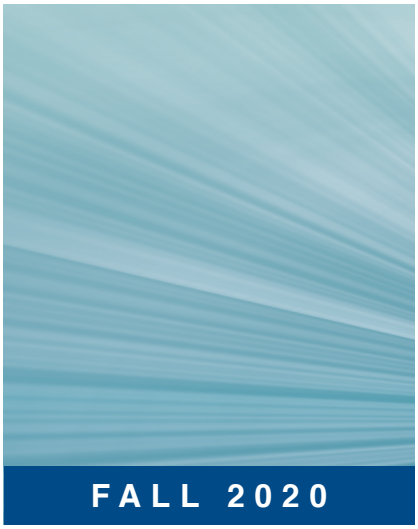
SPECIAL ISSUE

brief



The Immediate Financial Impact of COVID-19 on Senior Living Communities

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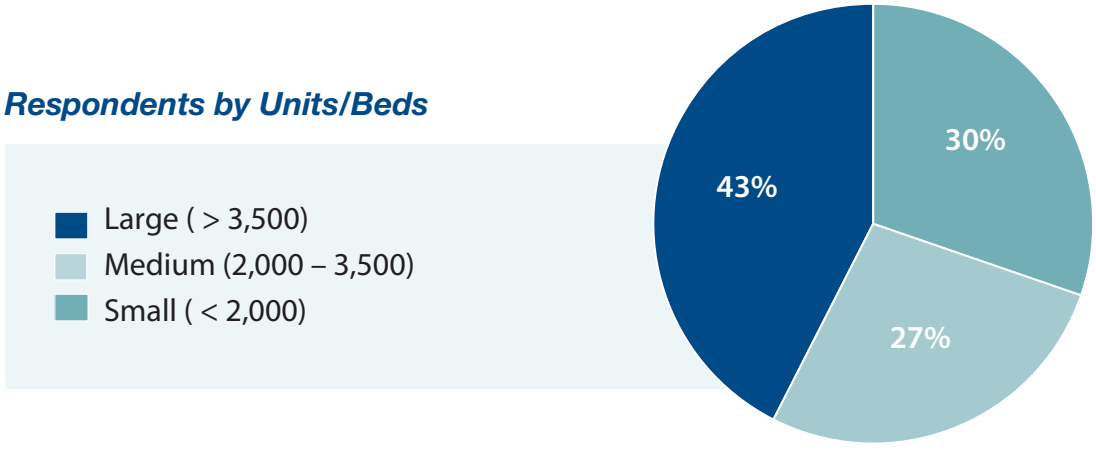
The Immediate Financial Impact of COVID-19 on Senior Living Communities

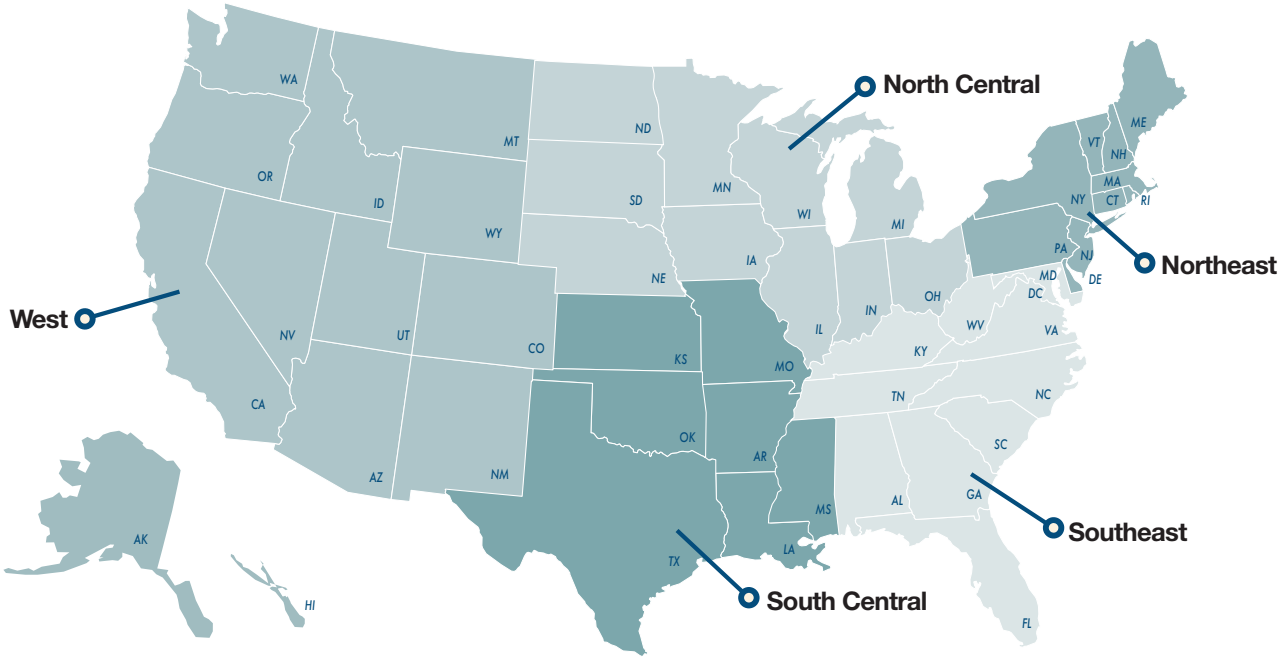
Although no one questions the challenges that the coronavirus presents to seniors housing operators — particularly given the media's tendency to conflate the industry with more institutional quarters — the pandemic's impact on the communities they manage varies. This article explores the range of impact, the underlying causes and insight into short-term challenges and recovery.

This summer, over thirty operators representing more than 180,000 units responded to the American Seniors Housing Association's (ASHA)/HealthTrust's survey regarding their experience between March 1, 2020 and June 30, 2020. The survey concerned:

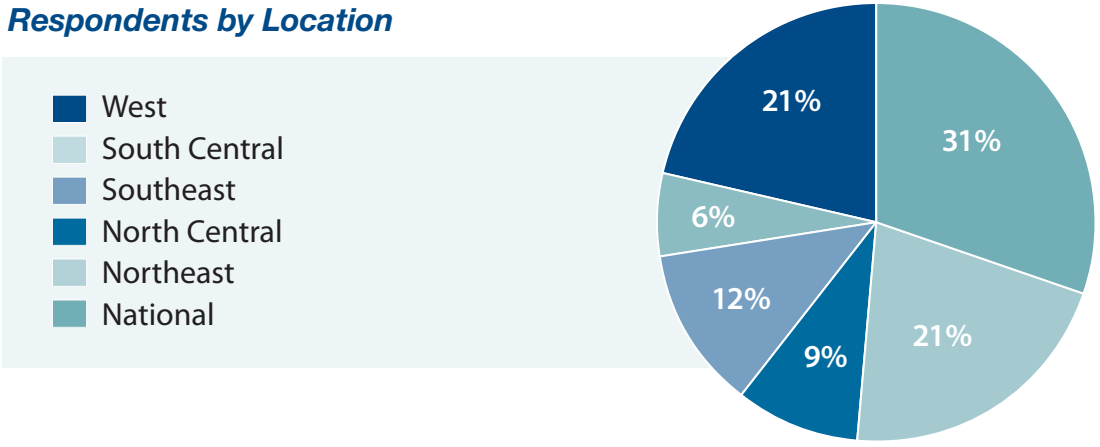
- Changes in occupancy and leads generation
- Variances in budgeted versus actual revenues and expenses
- Testing protocols and expenses
- Actual expenditures for personal protective equipment (PPE), sanitation and other needs to manage safely during the pandemic
- Experience with insurance renewals

Respondents by Units/Beds





Respondents by Location



Notably, respondents varied by geographic location and size, as shown above.

Irrespective of location and size, by mid-March, in order to protect residents and staff, most operators had implemented strict restrictions on visitation and either instituted admission holds or rigorous screening that included testing in conjunction with self-isolation. Consequently, move-ins dropped to a trickle or stopped entirely.

According to data collected for the soon-to-be-published 2020 edition of *The State of Seniors Housing*, communities comprised largely of independent living (IL) units typically see monthly turnover of 2–4% while those that are primarily assisted living (AL) report 3–7%; memory care (MC) communities in 2019 reported monthly turnover of 4–10%. At these rates with no material move-in activity, the outlook for occupancy levels was dire in April. However, the survey respondents generally fared better, as anecdotally, many were able to limit move-outs. In aggregate, occupancy losses varied from 70 basis points to 1,440 basis points with a central tendency around 500–600 basis points.

OCCUPANCY EFFECTS

By Level of Care	March 1 — Occupied Units/Beds	June 30 — Occupied Units/Beds	Occupancy Change
Independent Living	53,266	51,115	-4.04%
Assisted Living	66,607	62,201	-6.61%
Memory Care	28,613	26,750	-6.51%
Total	148,486	140,066	-5.67%
By Operator Size			
Small (< 2,000)	11,288	10,667	-5.50%
Medium (2,000 - 3,500)	23,446	22,528	-3.92%
Large (> 3,500)	113,752	106,871	-6.05%
By Operator Region			
National	88,158	83,355	-5.45%
Northeast	16,502	15,024	-8.96%
West	19,852	18,947	-4.56%
All Others	23,975	22,741	-5.15%
By Severity of Occupancy Loss*			
Lower Quartile	30,750	30,125	-2.03%
Median	22,440	21,440	-4.46%
Upper Quartile	35,709	32,512	-8.95%

Source: ASHA/HealthTrust COVID-19 Survey

* Each quartile represents the weighted average of all companies falling in that rank while the median reflects the average of the 5th and 6th deciles.

Broadly speaking, the decline for IL was much less than AL or MC; surprisingly, the difference between AL and MC occupancy declines was not material. In terms of operator size, those defined as "medium" reported the least decline (less than 400 basis points) while small operators and larger operators experienced a 550-basis-point to 600-basis-point decline.

In terms of geography, there was a critical mass of units reporting by national operators as well as those concentrated in the West and Northeast regions; their experience is contrasted with that of those located in the other regions (North Central, South Central and Southeast). The greatest occupancy loss by region was the hard-hit Northeast (nearly 900 basis points) while the West region reported an occupancy decline of about 450 basis points, below that of national operators and the total survey sample. Overall, the respondents suggested widely variant experiences with some reporting negligible impacts on occupancy (200 basis points) while others saw occupancy decrease over 900 basis points. Throughout this survey, the experience of those with the lowest occupancy losses ("Lower Quartile Severity") is compared with those with greater severity ("Median Severity" and "Upper Quartile Severity"), as a measure of COVID-19's impact on operations.

By July, operators had resumed admissions to most, if not all, their communities, but leads in early July remained below pre-COVID levels suggesting that the recovery may take longer than the four months it took to reach the current levels.

CURRENT LEAD ACTIVITY VS. PRE-COVID LEADS

	IL	AL	MC
Min	9%	14%	8%
Max	75%	85%	97%
Median	49%	58%	52%
Average	48%	58%	49%

Source: ASHA/HealthTrust COVID-19 Survey

Current leads, as a ratio of pre-COVID lead activity, for assisted living seem to be rebounding better than independent living or memory care; current lead activity for independent living was typically less than half pre-pandemic levels. While emerging hot spots are unpredictable – outside of hampering move-ins – based on the leads activity, refill of vacant units could be instant (< one month) for those operators who have relatively few units to lease to as long as 15 months. On average, operators may need five months to regain pre-pandemic occupancy levels.

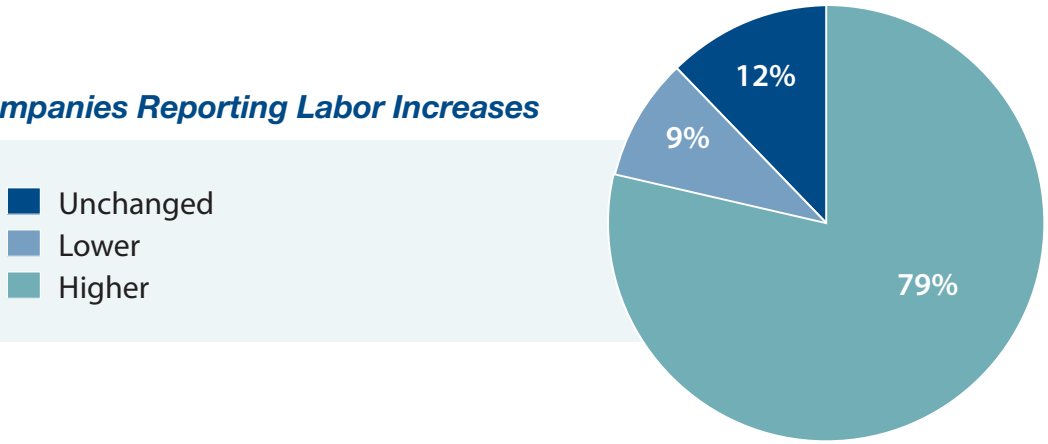
Besides anticipating depressed occupancies for some time to come, operators report that the occupancy hits experienced to date have had an amplified impact on their top-line revenues. While the total occupancy loss was over 550 basis points, the revenue shortfall compared to budget was nearly 8.25%. Compared to larger operators, those with fewer than 2,000 units were more adversely impacted with revenues falling 11.67% below budget; again, operators concentrated in the Northeast suffered most with revenues 11.68% below budget expectations.

REVENUE EFFECTS (MARCH 1 – JUNE 30, 2020)

	Budgeted Revenue	Actual Revenue	Change
Overall	$3,203,485,094	$2,939,813,184	-8.23%
Lower Quartile	$1,335,681,633	$1,263,678,824	-5.39%
Median	$486,638,602	$443,873,187	-8.79%
Upper Quartile	$649,456,700	$558,239,999	-14.05%
By Operator Size			
Small (< 2,000)	$244,217,474	$215,721,812	-11.67%
Medium (2,000 - 3,500)	$447,260,141	$415,850,267	-7.02%
Large (> 3,500)	$2,512,007,478	$2,308,241,105	-8.11%
By Operator Region			
National	$1,831,028,060	$1,699,679,679	-7.17%
Northeast	$473,363,289	$418,085,439	-11.68%
West	$459,044,734	$429,405,799	-6.46%
All Others	$440,049,011	$392,642,267	-10.77%
By Severity of Occupancy Loss			
Lower Quartile	$591,117,289	$553,536,951	-6.36%
Median	$457,232,680	$422,458,214	-7.61%
Upper Quartile	$855,817,611	$754,293,476	-11.86%

Source: ASHA/HealthTrust COVID-19 Survey

Companies Reporting Labor Increases



LABOR INCREASES (MARCH 1 – JUNE 30, 2020)				
	Total Reported Increased Expense	Monthly/FTE	Total/ Community	Ratio/ Revenues
Overall	$70,215,925	$165.47	$39,315	2.39%
By Operator Size (Occupied Units)				
Small (< 2,000)	$5,709,410	$172.40	$42,292	2.65%
Medium (2,000 - 3,500)	$4,583,730	$89.65	$17,297	1.10%
Large (> 3,500)	$59,922,785	$176.20	$43,234	2.60%
By Operator Region				
National	$26,716,185	$95.50	$23,664	1.57%
Northeast	$31,972,875	$674.31	$156,730	7.65%
West	$5,553,990	$119.18	$29,860	1.29%
All Others	$5,972,875	$118.14	$22,370	1.52%
By Severity of Occupancy Loss				
Lower Quartile	$1,931,804	$31.94	$8,327	0.15%
Median	$7,529,535	$216.44	$31,770	1.70%
Upper Quartile	$46,230,037	$504.11	$113,309	8.28%

Source: ASHA/HealthTrust COVID-19 Survey

The survey did not ask about concessions, but outsized revenue losses likely reflected great vacancy of higher priced units, a failure to charge for increasing levels of care and possible concessions.

The Life Care Centers of Kirkland headlines about not only the initial 81 positive resident cases but also the 46 infected staff members created aftershocks throughout the seniors housing and care sector causing operator struggles to acquire sufficient quantities of PPE and sanitation supplies while allaying staff's concerns for safety. Initially, unexpected impacts included:

- Extraordinary labor costs such as hero pay, unlimited paid time off (PTO), increased benefits including stipends for childcare, meals, and health care (e.g. telehealth doctor visits, etc.), agency nursing and overtime.
- Exorbitantly priced PPE and sanitation supplies, disposable plates and utensils, etc.
- One-time expenses such as UV lights, thermometers, health monitors, poly-carbonate dividers, electrostatic sprayers, tablets for residents, air purifiers, third-party surface cleaning and fogging services, touch-free systems (lights, faucets, soap dispensers), food carts, etc.

Interestingly, not all operators reported increased labor (inclusive of wages, payroll taxes and benefits) although most did.

In aggregate, respondents suggest that labor increases averaged about $165 monthly ($10 per week) per full-time equivalent (FTE). However, examining labor increases by operator size, geography and the severity of the occupancy hit suggest a wide range of experience. In the Northeast region, unbudgeted labor increases were more than 300% above the sample aggregate indication, at $674 monthly per FTE while national operators reported less than $100 monthly per FTE. Clearly, the extent of labor increases correlates strongly to the severity of the impact, despite those in the upper quartile reporting the biggest occupancy drops.

Generally, PPE expense follows the labor trends noted above: the more staff and the greater acuity and severity, the higher the PPE expense. Sanitation and cleaning supplies, however, were largely more uniform across the industry, outside of national operators who paid much more than all others. Further, the severity of the pandemic appeared to have no correlation to the subsequently incurred expense.

TOTAL PPE INCREASES (MARCH 1 – JUNE 30, 2020)

	Total Reported Increased Expense	Total FTEs	Daily/FTE	Total Exp/ Community	Ratio/ Revenues
Overall	$79,201,471	96,433	$6.73	$48,739	2.69%
By Operator Size					
Small (< 2,000)	$4,020,278	6,022	$5.47	$46,210	1.86%
Medium (2,000 - 3,500)	$4,073,241	9,853	$3.39	$20,265	0.98%
Large (> 3,500)	$71,107,952	80,558	$7.24	$53,185	3.08%
By Operator Region					
National	$62,688,568	67,039	$7.66	$56,732	3.69%
Northeast	$7,422,312	8,391	$7.25	$55,390	1.78%
West	$3,286,054	9,777	$2.75	$21,619	0.77%
All Others	$5,804,537	11,226	$4.24	$24,806	1.48%
By Severity of Occupancy Loss					
Lower Quartile	$6,565,830	15,122	$3.56	$35,300	0.52%
Median	$4,848,529	8,697	$4.57	$28,521	1.09%
Upper Quartile	$19,682,822	22,926	$7.04	$49,956	3.53%

Source: ASHA/HealthTrust COVID-19 Survey

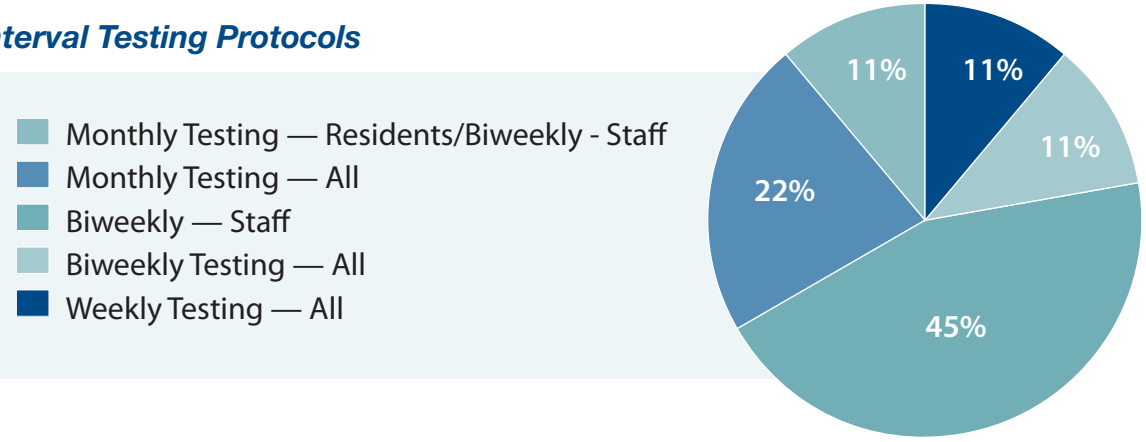
Many operators were unable to break out the plethora of one-time expenses incurred to pivot operations to distancing and safety. Typical purchases included:

- Thermometers, oximeters, safety monitors
- Tablets, laptops for resident communication
- Electrostatic sprayers
- Polycarbonate dividers
- Third party surface cleaning and fogging services
- Food carts
- Increased tech platform
- HVAC upgrades
- Visitation tents
- Touch-free doors, lights, faucets, soap dispensers

For those operators who tracked these expenses separately, these expenditures typically ran $2,500 to $6,000 per community. However, almost universally, these expenses represented less than 0.30% of total revenues.

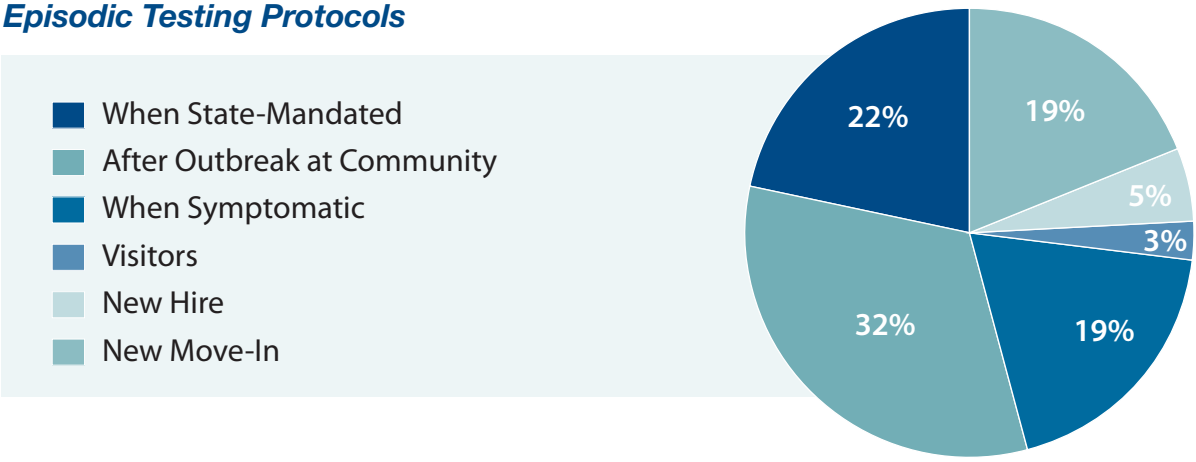
As the pandemic extended into months and more was learned about the coronavirus, an upswelling towards frequent testing resulted in CMS announcing in mid-July it would assist nursing homes with frequent, rapid testing and more businesses — including major league sports — demonstrating that business can resume at a reasonable degree of safety with regular testing. Yet by the end of June, only one operator reported a weekly testing program. Of the respondents to the testing protocol questions, only 35% indicated regularly scheduled testing.

Interval Testing Protocols



Generally, the operators who regularly test residents and/or staff suffered the most occupancy loss and seem to have adopted testing as a measure to contain and eliminate future spread. With a plethora of issues regarding testing — inaccurate results, long waits and high costs — most respondents only test in response to one or more of the following specific events.

Episodic Testing Protocols



Neither geographic location nor operator size correlated to testing protocols. However, costs could play a factor as to why so few operators have adopted regular testing protocols. Of those respondents who reported, the cost of tests administered varied from $37.50 to $180.00 with most suggesting well over $100.00 per kit. A few operators indicated that the cost was being borne by insurance companies or government offices, but most were absorbing the cost of $500 to over $15,000 weekly. The expected introduction of fast, cheap (<$20 per test) test kits will reduce the weekly outlay for those who are already proactively testing but will increase the expectation for testing by those who do not.

And testing will grow increasingly important as a recent ProMatura Group study[1] found that over 50% of potential customers identified COVID-19 testing with rapid results as being essential before moving into seniors housing. Further, *The Wall Street Journal* reported that as of late July,[2] nearly 70 employment and labor cases were filed claiming that workers were exposed or potentially exposed to the virus. Although most respondents have not captured increases in workers' compensation (worker's comp) and general and professional liability (GL/PL), those who have gotten quotes are reporting rising premiums with carve-outs for COVID-19 cases. At this early stage, aggregate increases for GL/PL far exceed those for workers' comp and suggests a 15–20% increase over the GL/PL premiums indicated in the soon-to-be-published 2020 edition of *The State of Seniors Housing.*

[1] *Impact of COVID-19 on the Seniors Housing Industry, A Study of Potential Consumers*, ASHA/ProMatura

[2] Families File First Wave of Covid-19 Lawsuits Against Companies over Workers Deaths, *The Wall Street Journal*, August 24, 2020

TOTAL WORKER'S COMP INCREASES (MARCH 1 – JUNE 30, 2020)

	Total Reported Increased Expense	Total Exp/ FTE	Total Exp/ Community	Ratio/ Revenues
Overall	$591,968	$12.69	$364	0.02%
By Operator Size				
Small (< 2,000)	-$2,165	-$0.37	-$25	0.00%
Medium (2,000 - 3,500)	$177,637	$16.28	$884	0.04%
Large (> 3,500)	$416,496	$13.94	$312	0.02%
By Operator Region				
National	$228,114	$10.89	$206	0.01%
Northeast	$20,500	$2.47	$153	0.00%
West	$273,217	$27.19	$1,797	0.06%
All Others	$70,137	$9.54	$300	0.02%
By Severity of Occupancy Loss				
Lower Quartile	$115,388	$7.63	$620	0.01%
Median	$228,382	$26.26	$1,343	0.05%
Upper Quartile	$173,190	$7.55	$440	0.03%

Source: ASHA/HealthTrust COVID-19 Survey

TOTAL GL / PL INCREASES (MARCH 1 – JUNE 30, 2020)

	Total Reported Increased Expense	Total Exp/ Community	Ratio/ Revenues
Overall	$2,085,382	$1,283	0.07%
By Operator Size			
Small (< 2,000)	$357,292	$4,107	0.17%
Medium (2,000 - 3,500)	$527,750	$2,626	0.13%
Large (> 3,500)	$1,200,340	$898	0.05%
By Operator Region			
National	$245,634	$222	0.01%
Northeast	$77,750	$580	0.02%
West	$904,706	$5,952	0.21%
All Others	$857,292	$3,664	0.22%
By Severity of Occupancy Loss			
Lower Quartile	$823,384	$4,427	0.07%
Median	$254,706	$1,498	0.06%
Upper Quartile	$807,292	$2,049	0.14%

Source: ASHA/HealthTrust COVID-19 Survey

In aggregate, unexpected expenses incurred due to COVID-19 equated to 6.6% of the revenues collected between March 1 and June 30. Larger operators suffered more of a hit than others and those in the Northeast reported expenses of nearly 12.0% of collected revenues, or almost 350% higher than the ratio that operators in the West saw. Operators who reported the least severity incurred COVID-19-related expenses of 2.6% and under $500 per occupied unit/bed, a fraction of those with the greatest severity, who indicated expenses at 10.2% of collected revenues and over $2,250 per occupied unit/bed.

TOTAL COVID-19 EXPENSE INCREASES (MARCH 1 – JUNE 30, 2020)

	Total Reported Increased Expense	Daily/ Occupied Unit/Bed*	Total Exp/ Community	Ratio/ Revenues
Overall	$192,616,461	$10.94	$107,848	6.55%
By Operator Size				
Small (< 2,000)	$13,688,519	$10.22	$101,396	6.35%
Medium (2,000 - 3,500)	$13,538,952	$4.83	$51,090	3.26%
Large (> 3,500)	$165,388,991	$12.29	$119,328	7.17%
By Operator Region				
National	$113,074,987	$10.81	$100,155	6.65%
Northeast	$48,606,061	$25.28	$238,265	11.63%
West	$14,386,517	$6.08	$77,347	3.35%
All Others	$16,548,896	$5.81	$61,981	4.21%
By Severity of Occupancy Loss				
Lower Quartile	$14,260,312	$3.84	$61,467	1.13%
Median	$18,156,992	$6.78	$76,612	4.09%
Upper Quartile	$77,235,411	$18.56	$189,302	13.84%

Source: ASHA/HealthTrust COVID-19 Survey; *assumes a straight-line change in occupancy

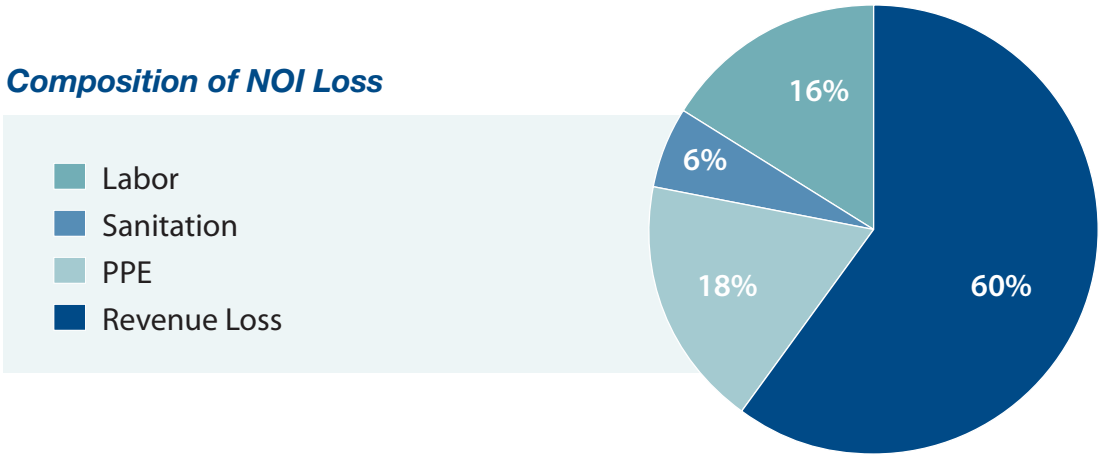
Unlike skilled nursing facilities that had been allocated nearly $10 billion in federal assistance, through August, private pay senior living operators received no assistance, outside of the relative few who obtained Payroll Protection Program (PPP) funds. And the impacts on net operating income (NOI) are severe.

TOTAL COVID-19 NOI IMPACT (MARCH 1 – JUNE 30, 2020)

	Budgeted NOI	Actual NOI	NOI Impact	Monthly Per Community	Ratio of Budget
Overall	$878,042,780	$604,238,202	($273,804,577)	-$38,327	-31.2%
By Operator Size					
Small (< 2,000)	$86,559,860	$57,266,531	($29,293,329)	-$54,247	-33.8%
Medium (2,000 - 3,500)	$142,924,741	$118,472,460	($24,452,281)	-$23,068	-17.1%
Large (> 3,500)	$648,558,178	$428,499,212	($220,058,967)	-$39,693	-33.9%
By Operator Region					
National	$396,734,919	$284,522,292	($112,212,627)	-$24,848	-28.3%
Northeast	$154,233,170	$77,368,660	($76,864,510)	-$94,197	-49.8%
West	$191,042,416	$160,153,180	($30,889,236)	-$41,518	-16.2%
All Others	$136,032,274	$82,194,070	($53,838,205)	-$50,410	-39.6%
By Severity of Occupancy Loss					
Lower Quartile	$104,848,962	$90,120,338	($14,728,624)	-$15,871	-14.0%
Median	$127,889,798	$92,093,552	($35,796,247)	-$37,760	-28.0%
Upper Quartile	$257,061,706	$115,535,207	($141,526,499)	-$86,720	-55.1%

Source: ASHA/HealthTrust COVID-19 Survey

But clearly, whether or not an operator experienced significant cases of COVID-19 in their communities, profitability has been adversely impacted, and to the extent that many operators could struggle paying debt service/lease payments. While the greatest impact thus far has been with those in the Northeast and those with the greatest severity, as the coronavirus continues to roll throughout the country, former safe havens can erupt with clusters. Small and large operators appear similarly impacted with medium-sized operators reporting lower losses.The NOI loss is primarily comprised of these factors: labor, sanitation, PPE, and revenue loss.



This survey captured the first four months of operations during the pandemic. While the initial outlay of increased labor and one-time expenses appear largely over, decreased occupancy levels, continued PPE costs, increased testing expectations, and growing insurance premiums will remain at least as long as the pandemic ravages the country. Nonetheless, the actual impact on any given community will vary based on the competitive pressures (i.e., the amount of new supply leasing up), community spread, and the strength of on-site management.

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