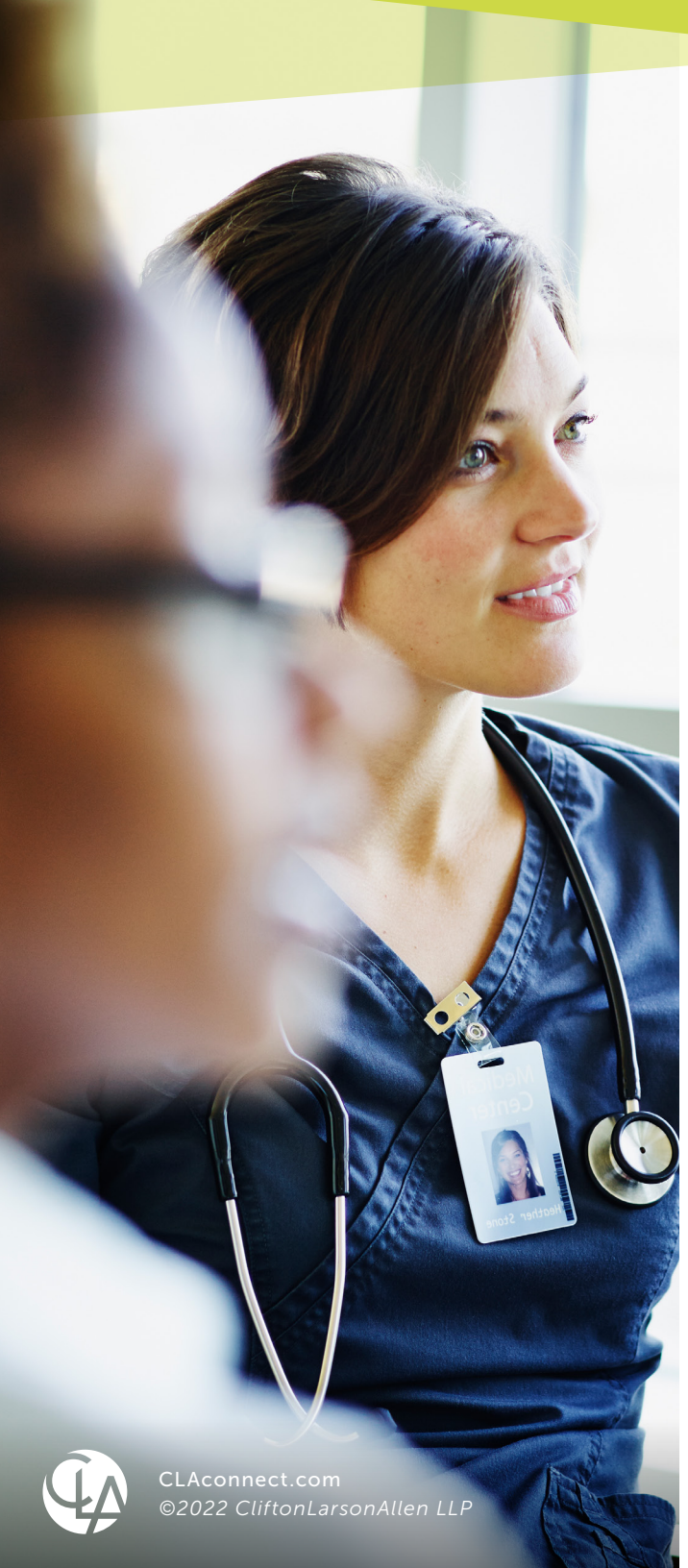
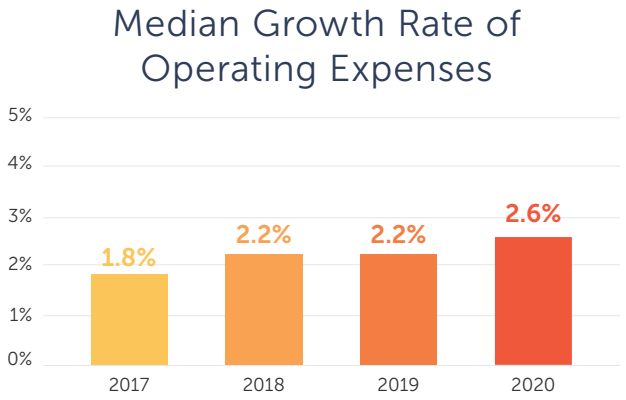


Cost structure

The rising cost structure brought on by COVID is apparent in the data. Signs indicate the rise will sustain due to broader economic variables. SNFs have spent billions of dollars on testing, infection control, PPE, and other areas, which exponentially increased their cost structure. Median cost PPD year-over-year increased by more than 10%. This is not surprising because in the heat of the pandemic, operators may have been paying a premium for PPE, providing "hero pay" to their staff, conducting extensive testing, and facing other COVID-related expenses. As infection rates have decreased and we have gained the clinical upper hand, some of these expenses could normalize. However, we expect agency staffing, competitive wages and benefits, and infection prevention to have continued effects on cost structure.

The reality is that 63.2% of payer sources are state Medicaid programs which, in many states, significantly underfund the cost of care. At first glance, operating margins may not show growth in operating expenses outpacing net patient revenues. However, when you factor in PHE, consider the margins pre-pandemic were 0.2%, and observe increased cost structure coupled with prolonged reductions in occupancy, it becomes clear that expenses are outpacing net revenues. These themes are independent of financial sponsorship, which is why industry associations representing both nonprofit and privately held stakeholders are joining forces to pursue legislative change.

Reform is critical for the financial future of the industry. However, it will likely be a slow and arduous process. Therefore, we encourage SNF stakeholders to take strategic action now to safeguard your enterprise's financial viability.



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Conclusion

Conclusion

While the effects of COVID-19 have dramatically impacted the market, and financial and operational issues persist, understanding the data can provide perspective and support your ability to forge a financially viable path forward. Get organized around what you are going to measure and what actions you are going to take.

- PHE funding sources are temporary
- Occupancy recapture has been slow; it's critical to understand your baseline and recapture in your local market
- Cost structure has been significantly impacted by labor and infection control costs

Thank you to all the SNF operators and industry advocates who have persevered during these challenging times. Do not lose sight of the fact that by 2030 every baby boomer will be age 65+. What you do matters.

We are here to help.

The environment may not be easier, but we can help shoulder some of your burden and position you for greater strategic focus:

- Industry focused, data-driven insights about your local market
- COVID funding reporting, compliance and audits
- PDPM assessments and reimbursement advisory
- Operational assessments and implementation
- Strategic financial modeling (CLA Intuition®)
- Outsourced accounting and project work
- Transaction support
- Risk based payment advisory
- We are industry professionals that can run alongside you

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Appendix

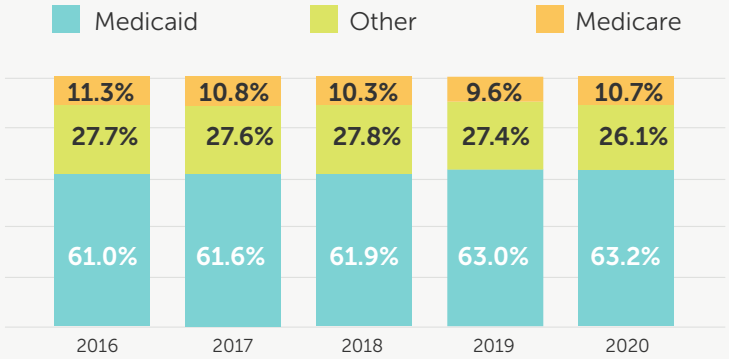
APPENDIX

Payer mix

The average payer mix measures the percentage of occupied resident days paid by various payer sources.

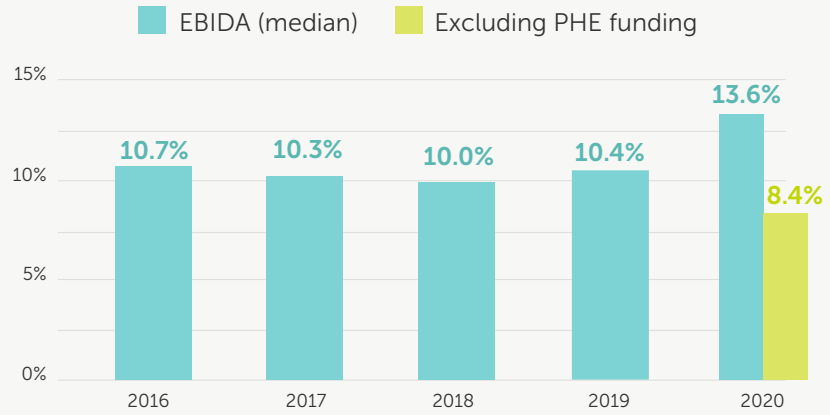
During the PHE, the Centers for Medicare and Medicaid Services (CMS) temporarily waived the 3-day hospital stay requirement providing operators with the ability to skill residents in place, avoiding high-risk transfers to hospitals. The result, some operators were able to increase their skilled mix in contrast to reductions in their occupancy.

Median Payer Mix



Earnings before interest, depreciation, and amortization (EBIDA)

EBIDA is a commonly used profitability measure because it eliminates capital-related costs. It is a rough measurement of cash flow for skilled nursing operators, so changes measured in this ratio provide a sense for how providers generate cash.



	2016	2017	2018	2019	2020
25th	4.7%	4.3%	3.9%	4.2%	6.6%
50th	10.7%	10.3%	10.0%	10.4%	13.6%
75th	16.5%	15.8%	15.6%	16.0%	20.1%

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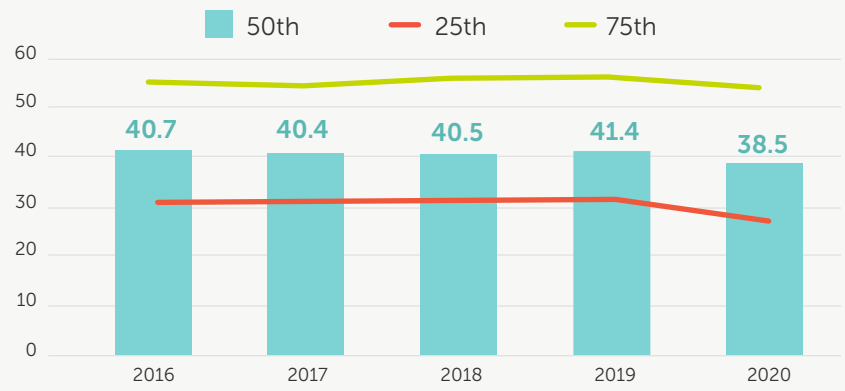
APPENDIX

Days revenue in accounts receivable

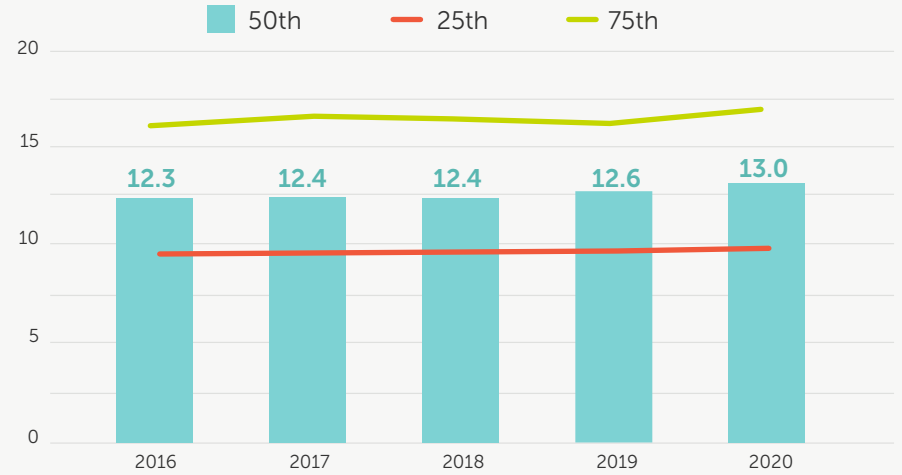
This ratio calculates the average number of days that receivables are outstanding, or how quickly a facility converts its receivables to cash. A lower value of days revenue in accounts receivable is desirable, as it indicates that a facility takes less time to convert its receivables to cash.



25th	30.7	30.5	30.5	31.3	27.6
50th	40.7	40.4	40.5	41.4	38.5
75th	54.8	54.2	55.6	56.0	53.8

Average age of plant

This ratio measures the average age of a facility by estimating the number of years depreciation has been realized for a facility by dividing accumulated depreciation by depreciation expense.



25th	9.4	9.5	9.6	9.7	9.8
50th	12.3	12.4	12.4	12.6	13.0
75th	15.9	16.2	16.1	16.0	16.8

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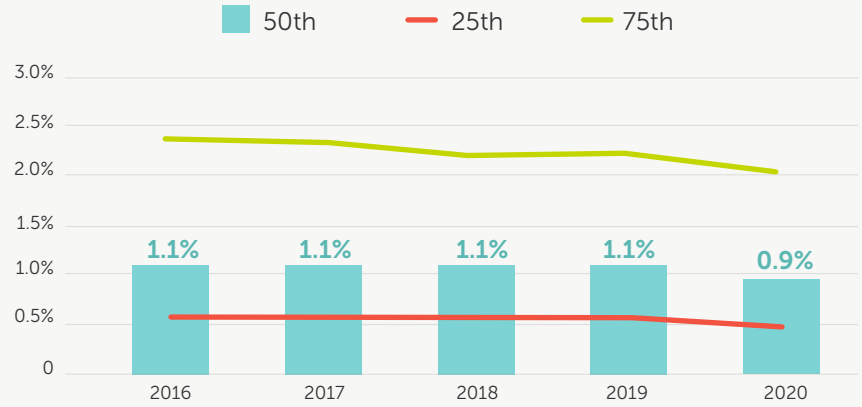
Capital spending ratio

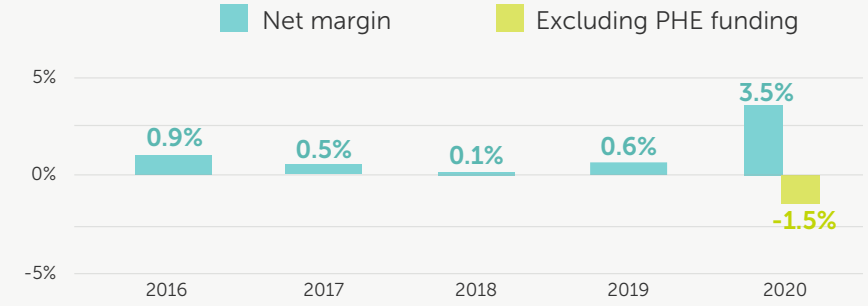
This ratio measures the capital spending of a facility as a percentage of annual operating revenues and indicates how aggressively a facility reinvests its revenue back into its facility.



	2016	2017	2018	2019	2020
25th	0.6%	0.5%	0.6%	0.6%	0.5%
50th	1.1%	1.1%	1.1%	1.1%	0.9%
75th	2.4%	2.3%	2.2%	2.2%	2.0%

Net margin ratio

This ratio measures a facility's efficiency in controlling costs in relation to its total revenue. This profitability measure is calculated by comparing a facility's net income or loss to its total revenue. An organization's ability to maintain its net margin ratio is vital for long-term sustainability.



	2016	2017	2018	2019	2020
25th	-4.9%	-5.3%	-6.0%	-5.1%	-2.9%
50th	0.9%	0.5%	0.1%	0.6%	3.5%
75th	5.8%	5.4%	4.8%	5.4%	9.8%

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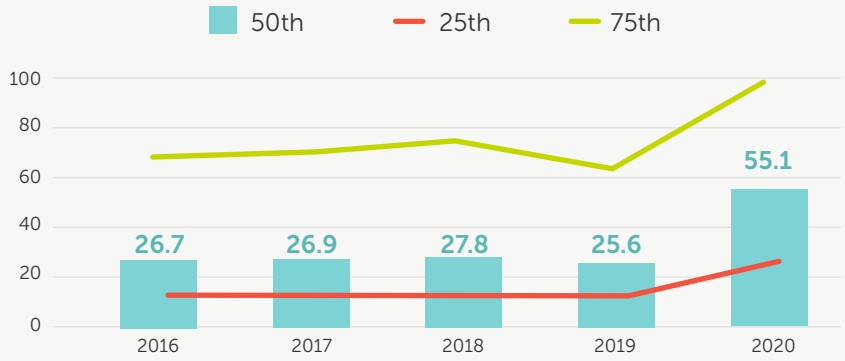
APPENDIX

Days cash on hand

This ratio measures how long an organization's cash on hand will cover average expenses. Similar to the current ratio (defined below), a high number of days cash on hand is considered favorable. However, an extremely high ratio may indicate that a facility could earn a higher rate of return by investing in longer-term investments.

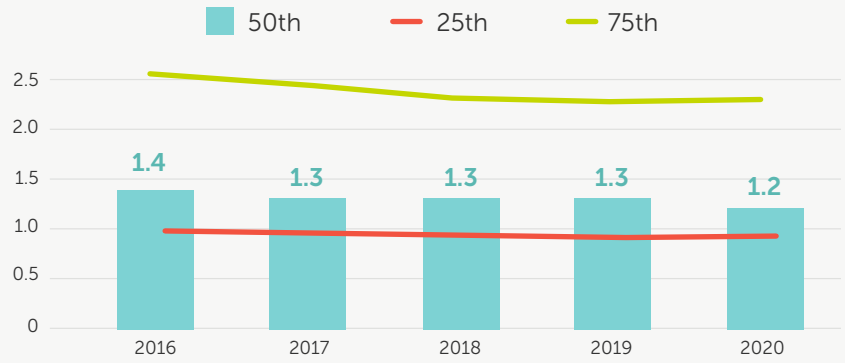
Due to the various PHE funding sources, SNFs were able to access temporary cash infusions to support operations; however, operating margins are under significant pressure. While balance sheets looked strong in 2020, SNFs are burning through cash at an aggressive pace.



25th	13.0	13.0	13.0	12.4	24.1
50th	26.7	26.9	27.8	25.6	55.1
75th	65.4	66.3	68.5	62.0	98.7

Current ratio

The current ratio measures the liquidity of a facility. It is used to determine the degree to which current liabilities are covered by current assets or the ability to pay short-term obligations when due.



25th	.7	.7	.7	.7	.7
50th	1.4	1.3	1.3	1.3	1.2
75th	2.5	2.4	2.4	2.3	2.3

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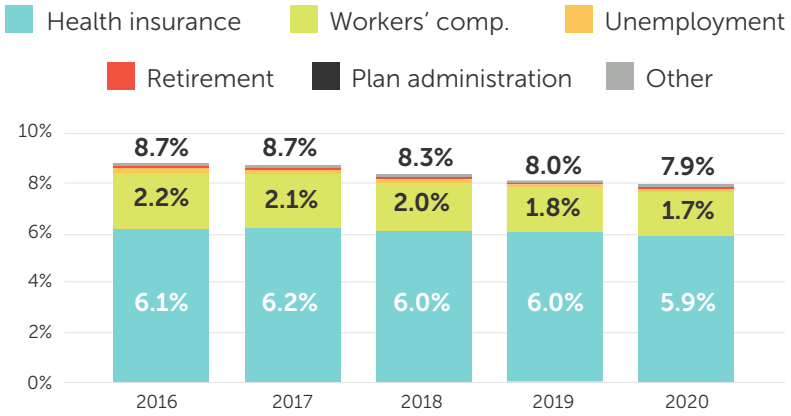
Fringe benefits

This ratio measures the relative percentage of fringe benefits. In addition to direct payroll costs, fringe benefits are additional costs of labor. Fringe benefits include:

- Medical, life, and other group insurance
- Workers' compensation insurance
- Pension or retirement contribution
- Uniform allowance
- Miscellaneous employee benefits



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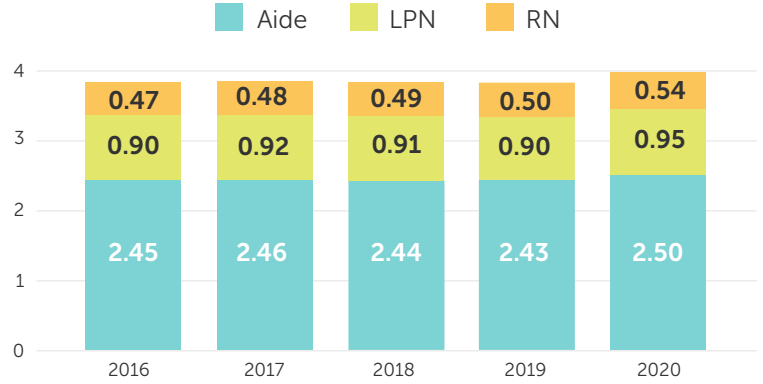
APPENDIX

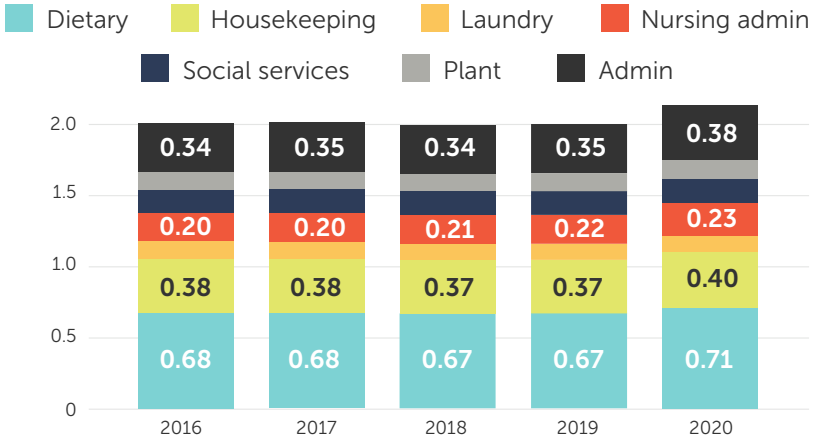
Hours per resident day

This ratio calculates the actual compensated hours paid per resident day.

Nursing Median Paid Hours Per Resident Day



Median Paid Hours Per Resident Day (excluding nursing)



APPENDIX

Total costs per resident day

Percentile	Nursing	Social services	Ancillary	Plant	Housekeeping	Laundry	Dietary	Admin	Benefits	Totals
25th	$84.81	$2.35	$15.89	$10.12	$5.45	$2.02	$17.63	$43.81	$13.69	$195.76
50th	$106.73	$4.02	$22.08	$12.54	$2.02	$3.04	$20.87	$57.57	$21.57	$255.55
75th	$135.19	$6.59	$30.86	$16.31	$7.12	$4.24	$25.78	$75.02	$32.28	$335.68

Salaries per resident day

Percentile	Nursing	Social services	Plant	Housekeeping	Laundry	Dietary	Admin	Total
25th	$71.05	$2.15	$1.97	$1.80	$0.00	$7.42	$8.54	$92.93
50th	$89.20	$3.74	$2.71	$5.02	$1.35	$10.29	$11.44	$123.75
75th	$113.54	$6.08	$3.91	$7.08	$2.42	$13.93	$16.22	$163.18

Salaries per compensated hour

Percentile	Nursing admin	RN	LPN	Aide	Total nursing	Social services	Plant	Housekeeping	Laundry	Dietary	Admin
25th	$33.50	$34.26	$26.35	$15.38	$19.86	$18.67	$18.16	$11.33	$10.68	$12.65	$25.76
50th	$38.82	$39.65	$30.36	$18.18	$22.46	$22.50	$20.83	$13.00	$12.63	$14.57	$30.06
75th	$45.95	$45.74	$35.17	$21.19	$25.38	$26.89	$24.10	$15.00	$14.77	$16.82	$35.42

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APPENDIX

Indicator formulas

Page 6

Operating Margin = $\frac{\text{Net Operating Income (Loss)}}{\text{Operating Revenue}}$

Page 8

Occupancy Percentage = $\frac{\text{Resident Days}}{\text{Facility Beds x 365}}$

Page 12

Wages Per Compensated Hour = $\frac{\text{Wages}}{\text{Compensated Hours}}$

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Payer Mix = $\frac{\text{Resident Day Mix}}{\text{Total Resident Days}}$

Page 18

EBIDA = $\frac{\text{Net Income (Loss) or Change in Unrestricted Net Assets + Interest Expense + Depreciation Expense + Amortization Expense}}{\text{Total Revenue}}$

Page 19

Days Revenue in Accounts Receivable = $\frac{\text{Accounts Receivable}}{\text{(Resident Revenue/365)}}$

Page 19

Average Age of Plant = $\frac{\text{Accumulated Depreciation}}{\text{Depreciation Expense}}$

Page 20

Capital Spending Ratio = $\frac{\text{Capital Purchases}}{\text{Operating Revenues}}$

Page 20

Net Margin Ratio = $\frac{\text{Net Income (Loss) or Change in Unrestricted Net Assets}}{\text{Total Revenue}}$

Page 21

Days Cash on Hand = $\frac{\text{Cash and Cash Equivalents}}{\text{(Operating Expenses – Depreciation)/365}}$

Page 21

Current Ratio = $\frac{\text{Current Assets}}{\text{Current Liabilities}}$

Page 22

Payroll Taxes and Fringe Benefits = $\frac{\text{Benefits Mix}}{\text{Total Salary Expense}}$

Page 23

Hours Per Resident Day = $\frac{\text{Compensated Hours}}{\text{Resident Days}}$

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About CLA

The CLA Promise

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Investment advisory services are offered through CliftonLarsonAllen Wealth Advisors, LLC, an SEC-registered investment advisor.

The four essential elements of the CLA Promise

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Our dedication to health care

CLA has developed one of the nation's largest health care practices. Our team includes CPAs and a diverse range of experienced professionals with backgrounds and skill sets ranging from CEOs and CFOs to RNs, certified coders, and certified medical practice executives. Our professionals are regular contributors in national publications and at national and regional conferences. By working together, we help our clients build enterprise value through strategy, operations, finance, and compliance services.

Health Care Innovation and Insight Blog HI2
Get help navigating the continuously changing health care landscape. Stay current on new payment models, emerging innovations, and new regulatory and legislative policies.
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Our health care network

Our practice consists of
470+
health care professionals

90+
health care principals

We currently serve
10,100+
health care clients

which includes
3,200+
aging services providers

200+
home care, hospice, and other community-based providers

900+
hospitals and health systems, including approximately 80 critical access hospitals

5,800+
physicians, dentists, and medical practices

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Services for SNF operators and owners

Our customized services support the evolving needs of organizations serving aging adults. We are a premier resource for health care providers and offer deep industry specialization and a seamless experience to those we serve. These advantages propel us forward as we create opportunities, develop relationships, and provide value for skilled nursing facilities as we help our people grow their inspired careers.

Due to escalating operating costs, personnel shortages, and changing reimbursement models, skilled nursing operators and owners are being forced to reexamine the way they do business. CLA understands that these challenges require more than ordinary answers; they require forward-thinking and creative approaches to help carry you forward. We proactively stay informed of industry trends and the regulatory and operational environment to help position your organization for upcoming challenges and opportunities.

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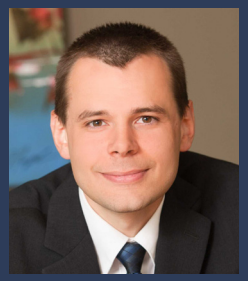
We can help

Primary author:

Stephen Taylor
Principal, Senior Living & Care Leader
stephen.taylor@CLAconnect.com
314-925-4397

Contributing authors:

Matthew Wocken
Principal



Seth Wilson
Data Analyst Manager

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