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A Business Proposal for the Design and Implementation of a Long-Term Health Care Facility

Laura E. Metzger

A BUSINESS PROPOSAL FOR THE DESIGN AND IMPLEMENTATION OF A LONG-TERM HEALTH CARE FACILITY

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An Abstract Presented to the Faculty of the Graduate School of Lindenwood College in Partial Fulfillment of the Requirements for the Degree of Master of Business Administration

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ABSTRACT

This thesis will focus on the possibility of starting a new residential care facility in O'Fallon, Missouri.

In the United States the elderly population is increasing at a faster rate than ever before. It is expected that by the 21st century various forms of elderly health care services will be in high demand.

The purpose of the present study was to investigate the revenues and expenses associated with a residential care facility for the elderly. The issues of funding, design, marketing and implementation of this type of business were examined.

Three subjects participated in the study based on their education and experience in operating a small business. The subjects reviewed a business plan and completed an evaluation questionnaire.

Results of the evaluation showed that there seemed to be a market for a residential care facility in O'Fallon.The subjects concluded that success of the business will be based on the prospective owner's willingness to acquire additional health care

education, as well as the operation's profitability variables, such as occupancy rate, service costs, employee turnover, and the level of competition.

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Dedication

I dedicate this project to my husband Tim, and my two sons, Kyle and Lee; without their help, tolerance and humor I would not have been able to finish.

Acknowledgement

Acknowledgement to Mr. Dan Kemper for his help, guidance, and support; to my reviewers Mr. Joseph Silverio and Mr. Jan Kniffen; and to Mr. Dick Ford, Mr. John Elsuffer, and Dr. Ralph Wehrmann for their participation in the study evaluation.

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Preface

When an individual decides to investigate the possibilities of entrepreneurship, one of the foremost decisions to make is choosing what kind of business to own.

A business that appears to be in demand now and in the foreseeable future is health care. Specifically, alternatives to long-term health care for the elderly. Major factors contributing to the increase in this industry are rising medical costs, the aging of society, and the lengthening of life expectancies.

Among other things, a long-term health care facility can be a rewarding and profitable business if the residents are receiving high quality care at an affordable price, the employees are well trained, and the owner is cost-effective while operating in the best interest of the employees and the residents.

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Chapter I

INTRODUCTION

The Long-term Health Care Industry

Alternatives to long-term health care have been growing by leaps and bounds in the U.S. in recent years (Morris 4). Three major factors have contributed to the increase in long-term health care alternatives: the rising medical costs, the graying of society, and the lengthening of life expectancies (Pieper 3). Regardless of what type of long-term care a person chooses, quality and cost seem to be of utmost importance (Findlay 92).

To ensure quality nursing home care, the "Omnibus Nursing Home Act" went into effect in 1990. This reform law (part of the Omnibus Budget Reconciliation Act (OBRA) of 1987), requires nursing homes receiving Medicare or Medicaid to follow a set of guidelines for operation (Beck 77). If the facility does not comply, penalties of up to $10,000 a day can be incurred. Many states have hired nursing-home "ombudsmen" who investigate clients' complaints. The ombudsman gives the clients a chance to voice their concerns

about the facility in confidence (Findlay 93).

Dr. William Roper, an administrator for the Health Care Financing Administration (HCFA) (a federal agency that oversees Medicare and Medicaid programs) believes that "the quality of care in nursing homes today is better than ever," but adds, "it should be even better" (92). To back his statement, he referred to a document that the HCFA published about a 1988 nursing home investigation. The HCFA visited 15,000 nursing homes in America and graded each home on 32 quality measures. The study compared the grades statistically with the performance of other nursing homes in the same state and across the country.

The results from the "single-day" inspections were published in a 75-volume state-by-state guide. The massive report found that only 2,300 nursing homes met minimum standards on 32 key measures of the quality of care, from cleanliness and privacy to prompt care of bedsores and proper administration of medication. He added, "almost all nursing homes passed muster on a cluster of 13 measures that included such basic provisions as availability of emergency medical care and freedom from mental or physical abuse." The HCFA guide is by no means definitive, as emphasized by Dr. Roper, but it will help

consumers ask the right questions (92).

Information and resources on finding a nursing home have proliferated. Organizations like the Department of Aging, the American Association of Retired Persons (AARP), the American Association of Homes for the Aging, the Better Business Bureau, city and county welfare agencies, long-term-care ombudsmen, and social service agencies all provide assistance, in a variety of ways to people seeking long-term care (92-93).

According to a 1989 report by the Teachers Insurance and Annuity Association and College Retirement Equities Fund, the "85 years and older" population is expected to grow "three to four times as fast as the general population between 1990 and 2010" (Coming Crisis 49). The report also claimed that the 85 and older population is expected to increase from 2 million in 1980 to 16 million by the year 2050 Life expectancies, which at age 85 has increased by 24% since 1960, are projected to increase another 44% by 2040. The report concludes that the significant increase in the "85 and over" age group is important to the long-term care industry. For instance, while only 5% of Americans over 65 currently live in nursing homes, the percentage rose sharply to 22% for the "85 and older" group in 1990 (49).

Recent cuts or changes in some governmental funding programs have had a direct impact on long-term health care. For instance, the "Prospective Payment System," implemented in 1983, caused hospital admissions and length of stay to decrease. The program forces people into nursing homes a lot sooner than before (Morris 5).

Another example where the long-term health care industry has benefitted from governmental change is the 1989 provisions to the Medicare Catastrophic Coverage Act (Eakes 85). The provisions were designed to protect spouses of nursing-home residents from being impoverished. The provisions help older persons with low incomes and modest assets afford long-term health care. The significant changes to the Act fall into three categories: 1) the New Income Rule, 2) the New Resource Rule, and 3) the New Transfer of Assets Rule. How the provisions affect an individual depends on the state in which they live and on specific individual circumstances (85).

A third example of a governmental funding change, and its effect on the long-term care industry, can be found in the reduction in housing availability for the low-income elderly. The Department of Housing and Urban Development's (HUD) "202" program had been

severely "gutted" by the Reagan Administration in 1981 (Communities 126). Under the "202" program, named after Section "202" of the Housing Act of 1959, HUD makes 40-year loans to non-profit groups that build housing for the elderly. Residents pay up to 30% of their monthly income for rent and HUD pays the rest.

Not only has the quantity of new units built shrunk steadily, (from 25,000 housing units in 1976 to 8,000 in 1990), but also the quality of the HUD housing has diminished. For instance, before the 1981 changes in construction took effect, outer brick construction, elevators, meal services, and spacious areas were allowed. After 1981 there were limits set which included reduced floor space dimensions, no meal service, less durable materials for construction, and disallowed elevator systems (126).

Depending on the type of long-term health care used, the costs can be devastating. According to 1990 national estimates, one year in a nursing home costs an average of $22,000 (Coming Crisis 49). By the year 2018, nursing home costs are expected to be $44,000 or more a year. Since the median household income for Americans 65 and over is around $19,000 a year, a nursing home care bill would "exhaust the assets and available income of most elderly people in just one year"

(49).

Most long-term care charges can be covered by Medicare, Medicaid, third-party insurance, self-pay, or charity. The facilities that are reimbursed by Medicare and Medicaid are required to maintain extensive documentation to comply with State and Federal regulations (Goldsmith 5). Medicare pays a limited amount of an aged person's health care bill. Medicaid pays for charges Medicare doesn't cover once the individual's financial resources have been nearly depleted.

Some insurance companies sell "retirement assurance" policies to help the elderly pay for long-term care (Sherrid 62). Over 100 insurance companies now offer coverage for long-term care in a nursing home or, in some cases, the individual's own home (Truth 166). However, since long-term care insurance policies aren't heavily regulated they must be reviewed very closely by the prospective client (Sherrid 64).

Types of Firms in the Long-Term Health Care Industry

Nursing home care is the most widely known long-term health care option, but it is not the only option available. It is estimated

that 25% of all nursing home residents would not need to be there if other long-term health care alternatives were available and utilized (Pieper 3). The elderly who receive services in the community may, at some point, need the type of care that can best be provided in a residential facility. At the same time, people who require residential care may return to the community in need of other services.

There are three basic types of residential care facilities for the elderly, each offering different levels of care. Each type is considered a "nursing home." The three basic types of nursing homes are 1) Domiciliary Care Facilities (DCFs); 2) Health Related Facilities (HRFs); and 3) Skilled Nursing Facilities (SNFs). A DCF is a public or private residential care facility (RCF) I or II which serves three or more residents and is inspected and certified by the Department of Social Services. A DCF houses frail, elderly people who are not ill but who cannot fully care for themselves.

The differences between an RCF I and an RCF II are found mostly in the physical care of the residents. Both RCF I and II provide shelter, board and protective oversight to the residents. Protective oversight includes storage and distribution or administration of medications and care during short-term illness or

recuperation. However, in an RCF II the residents are provided with supervision of diets, and assistance in personal and health care. An RCF II must provide health care oversight under the direction of a licensed physician (Long-term Care 3).

An HRF (also known as an ICF, Intermediary Care Facility) fills needs which fall in between a DCF and an SNF. An HRF is designed for people whose medical conditions require constant attention, but not on the same level required by an SNF (Directory 2).

An SNF is designed for persons whose medical condition is not severe enough to require admission to a hospital. Inhabitants of an SNF have medical conditions which are not of an emergency nature but need continual skilled medical care. Both HRFs and SNFs are inspected by the Department of Health because they serve the aged ill (2).

Goldsmith explains that a nursing home can be operated one of three ways, for-profit, not-for-profit, and governmentally-owned (i.e. federal, state, or local) (5). He adds that, of the 20,000 nursing homes in the United States, 15,000 are owned by individual or corporate proprietors as for-profit businesses. Forty percent of the 15,000 for-profit businesses are owned by chains, while the remaining

60% are family-owned and operated (5).

Goldsmith also reports that there are only a handful of nursing home giants in the U.S. (which are all for-profit operations) (5). For instance, Beverly Enterprises operates more than 1,000 facilities in 46 states. Another company, the Washington-based Hillhaven Corporation, has 400 homes in 40 states. The Dallas-based National Heritage has 231 homes in 29 states. Silver Spring, Maryland-based Manor Care, has 142 homes in 24 states. Lastly, Houston's ARA Living Centers, with 255 homes in 13 states, and the Milwaukee-based Unicare Health Facilities, with 139 homes in 13 states, round out the for-profit nursing home giants (5).

The second category of ownership, which accounts for approximately 4,000 facilities, is the voluntary, not-for-profit homes (6). Not-for-profit homes are usually operated by a religious or charitable organization. The not-for-profit facility must ensure that no part of the home's net earnings benefit any private shareholder and all "profit" rolls back into the business (6).

The third category is made up of 1,000 nursing homes owned by governmental agencies (5). For instance, facilities operated by the Veteran's Administration are governmentally owned. Residents of

governmentally owned homes either pay a portion of the fee or nothing at all (5).

Major regulated differences between the not-for-profit, for-profit, and governmental long-term care facilities are seen in the staffing (6). In 1990, Goldsmith reported that national data revealed the average number of full-time equivalent employees per 100 beds for proprietary (for-profit) homes was 65.4, 83.8 for not-for-profit homes, and 87.6 for governmental homes. Private homes tend to have 15-20% less staffing than not-for-profit homes. The staffing differences occur in the secondary administrative areas, but mostly in the nursing and therapeutic services (6-7).

Nursing homes are the most common choice in long-term health care however, they are not the only choice. Alternatives to nursing homes include living at home, E.C.H.O. housing (elderly cottage housing opportunity), shared housing, boarding homes, retirement centers, congregate housing, residential hotels, hospice care, hospital care, and living with family members. Each form of care may enlist one or more support systems to help the individual avoid entering a nursing home.

Some examples of popular support systems include information

and referral agencies, health promotion programs, emergency call systems, transportation, adult day care, respite care, senior citizen centers, home delivered meals, public meal program, home health care, friendly visitor, counseling, congregate meals, telephone reassurance, homemaker services, equity conversions, home renovations, personal care, chore services, and live-ins. The programs are sponsored by communities, religious groups, health care industries, financial groups, or governmental organizations. The costs for such programs vary and some are covered by Medicare, Medicaid, health or life insurance policies. Not all alternatives to nursing homes are available to all consumers. Some programs are developed specifically within a community, while others are offered state-wide (14).

As mentioned, one alternative to a nursing home is a residential hotel. Because of their increasing popularity, residential hotels are becoming more available in urban areas, especially in the South and in the West. "Residential hotels are an excellent idea for people who like hotel living, particularly single people" says Goldsmith (99). Minimum requirements for those living in residential hotels are that the individual must be ambulatory and in reasonably

good health, as certified by a physician. The hotel offers its residents the same services other hotels offer, (e.g. maid service, room service, security, restaurant). However, the residents also benefit from social activities and various special services (98-99).

Another popular alternative to nursing home care is a retirement or life-care community. These types of communities are developed so they may be completely self-sufficient retirement cities or villages with a "country-club atmosphere." The communities usually have several different types of housing arrangements from which to choose.

The types of housing available in a retirement community range from apartments to condominiums to duplexes to bungalows. Some of the most common services and amenities life-care communities offer are golf courses, swimming pools, fitness centers, tennis courts, restaurants, shops, clubhouses, health clinics, security, housekeeping services, and transportation. Retirement communities usually have a substantial entrance fee in addition to monthly payments for the remainder of the resident's stay (100).

Congregate housing is designed specifically for older persons. Congregate housing takes the form of efficiency apartments which

contain a kitchen, bathroom, and a large living-bedroom. Some apartments offer the choice of one or two bedrooms. The apartments are specifically constructed to compensate for some of the losses in functioning that may accompany aging. Congregate housing does not differ greatly from life in any other apartment except for the increased safety and comfort amenities installed. The owners of congregate housing must supply one communal activity each day, for example, the noon meal. Some owners also provide regularly scheduled leisure activities for their residents.

Congregate housing is available in all price ranges. Many have sliding rent scales that adjust to the financial resources of the tenant. Low income subsidized housing exists in many communities as well as more expensive luxury apartments (18).

Another alternative housing form is called "phased housing." Phased housing links congregate or residential housing with intermediate and skilled nursing home facilities in the same general location. Each type of housing is separate but are in close proximity to each other. Phased housing, as Pieper describes it, is typically arranged with residential housing situated around the perimeter. The residential housing (congregate housing) is usually arranged by four

apartment units surrounding the intermediate and skilled care units. Occupants of the private housing units have access to all of the other units. The entire complex is fenced in at a discrete distance to provide security for the residents. This arrangement works well in rural areas but not in urban areas.

In the city, a phased housing is built up, rather than out. The residential housing, the intermediate care and the skilled nursing care are separated by wings or floors (19).

Board and care homes may be classified as a residential care facility I or II depending on the licensing structure and if it has a Medicare and Medicaid reimbursement program. However, most board and care homes are not. Board and care homes are usually less expensive than the other housing alternatives previously discussed, however, the costs are rarely covered by insurance. Board and care homes provide private or semi-private bedrooms, shared restrooms, basic housekeeping services, communal dining, and limited nursing and security (19).

Shared housing is an alternative to nursing homes because it allows several people to move into a home and share the expenses. The bedrooms are private but the other rooms in the house are

shared. The shared housing roommates are usually in a similar state of health and financial status (28).

An E.C.H.O. home is popular in rural areas. An E.C.H.O. home is a mobile home that is placed next to a permanent house. The individual who lives in the E.C.H.O. home has the freedom of living on their own but the comfort of having someone near in case they need assistance. These types of homes are subsidized by the government (29).

Life-care or continuing-care arrangement is an alternative that involves turning over assets in return for a guarantee of having the person's needs taken care of for the rest of their life (29). Continuing-care involves a company ensuring that the client's housing, medical, social, and psychological needs are met until they die. There is considerable risk to this type of arrangement because if the company bankrupts, the client will get nothing in return (29).

Hospice care involves an individual receiving hospitalized care from a licensed nurse but in the comfort of their own home. A nurse visits the patient on a regular basis to administer medications, obtain vital signs, and monitor the patient's progress. Hospital care is provided to the elderly on a short-term basis. The individual who is ill

may be transferred to a skilled nursing facility if the health status does not improve but stabilizes after a period of time.

Having a parent or parents move in with their adult children is an alternative that can be either a great solution or an absolutely terrible one. Pieper cautions that this type of arrangement should be approached with careful forethought because it usually involves a radical change in lifestyle for the whole family. In most cases, the parent who takes permanent residence with their adult children helps pay for the added expense (13).

Size of Firms in the Industry

The size of long-term health care facilities vary widely. In most cases, the type of housing will demarcate or limit the size of the firm. According to the Missouri Department of Aging, the average size of skilled and intermediate care nursing homes operate most efficiently by a factor of 120 units (Long-term Care 3).

Residential care facilities I and II are varied in the size of their firms. According to the Missouri Department of Aging an RCF I and II can have no less than three residents (3). The Department claims that the average size of a residential care facility I and II is 30.

Nationwide, congregate housing, life-care communities, residential hotels, phased housing, and board and care facilities operate from 5 to over 1,000 units.

According to the Missouri Center for Health Statistics, in 1988 there were 198 licensed home health agencies in Missouri. The agencies, broken down by type of auspice (skilled and intermediate nursing homes, hospital agencies, residential care facilities I and II, and board and care homes), serve St. Louis City and 114 counties (Helmig 1).

The Center conducted a survey from 1985 to 1988 and discovered that the two major metropolitan regions, East-West Gateway (St. Louis Area) and Mid-America (Kansas City Area) comprise 59.5% of total home health care patients (43). These regions contained 47.8% of Missouri's population of people over 65 years of age. The home health agencies serving minor metropolitan counties represent 15.5% of total home health patients. The agencies serving rural counties make up the remaining 25 % (43). The total number of patients in Missouri in 1988 was 71,289 (1).

In St. Charles county (circa 1988), the focus of this business plan, there were 44 licensed home health care facilities in operation.

The 44 facilities served 12,780 patients. The average number of beds in Skilled Nursing facilities in St. Charles County was 120. For Intermediate, Residential I, Residential II, and Board and Care homes the average number of beds was 60, 30, 50, and 10, respectively (1). Appendix B reveals a list of long-term care facilities in O'Fallon and surrounding areas.

Investment Required

The investment required for starting a long-term health care operation varies, depending on the type of facility. Recently, the majority of new long-term health care businesses in Missouri have been board and care homes, residential care facilities, skilled nursing homes, and life-care communities (1). The average amount of investment to start a small-sized facility (e.g. 24-bed RCF-II) costs approximately $100,000. The average amount of investment to start a medium-sized facility (e.g. 120-bed skilled nursing costs approximately $3,500,000 (Certificate III-3). The average amount of investment to start a large-sized facility (e.g. life-care community) costs approximately $35,000,000 (Zwieg 352).

The investment for long-term health care businesses generally

includes purchasing the facility, land, furniture, appliances, and medical equipment. Start-up costs also include other forms of working capital such as building up an inventory of medical supplies, kitchen utensils, food supplies, bedding, cleaning supplies, and office supplies and equipment.

Services Provided

The demand for comfort, convenience, and good quality care has forced the long-term health care industry to fit the needs of the consumer rather than fitting the needs of the business (Goldsmith 1). Successful health care businesses are pleasant and appealing, and offer their clients a home-like atmosphere. The services long-term health care operations offer depend on the type of facility. The special service centers provide can be categorized into five areas: 1) nursing 2) rehabilitation 3) dietary 4) activity, and 5) social (Directory 66). As expected, the more extensive the services are, the higher it costs to live there.

In general, most nursing homes, provide some form of professional nursing service. Nursing services include a fulltime skilled nursing staff that is available on a 24-hour basis. The nursing team

is made up of a director of nursing, one or more registered nurses on each shift, licensed practical nurses, and nurses aides. The nursing staff works with other medical services departments to ensure that the resident is receiving proper care. The medical departments, classified as part of the nursing service, include oral health service, pharmaceutical service, and bathing-whirlpool systems (66).

The rehabilitation services are provided for individuals who seek speech or physical therapy. Rehabilitation services range from intensive physical therapy to a basic rehabilitation maintenance program. A physical therapist may be available full-time or on a consultant basis (66).

Recreation in long-term care plays a crucial role in meeting many interests and needs of individuals residing in this type of environment. A certified activity director or a therapeutic recreational advisor are employed to design exciting, therapeutic activities daily. If a facility has a social services department, which many of the large operations do, trips are planned and transportation is provided. For smaller operations, planned outings and transportation may or may not be available. All facilities offer basic forms of social activity like, arts and crafts and bingo. The social services department also offers

psychological consultation to ensure the resident's psychological well-being (67).

Dietary services are provided by a dietary manager and a registered dietician. Three well-balanced meals and nutritious snacks are provided daily to meet each individual's nutritional needs. Therapeutic diets, as ordered by physicians, are also prepared. Meal service is available in all health care facilities. The meals may be served cafeteria style or the residents may order from a menu. Larger operations employ a full time dietician while small operations hire a consultant (67).

In addition to the five categories of special services home health agencies offer, some also offer homemaker services. The resident's rooms and laundry are cleaned regularly. In addition to homemaker services, home health agencies offer their residents a choice of physician, private or semi-private rooms, monthly family council meetings, occupational therapy, outdoor sitting areas, walking areas, call lights in resident's rooms, and an ombudsman department to handle concerns (67).

Profits Realized

Only for-profit facilities will be discussed in this section since the not-for-profit and governmentally-owned facilities operate under different conditions (e.g. profits roll back into the operation). Profits to be realized in a nursing home will depend a lot on the cost of operating and if at full capacity. The examples used earlier in the "Investment" section of this chapter will be used again. For example, a 24-bed RCF-II realizes a $8,445 monthly after-tax profit when at full capacity, a 8.4% return on investment (Certificate III-3). A 120-bed SCF realizes a profit of approximately $230,000 once the facility is 95% occupied, a return on investment of 6.6% (Certificate III-3). The 1,200 unit retirement community will bring in $20,000,000 in revenues once it is at capacity (Zweig 352).

Statement of Purpose

The growing elderly population has increased the demand for long-term health care by leaps and bounds (Morris 4). With the increased demand, the industry is looking for better ways to meet consumer's needs (Goldsmith 1). Because the cost of housing a person

in a nursing home can impoverish the average elderly person within a few years, more people are entering them as a last resort. For this reason, alternatives to nursing homes for long term care are flourishing.

The traditional long-term health care facility, the nursing home, is but one of many choices available. However, if the person is debilitated, bedridden, severely disoriented, or in need of stringent medical care, a nursing home is the only choice (Pieper 13). If the individual does not fit this description, then there are other options for long-term health care. Regardless of what type of housing the aged person chooses, "quality of care and freedom of choice are vital component parts of long-term care" (Directory 66). Long-term care must meet the individual's social, housing, medical, psychological and emotional needs. The living arrangements should be linked with service supports and appropriate for persons with varying economic and functional capacities.

An RCF I is, as described earlier, one type of facility that is increasingly popular among the elderly, as well as those seeking an enterprising venture. Some reasons why an RCF I (as opposed to an RCF II, ICF, or SNF) is attractive to someone who wants to start a

long-term care business are 1) they are the most unconstrained by rigid governmental standards; 2) the number of employees needed per residents is lower; 3) the residents are generally in good physical and mental health; and 4) the manager does not need to be a licensed health care administrator.

Some reasons why the elderly look favorably towards living in an RCF I as opposed to an RCF II, ICF, or SNF, are because 1) the atmosphere is more like a home than an institution; 2) they can socialize with others who are in the same state of mental and physical health; and 3) the costs of living in an RCF I are significantly lower (Long-term Care 76). Therefore, this study will investigate the revenues and expenses associated with an RCF I, examining the issues of funding, design, marketing and implementation.

Chapter II

LITERATURE REVIEW

The elderly population, people 65 years and older, have increased eightfold since 1900, from 3.1 million to 24.9 million in 1980. During this rapid growth, older people have acquired a new role in America. Politically and nationally the elderly have become society's responsibility. Since World War I, aging has been elevated to the position of a social problem. Supporting, and even expanding, the seriousness of the elderly social problem is the elderly's declining economic power. This economic decline has been caused by many things, such as recession, inflation, and stagflation (Boling 12).

Adding more pressure to the aged person's financial security is how family members care for them. Each decade since 1950 has had fewer elderly people living in extended family settings. In turn, the aged are being forced to support themselves. To absorb some of the costs, payment for income maintenance, health care, and other social services have become public rather than private. The four most well known public-pay programs are regulated by the government: Social

Security, Medicare, Medicaid, and the Older Americans Act. Other pay assistance programs are funded by religious charities and community organizations (12).

Because of the growth of the elderly population, the number of long-term care facilities are expected to continue to increase (vii). The reason why some elderly people need long-term care is because there are many adults who need assistance in accomplishing routine activities of daily living, (ADL), such as meal preparation, transportation, and housekeeping. There are also adults who need more extensive help in accomplishing the instrumental activities of daily living, (IADL), such as eating, bathing, and moving from room to room (HRS 3).

There are many choices available to those searching for long-term health care. If a person is not mentally or physically inept, then an intermediate care facility (ICF) or a skilled nursing facility (SNF) probably best suits their needs. For those adults who are mentally and physically fit the choices in long-term care are more wide ranging. Even though the full service nursing home is the most well known form of long-term care, other alternatives have been gaining quick popularity. One of the more popular alternatives to an

ICF or an SNF is the residential care facility (RCF).

Residential care facilities are categorized as being a level I or level II form of care. Although there are very few differences between the two levels of care, the main difference is in the type of administration. In an RCF II there has to be a licensed health care administrator on staff. This person manages the operation and medical care at the facility. A level I RCF, (RCF I), needs only an administrator who is over the age of 21 and who completes one continuous education workshop in health care each year (Long-Term Care 76). Whether an RCF is arranged as a basic or deluxe home, the care is usually less expensive than ICF or SNF care (HRS 3).

Residential care facilities are a form of nursing care which are not certifiable for Medicaid payments, so the residents pay for the services themselves. State Social Service departments may supplement the income of the poor to help pay. The supplemental income rates are often set at the level described in the supplemental security income program, (SSI) (Kane 66).

Another form of assistance is in long-term-care insurance. A growing number of insurance companies now offer policies for long-term health care. In 1990, Luciano reported that less than 15%

of people 65 and older were likely to spend a year or more in a nursing home. Even so, sales in long-term-care policies rose 36% to 1.5 million policies. Insurance companies offering long-term care coverage, with premiums of $500 to $4000 a year, went from 75 in 1987 to 118 in 1990 (36).

Residential care facilities are also known as boarding homes, domiciliary care homes, retirement centers, adult foster care homes, sheltered care facilities, rest homes, convalescent homes, and halfway houses. Generally speaking, an RCF is a private home where a small number of people receive room and board in a family-like setting. Such homes do not have to be certified, but must be state licensed. RCFs are regulated but are not expected to adhere to the rigid health standards enforced in ICFs and SNFs (Long-Term Care 3).

As the elderly population rises, so does the need for long-term care. In the last 20 years health care industry has moved closer to fitting this special group's needs. The size of the health care operation is variable, ranging from a small family-owned business, to a large corporation operating 200 facilities across the country. In both extremes the business has proven to be profitable. In recent nursing home studies, it showed that the most profitable homes where the

ones that were able to keep their variable costs down and their occupancy level up. For this reason alone, the style of management involved with operating a nursing home is very important to the business's chance of survival (Vogel 686).

Organizational Plan

"Entrepreneurs are not supermen or wonderwomen. They are for the most part, ordinary people," says Cominsky (19). "An entrepreneur,' he adds, 'should be healthy, able to get along with people, have a high level of self-confidence, be willing to take risks, and be able to make good decisions," (19).

There are many people in the workforce who would like to be self-employed, but are afraid they may not have what it takes, however there are also those who would be better off working for someone else. In addition to the personal traits Cominsky suggested entrepreneurs should have, the owners of nursing homes should sincerely care about elderly people and demonstrate the desire to provide what is best for the resident's wellbeing (Findlay 92).

Siropolis warns potential business owners that it is foolish to choose a product or service that little is known about (167). Choosing

the wrong product or service to sell can weaken ones' chances of success. However, some entrepreneurs do go into entirely unfamiliar fields and succeed. As a general rule, though, entrepreneurs should pick a product or service that they know intimately, that they believe will grow at a rate faster than that of the economy as a whole, and that they are enthusiastic about (167).

Three important questions an entrepreneur must ask themselves once a product or service has been selected are: 1) what need will the product or service fill; 2) what is unique about the product or service; and 3) what does it offer customers that competing products or services do not offer (168)? Once these questions have been answered entrepreneurs need to look closely at their own skills and at industry trends to see how well they blend together. Does this person really have what it takes to succeed with that product or service? Finally, the potential owner should ask himself or herself if this is the kind of business to run, the kind of work to do, and the kind of person they want to be (101).

In a business plan, the owner's education and previous work experience is described. This information is vital because it helps investors and creditors decide whether to help finance the business

(162). The owner's skills are a fundamental point to evaluate when considering a new business. If a new business is able to offer some benefits and the owner can offer a positive contribution to the business then the operation can be planned (Starting ii). When an owner develops an objective analysis of both personal abilities and business requirements for a particular product or service it forces the individual to evaluate the chance of success (Siropolis 161).

Once the entrepreneur chooses a product or service and makes sure that the choice fits his or her skills and desires, the decision to buy an existing business or to start from scratch must be made. Lawyers and bankers often advise people to buy a business that is already in operation because it is less risky. An established business has already proven its ability to draw customers and turn a profit. However, past records do not eliminate risk. The ability to keep the business profitable will be up to the new owner (102).

When a would-be entrepreneur decides to buy an existing business, understanding the seller's motives is important. Sometimes the owner wants to sell because they need the cash, or they don't feel they can pass it on to younger family members, or the business has become too big for them. Other times the sellers may hide the real

reasons for selling the business. The seller may fear the financial future of the business and family, or technology is too complex to cope with, or the product or service is outdated (104).

Besides understanding the motive for selling the business, one needs to evaluate the financial aspects of the business. Financial statements from the last five years are a good place to start. Once the buyer reviews the statements, the business's net worth can be estimated. The statements show the seller's financial health, as well as profitability. Many questions may come up during this type of audit and for this reason the buyer normally hires an accountant and a lawyer to help (105).

Having thoroughly examined and questioned the financial aspects of the seller's business, the buyer can then set a price. There are two traditional approaches in pricing a seller's business, earnings and assets. The earnings approach requires the buyer to focus on either past or future after-tax profits. The asset approach requires the buyer to focus on assets only (106). Setting a price using the earnings approach can be accomplished by using capitalizing profits or personal return method (107).

The capitalizing profits method takes the expected percentage

return on investment divided by the estimated yearly after-tax profit to come up with the purchase price. To estimate the purchase price of an existing business, the return on investment expected during the first year of operation is divided by the expected yearly profit, after taxes are withdrawn (108).

The personal return method gives the buyer's personal return expressed as a percentage of personal investment. Entrepreneurs can earn a return on their investment in the form of a salary, dividends and interest, stock, and fringe benefits (108).

The asset approach to setting a price for buying a business ignores future earnings but instead focuses on the seller's assets. This method is not recommended because it doesn't tell the buyer enough about the true worth of the business. The three traditional asset methods are book value, adjusted book value, and selected assets. Book value is the difference between the business's assets and liabilities. The adjusted book value method adjusts for the difference between book and market value of assets. The selected assets method estimates the value of certain assets the buyer is interested in (109).

If an entrepreneur decides not to purchase an existing business but to start from scratch a lot more preliminary work will

need to be done. New ventures are very risky, Siropolis warns. The new business's profits will have to be estimated. Market information will also be required before a financial institution will loan money. There has to be the existence of a real business opportunity, where a product or service is needed and desired by customers (111).

"The entrepreneur usually has some idea, from the very start, of where to locate a business," says Siropolis (170). Some people choose a location close to home, or within a specific climate, but the best location for a business should be a combination of personal preference and business logic. For instance, it is logical to build an SNF and ICF within minutes of a hospital and medical clinics, since the patients frequently are in need of physician's care. If a business is not in a good location it could mean the difference between profitability and bankruptcy (170).

While location of a business is important to survival, the principals in a business will undoubtedly have a larger impact on the success of a business. Depending on the type of the long-term care facility and the personnel employed, the owner may need prior experience working with the elderly. For a small residential care facility the principal employees may include a health care

administrator, a nurse, a cook, and a housekeeper. A larger RCF may extend the smaller facility's principal employee list to include a physician, a pharmacist, department heads, and departmental staffs. The number and qualifications of the principals of a facility vary, depending on the job responsibilities, total number of staff employed, and the owner's input (Long-term Care 3).

The organizational structure is yet another important part of a business plan. The organization should be defined in terms of skills, not in terms of persons (Siropolis 172). The plan includes the skills and talents that will be needed to help the business survive and grow. Once the organization has been defined, the owner can then decide how to hire a qualified staff. Siropolis explains that entrepreneurs usually cannot hire full-time professionals but they should plan as if they are affordable. He claims that through such a procedure an entrepreneur is less likely to overlook needed skills (172). Regardless of what type and how many employees are hired in an RCF, there are strict guidelines as to who must be on the staff, their working hours, and their job qualifications (Long-Term Care 3).

When developing a business plan, the image the owner wants to convey to others is a very important part. A positive image conveys

credibility. There are numerous ways of creating a positive image for a nursing home. Becoming involved with the community in which the home operates is one very effective image builder. Community involvement may include development of a community advisory board, hosting neighborhood open houses, publicizing enthusiastic families and volunteers, and cosponsoring community events such as local arts and crafts festivals (Allen 564).

There are several image-producing marketing tools available to the nursing home administrator. Key factors on which potential customers will judge the facility are physician recommendations, personal tours, meeting the staff and other residents, general appearance of the facility, friendliness of the staff, appearances of the residents, and the cleanliness of the bathrooms (564).

Not only is creating a positive image for a business necessary for success, but creating a "new" image for the nursing home industry is seriously needed. Many elderly people come to fear and dread the experience of living in nursing homes long before it ever happens (Boling 65). Boling described five important factors to consider when creating a new image for a nursing home: 1) establish a stronger sense of collective professionalism; 2) provide pre-entry counseling

programs; 3) give person-centered care; 4) develop an evaluation program, and 5) diversify long-term care services (65).

Professionalism is conveyed to the community by the presence of skill and proficiency as a prerequisite for employment. Professionalism includes education requirements, and continuing training programs. The employees of the nursing home should have a sense of mission. Those who work in a home should have a lot in common, share the same basic values and norms about the work. These principles, along with others can help convey professionalism in the nursing home business (65).

The second important factor, pre-entry phase of counseling, is best accomplished by a social worker trained in geriatric care. Not only does the counseling extend itself into the community, thereby destroying old stereotypes and building new images of greater trust, it also helps the residents lead a wholesome pattern of adjustment to the nursing home style of life (69).

The problems of nursing home adjustment begin at the point of deciding whether or not to enter a nursing home. Management should try to ease the negative image that may exist in the minds of the prospective residents prior to entry. One way to help in the

transition is by getting to know the resident; personal and social traits, children, former occupation, hobbies, and consuming interest. A special program designed to inform the resident about institutional living is also helpful. One should get information about appropriate ways to adjust. Counselors can discuss some of the problems residents encounter and the solutions to those problems. The pre-entry program plus the home's other efforts to erase the "total institution syndrome", will make the transition from community to institution a much easier experience (68).

A person-centered care program will convey a positive image about living in a nursing home. This type of treatment is designed to treat each resident as an individual. The major objective with person-centered care is communication and interaction among residents. The home should be furnished to facilitate interaction. For instance, does the home have institutional traits? Some facilities do not require employees to wear uniforms, meals are served family-style (as opposed to cafeteria style), and no residents are ever parked in wheelchairs out in the halls (70).

Person-centered care programs include preparing the elderly for social adjustment to nursing home living. The two most important

factors in social adjustment are socialization and engaging activities. The administrator must ensure that the employees understand and support this type of educational program (72). "Professionalism, counseling, and person-centered care should be accompanied with a persistent monitoring of care" says Boling (74). Monitoring care through evaluation procedures will improve the quality of care and the general image of the nursing home in the community (74).

Essentially, changing the image of the nursing home is concerned with quality. Boling offered five steps to determine individual nursing home standards for quality: 1) The administrator should integrate the home into the community, linking the residents with their pasts; 2) A system of career development in nursing home care should be created; 3) The administrator should insist on the continued socialization and self development of residents; 4) The families of residents should be involved in the life at the nursing home; and finally, 5) The administrator should diversify services through alteration and extension of present programs (76). The use of social science for humanitarian purposes to create a positive image for nursing home care is simply a good business decision (77).

The image a business conveys to its customers, community,

and to their competition is very important but before image building can be practiced one of the most crucial decisions that new business owners must make is whether to set up the business as a sole proprietorship, a partnership, or a corporation (either standard or subchapter S) (Starting 3). Control of the business, raising capital, tax considerations, business continuity, and personal liability are all factors which must be considered when evaluating the different business forms. Each business form has advantages, as well as disadvantages, over the others (3). In the end, the decision is usually based on personal preference, taxes, and personal wealth (Siropolis 172).

A sole proprietorship has the most control of the business. In this form the owner has absolute authority over all decisions. Control of the business is shared in a partnership and dependent on stock ownership in a corporation. In a partnership, lack of a written agreement may lead to a dispute. In a corporation, control is exercised through regular board meetings and annual stockholder meetings and must be well documented. Personal assets make up a large amount of investment collateral when securing capital or line of credit for sole proprietorships and partnerships. Theoretically, a

corporation can sell stock to raise capital, but normally personal resources and credit are used (Starting 3).

There are many long-term care facilities that are organized as sole proprietorships or as partnerships but as a whole, most nursing homes are incorporated. One reason why long-term care facilities are incorporated is because of the limited liability, usually to the amount of investment. Creditors cannot reach the owner's personal assets unless the assets were pledged as collateral in the event of loan default (Business 4). Sole proprietorships and partnerships have unlimited liability, in terms of the debts of the business and any legal judgements against it (Cominsky 106). When a business is offering services in health care the chance for suit in malpractice (whether guilty or not) can be financially devastating (Allen 13).

Another reason for incorporating a business is for the fringe benefits. For key employees of the corporation, group life, medical and dental insurance premiums are tax deductible to the corporation. A sole proprietor or partnership would have to pay these costs personally out of after-tax dollars (Cominsky 106).

The corporate tax structure is a plus for business corporations because corporate taxes and personal taxes have a graduating tax

payment, as shown in Table 1. A proprietor or partner must declare the business income as personal income and leave no profit in the business. As a corporation, once the owner deducts an employee's salary, profits can remain within the business. Corporate taxation is based on the amount of profit remaining. Depending on the owner's personal tax bracket, the corporate tax impact may be much less (107).

Cominsky gave an example of how much tax money could be saved under the corporate tax structure. If the owner was in the 40% personal tax bracket and left $25,000 retained earnings in the corporation each year for three years, the cumulative tax would be $11,250 (25,000 x 15% x 3). If the money was taken out personally, the tax impact would be $30,000 (25,000 x 40% x 3). By leaving the money in the business, there would be a net gain of $18,750 in cash. This money can be used for expansion or as an asset if the business was up for sale (107).

The ease of raising money by selling shares of stock to investors is another advantage that incorporating a business brings. If the entrepreneur wishes to sell the business, the sale can be accomplished by selling stock without dissolving the corporation

Table 1

Federal Income Corporate Tax Table (As of 1990)*

Income Range	Percent In Taxes
<$50,000	15%
$50,000 - $75,000	25%
>$75,000	34%

>$100,000 add 5% up to a minimum additional tax of $11,750. Taxable income of $335,000 or more pay a flat tax of 34%.

SOURCE: 1990 U.S. Master Tax Guide. Washington, D.C.: U.S. Internal Revenue Service, 1989.

(Siropolis 205).

The disadvantages to incorporating a business must also be evaluated before a decision can be made. For instance, a corporation is closely regulated by the state. The owner of the corporation should keep very good records to avoid unnecessary complications that may arise if out of compliance with the state. Extensive corporate record-keeping requirements can be very time consuming. Besides keeping minutes of board meetings, financial records, and documentation of business activities, the corporation must make reports to the state agency that regulates corporations. Another disadvantage is the cost of incorporating. Because of the legal complexity of incorporating, the corporation costs more to form than a sole proprietorship or a partnership (205).

The last major drawback to incorporating a business is the double taxation. A corporation must pay income taxes on its profits, and shareholders must pay income taxes on dividends, if dividends are paid out (205). Dividends are not tax-deductible for a corporation and since the dividends come out of after-tax profits, they are taxed twice (206).

Entrepreneurs need help in developing the tax portion of the

business plan from accountants and lawyers. Tax laws change a little bit every year so it is important to hire an expert who is up to date. Federal income taxes, as well as laws covering state, county, and municipal taxes, Social Security taxes, and estate taxes are equally complex (552).

Taxable income is the amount of profit a company earns before federal income taxes are deducted. Taxable income is the profit reported to the IRS in accordance with its income tax regulations. How much a business pays in federal income taxes depends on the legal form of the organization (a regular corporation, an S-corporation, a partnership, or a sole proprietorship) (555).

A regular corporation is considered by the IRS as being A "legal person, separate and distinct from its owners." For this reason income tax rates are different than rates for either sole proprietorships or for partnerships. The exception to this rule is an S-corporation. S-corporations are taxed as if they were partnerships (555). Corporations get tax breaks up to $75,000 of their taxable income. In Table 2, Siropolis shows how the corporate tax break helps small businesses survive and grow.

An S-corporation is a cross between a regular corporation and a

Table 2

Corporate Tax Break
Profit Remaining After Tax Deduction

With Tax Break		
Taxable income		$66,000
Less: federal income taxes		
on first $50,000 (x 15%) =	$7,500	
on next $16,000 (x 25%) =	4,000	11,500
Net profit		$54,500
Without Tax Break		
Taxable income		$66,000
Less: taxes ($66,000 x 34%)		22,440
Net profit		$43,560

SOURCE: Siropolis, Nicholas C. Small Business Management. Boston: Houghton Mifflin, 1990.

partnership. An S-corporation has limited liability, like a regular corporation and is not subject to corporate federal income taxes, like a partnership. The S-corporations's profits are taxed the same way as the owner's salary and wages, hence, no double taxation. Siropolis advises entrepreneurs to consider operating as an S-corporation if the business has less than 35 shareholders. He indicated that the advantage stems from the fact that the top rate for individual federal income taxes will not exceed 28 percent. This compares to the higher maximum corporate rate of 34 percent. Partnerships and sole proprietorships follow the same tax laws as the S-corporation. The individual partners are taxed in a partnership (556).

Not only are the income tax payment plans an important part of business tax planning but also are inventory values, targeted jobs credit, estate and gift taxes, employment taxes, and excise taxes are all tax sources that must be evaluated when developing a tax plan (557).

Once the entrepreneur has decided on how the business will be organized, the finer details of the business plan can be drawn. When planning a long-term health care operation entrepreneurs should find out: what is the level of unmet needs for long-term care

beds in the community; how many competitors are there; what are their present and projected bed capacities; and is there enough unmet bed need to expect that a new nursing home would fill up sufficiently, quickly and maintain the desired level of occupancy over an extended period of at least 5, preferably 10, years (Allen 12)? Table 3 gives the number of adults over 65 and the number of nursing home beds available to the group.

There are economic considerations that come into play when planning a nursing home business. One must consider if the expected residents are likely to have the present and future income to keep the occupancy level high. Another consideration is whether or not the home be designed to appropriately mix private and public paying residents. Assessment of the community itself and if it is likely to maintain or improve its economic condition over the next several years should also be reviewed. There is a basic planning process that should be followed when creating a new nursing home. When evaluating a community to decide whether or not a nursing facility should be constructed, the competitive, economic, and political environment in that community must be appraised (12).

Governmental permission is needed only if the facility is an

Table 3

Distribution of Nursing Home and Care Facility Beds in the Major Metropolitan Region of the East-West Gateway

Geographic Area	Population Age 65+	Number of Beds SNF	ICF	RCFII	RCFI	Total	Beds/ 1,000
Franklin	9,851	814	45	40	35	934	94.8
Jefferson	13,712	921	291	147	355	1,714	125.0
St. Charles	13,555	785	280	196	84	1,345	99.2
St. Louis Co	123,712	7,951	781	912	240	9,889	79.9
St. Louis City	70,635	2,563	1,112	469	972	5,116	72.4
Region Total	231,469	13,034	2,509	1,764	1,686	18,993	82.1

SOURCE: Licensed Skilled Nursing, Intermediate Care, Residential Care II and Residential Care I Facilities in Missouri. Jefferson City: Missouri Department of Social Services, 1989.

ICF or an SNF. The permission is granted through a "Certificate of Need" application. The likelihood of obtaining a certificate to build a facility must be an early consideration. There are other political and legal considerations for all types of long-term care operations. A business must obtain required federal, state, and local governmental permits before it can start operating. The political climate in the town where the nursing home will be built should be supportive of elderly programs. If the proposed nursing facility will not be welcomed in a community, it is possible that any needed permits may be delayed, disapproved, or interpreted so strictly that costs to operate rise unacceptably. The perceived unmet needs will influence the role planned for the proposed nursing facility. Allen suggests that all of these considerations amount to conducting a "needs assessment" for the proposed nursing home (13).

The next step in creating a nursing home is setting short and long-range objectives, broad goals, and plans that will direct the efforts. Allen gave several examples of broad goals a home may set. For instance, a broad goal might be to build the home in the same architectural style of the community, in a location near the local hospital and physician's offices, or in a residential section of the town.

Once the broad goals are set, more specific objectives and plans can be developed. Allen suggests that a short-range objective might be set to have a 150-bed facility in operation within 18 months and, as a long-range objective, a second facility of an additional 100 beds in operation within 5 years (13).

The third step in the creation of a nursing home is to translate broad planning goals into functional efforts on a more detailed basis. For instance, at this level the building site is chosen, allowable cost levels are determined, and blue-prints for the home are drawn. The planning process moves from general to specific. The budget is the most powerful planning and control tool for the manager of a nursing home. In the end, all of the plans have to be translated into dollars allocated in the budget. Once the nursing home's plans have been made, the next step is to take the necessary actions to put them into effect and transform them into operations (13).

In many cases the owner of a nursing home is also the administrator. The key employees of the home have specific responsibilities unique to their job. The nursing home administrator's duties encompass nearly every aspect of running the facility. The administrator's responsibilities range from recruiting professional

medical personnel to assuring the efficient operation of the laundry department. The administrator is also responsible for the money coming in and going out of the facility. In other words, the administrator is the one person held accountable for the entire financial operation of the facility (227).

The bookkeeper primarily records the daily cash transactions of the facility. The accountant uses the information compiled by the bookkeeper to generate reports on the financial standing of the facility. Even though the bookkeeper and the accountant record financial transactions, the administrator is the chief financial officer of the facility. The administrator must have some knowledge of bookkeeping to be able to ensure that the bookkeeper is qualified and is recording transactions properly. The administrator should have some understanding of accounting to be able to assess the accountant's performance. Finally, the administrator must be able to interpret the financial reports developed by the accountant. The report results will be used to make informed decisions about the facility (228).

There are many types of costs in operating a nursing home. The administrator must assure the availability of funds for

conducting business and monitor cash flow closely. If supplies aren't purchased and salaries aren't paid, then the home cannot operate. The good financial manager understands procedures for billing and collections so that money owed to the facility comes in on a regular basis. When creating a nursing home business the administrator must know how to set rates for the services offered. A forecast of the number of residents who will require these services must also be made (228).

Financial management is important in planning and budgeting (228). To form a budget, the administrator must be able to predict the costs of running the facility and how much the company can expect to earn in future years. Once the facility has been in operation, the past financial performance and investigation of earlier budget shortfalls or successes are essential for preparing a realistic and useful budget. If the administrator is not familiar with the costs and earnings of all departments in the facility then the organization cannot be guided successfully (229).

Developing a program of risk management identifies where dollar losses may occur, how severe such losses might be, and how to treat these risks. The chance of financial loss is a risk to a business.

Such losses can be reduced sales revenues, increased operating expenses, reduced assets, or increased liabilities that could not be foreseen. When such losses do occur, because of fire or theft or lawsuit, for example, the entrepreneur is caught by surprise (Siropolis 577). To assure that a risk management program fits the needs of the company, an insurance agent and a lawyer should be consulted (173).

Risk is classified into three categories: pure, speculative, and fundamental. Pure risk results in a loss or no loss, but with no possibility of gain. The entrepreneur can do little to avoid pure risk. For example, fire, death of a key employee, bankruptcy of a customer, theft, and traffic accidents are all pure risk factors (577).

Speculative risk allows the entrepreneur to either gain or lose. For example, purchasing real estate or common stock on the hopes that its value will appreciate is a speculative risk. These are investments that the entrepreneur, not fate, exposes to risk (578).

Fundamental risk is different from pure and speculative risk in its impersonality. Fundamental risk hits all ventures, not just one. Sources of fundamental risks are economical, political, social, or natural forces experienced by society. For example, floods, earth-

quakes, inflation, and war are all fundamental risk factors (578). Risk management programs are designed to help protect entrepreneurs against possible loss. An insurance agent can pinpoint risks that may cause dollar losses, estimate how severe these losses may be, and select the best way to treat each risk. Financial statements are used as a starting place for pinpointing where losses may occur. Each aspect of the operation is reviewed and the effect of its loss is identified (579).

Once the risks of the company have been pinpointed, an estimation of the effects of losses must be made. After estimating the cost of each possible loss, the frequency of loss occurrence and its seriousness should be estimated. Finally, after all estimations are summarized, and the entrepreneur, following expert advice from an insurance agent and a lawyer, can purchase an insurance protection that best treats each risk (579).

Operation of a long-term care facility offers numerous encounters with legal and business terms. The administration should be familiar with these terms relating to law, risk management, and wills. The relevant sources of law include an understanding of the constitution, statutes, common laws, regulations, and codes. Legal

terms should be understood because once a nursing home obtains a license to operate, and is operating, a set of risks are brought to the facility (98). Employer's Liability Act is but one of the many risks a facility may encounter. The Employer's Liability Act investigates the extent to which employers are liable to their employees for injuries to the employees. Strict liability is where an employer is held strictly liable and is subject to liability without fault. Vicarious or imputed liability is where the employer is held responsible for the acts of employees within the scope of their employment (98).

There are many legal terms and definitions that must be understood by the nursing home administrator. For instance, "scope of employment" is the range of employee activities held by the court to be the legal responsibility of the employer. A "borrowed servant" is a person under temporary employ of another person. Using the concept of imputed liability, the nursing home might be found liable for the wrongful acts of the "borrowed" employee. An independent contractor is not an employee of the home. The home would not be liable ordinarily for the negligence of an independent contractor. The administrator should consult a lawyer or an insurance agent to gain help with interpretation of applicable laws (Allen 98).

Financial Plan

The budgeting process in the nursing facility is a period of planning to meet short and long-term goals. The physical budget is a record of anticipated revenues and expenses for the next fiscal year. It is also an examination of internal and external changes that management believes will affect the operations of the facility. A strategy is built in to deal with these changes for the future. In addition to the fiscal budget, many nursing homes also prepare less detailed budgets for the two, three, or five years following the fiscal year. The long-range planning budgets are formed to help guide the organization to meet its long-term goals and objectives (302).

The budget is a managerial tool that is used by the nursing home administrator and staff. It provides a meaningful comparison between actual and projected expenditures and revenues. Adjustments between budget items can be made anytime after the budget is completed. Nursing home budgets characteristically have a number of objectives. However, the number one objective that should remain throughout the budgeting process is providing a high quality of care to service recipients (303).

Generally, nursing home administrators use either the top-down method or the participatory method of budget preparation. With the top-down approach, the administrator prepares the fiscal budget without help from others. This method is more suitable for small homes where there are few department heads. Top-down is also the popular method used by franchises. When a chain facility uses top-down budgeting, the local administrator is given a "suggested" budget with the corporation's goals built into it. Even though the top-down method is quick, it has several disadvantages for a medium-to-large scale nursing home. The top-down method may stifle innovation or impose an unpopular or unrealistic budget on department heads or chain facility administrators (303).

The participatory method of budgeting requires input from staff members and the administrator. The administrator initially gives the department heads a guideline for the preparation of departmental budgets. The departmental budgets are reviewed by the administrator, adjusted if necessary, and combined into one organizational budget (304).

As the top-down budget method was more appropriate for a small nursing homes, the participatory budget method best fits the

medium-to-large nursing homes. Participatory budgets are much more time consuming but the advantages far out-weigh the disadvantages. Communication between the administrator and staff is needed to successfully plan a participatory budget. Input from those most knowledgeable about the daily operation of the individual departments can result in a more realistic fiscal budget (304).

Allen suggests that the optimal method of budgeting will depend on, for the most part, whether is it is free-standing (not affiliated with a hospital or other type of nursing home) or a unit in a small or large chain, and the administrator's time constraints. When the administrator designs the budget process, one of the first decisions must be what type of information is desired and how detailed must it be. Once this decision has been made the administrator must map out the logistics of each activity and determine who will participate in the budget process.

In the case of top-down budgeting the administrator and other administrative personnel (e.g. bookkeeper, comptroller, business manager) will be involved. Participatory budgeting includes the administrator, the accountant or comptroller, bookkeeper, personnel director, and department heads and their assistants. A timetable for

planning the next fiscal year's budget, at least two to five months before the beginning of the next fiscal should be allowed for the entire process (305).

Allen indicated that there are five basic steps in planning a budget for a nursing home: assessing the environment, programming, developing the operating budget, developing the cash budget, and developing the capital budget. When assessing the nursing home environment, an administrator needs to look internally as well as externally to be prepared for political, economical, and social changes. These changes may or may not affect the nursing home's budget. Although the administrator has no control over the external environment, failure to anticipate its effects on the operations of the facility or showing ignorance to the trends, leaves one less able to deal effectively with changes (305).

Some external environmental trends may occur with increased or decreased competition, altered reimbursement policies, amended licensing laws, revised quality review regulations, swings in the economy, inflation, deflation, or stagflation, a reduction in the potential service population, and changes in disease patterns among patients. Most of these fluctuations in the external environment may

affect the plans and operations of the facility (305).

After the environmental factors and their affects on the nursing home have been assessed, the home's objectives for the coming year can be determined. Allen calls this process "programming." Through programming the administrator can alter internal operations to respond to the external influences on the facility. A program can be used in periods of rising inflation by increasing salaries by a percentage. The percentage approximates the rise in the cost of living by a certain time during the following year. An increase in salary expense can then be included in the budget. This foresight can prevent a situation in which funds are not set aside for this purpose. If cost of living increases are not planned for recruiting problems, high staff turnover, or a strain on operating funds when a salary increase is finally provided may occur (306).

Allen offers other considerations for programming such as changes in service volume, services offered, payer mix, personnel needs and capital needs. The cummulation of the expected external and internal events should determine the objectives of the facility for the next year. The objectives of the facility form the basis of assumptions made in the budgeting process (306).

The final steps in planning a budget for a nursing home results in four types of budgets: the operating budget, the cash budget, the capital budget, and the pro forma financial statements. Two parts make up the operating budget of a nursing home: the expense budget and the revenue budget. The expense budget lists the anticipated expenses of the facility for the coming year. Anticipated expenses should include expected patient service volume, staffing patterns, equipment repair and replacement needs, and the volume of supplies. Anticipated expenses should be broken down by month. Monthly expense budgets facilitate preparation of the cash budget (307).

Several strategies are used when determining nursing home expenses. One tactic is to increase all of the current year's expenses by a certain percentage. Unfortunately, this method, though quick, defeats the purpose of budgeting and environmental assessment and programming. Most nursing homes predict expenses by examining monthly and yearly trends in costs and utilization (311).

The second section of the operating budget, the revenue budget, projects the monthly income for the next fiscal year. The nursing home has two sources of income: operating or patient services

revenues and nonoperating revenues. Estimation of the operating revenues is accomplished by multiplying the expected service volume by the charge per unit of service. Rates for service may be determined in several ways. Public-pay patient's allowable rate per unit of service may be somewhat less than charges. In this case, the reimbursable rate should be used in projecting revenues for public-pay patients. Private-paying patients' charges can be based on the cost plus profit for providing the service. This method uses the results of the cost-finding process and breakeven analysis. Rates may also be based on competitive charges for similar services in the community or on the price that the market will pay (312).

Non-operating revenues, such as interest income, borrowed funds, and charitable donations, are dependent on any number of factors but are relatively predictable on a monthly basis. Non-operating revenues plus the monthly operating revenues equal the total expected revenues budget for the nursing home. Total expected revenues are compared to the expected expense budget. If revenues do not meet the expenses then the service volume should be reevaluated and either increase patient service volume, reduce budgeted expenses, or raise the patient service rates (312).

As a managerial tool, the operating budget helps the administrator control the finances of the facility. Throughout the year (on a monthly basis) the administrator compares the actual versus budgeted monetary and volume values. Any significant deviation from the budgeted amounts are investigated to identify the source of the variance. Allen calls this investigative procedure "variance analysis." Once the sources of variance are known the budget can be adjusted accordingly, or the cause of the variance can be eliminated (312).

The next step in the budgeting process is the preparation of the cash budget. The cash budget is prepared on the cash basis of accounting as opposed to the operating budget which is prepared on the accrual basis of accounting. The cash budget estimates monthly cash inflows and outflows and in turn, can be a useful planning tool. To develop a cash budget, cash inflows and outflows must be determined. Projecting cash inflows can be very involved if most or all of the patients pay for their services through Medicare, Medicaid, or other reimbursement-type programs. Private-pay patients are required to pay within 30 days of billing. Public-pay patient payments are received anywhere from 20 to 90 days or more from the date of billing (313).

In nursing homes, the percentage of occupancy is conventionally the bed or patient day of care (Vogel 667). Occupancy rates are based on the formula: {(patient days of care/# of licensed beds)/# of days in reporting period} x 100 (Mosely 1). Most nursing homes analyze their costs by using a single equation cost function. There are many facility, patient, and reimbursement characteristics which are important cost determinants in nursing homes. However, some nursing homes use multi-equation models that incorporate interactions among regulation, private demand conditions, and cost (Vogel 666).

Average operating or variable cost is preferred to total costs, (including capital costs) in nursing home cost analysis. Fixed costs do not vary greatly once a facility has been established (667). Fixed costs are not linked to the other variables reflecting scale (bed size) and product mix. Capital costs are omitted because the amount and value of an enterprise's capital are difficult to measure. They often reflect accounting and tax procedures rather than any objective measures. In addition, there is little chance of substituting capital for labor in most nursing care programs. Variable costs, especially labor costs, are a large portion of a nursing home's total nursing home costs (667).

Additionally, the existing reimbursement systems emphasize operating costs and translate capital charges into them because of specific allowances (e.g. depreciation) (668).

Contrary to the assumption that nursing home costs yield a conventional U-shaped cost curve (scale-related decline in average cost followed by increase in cost due to communication difficulty, etc.), the costs actually increase equivocally with the scale size increase. The age of the facility may also play into the costs since newer facilities tend to be larger and more expensive than older ones (668).

Scale is measured either in number of beds or the average daily census (quotient of yearly patient days divided by 365). There is no empirical difference between the two measures (668). When considering the effects of scale, two factors come into play: capacity of the facility and degree of utilization or occupancy rate. According to Vogel the conventional hypothesis about scale of operations is divided into two sub-hypotheses: 1) average costs first decline and then increase with bed size (holding occupancy rate constant) and 2) average costs first decrease and then increase with occupancy rate (holding bed size constant).

A 1979 national study conducted for the Health Care Financing

Administration, (HCFA), revealed that unlike the scale factor, the occupancy factor did not appear to significantly influence costs across any grouping of facility sizes, although costs fell smoothly as occupancy rates increased. Overall, the HCFA study found that State regulatory environments were more important than underlying "real" factors of scale or occupancy rates. Additionally, the study showed that nationally, scale and occupancy rates appear unimportant except in very small facilities (670).

Vogel indicated that the classification of the nursing home can also have an effect on operational costs. He stated that for-profit proprietary facilities were less costly than government and non-profit. In a 1980 nursing home study it was concluded that non-profit homes ranged from about $1.75 to almost $12 per day more costly than profit-oriented homes. Governmental homes ranged from $2.50 to over $7.00 more expensive than their proprietary counterparts (678).

A 1978 nursing home study concluded that average costs in proprietary homes were about 7.5 percent lower than in voluntary, non-profit homes. In addition, he suggested that the proprietary homes were probably advantaged over non-profit and governmental homes because they were less costly to operate. Such disparities

might arise from profit oriented, cost-minimizing actions by proprietors, possibly a lighter case load in proprietary homes, or from the impact of governmental regulation, or a combination of all of these factors (673).

Cost differences can depend on whether a nursing home is free-standing or if it is incorporated with another facility. Generally, when nursing homes are incorporated with another facility it is usually a hospital or a retirement center. Data from a 1977 Medicare cost report for skilled nursing facilities (SNFs) indicated that hospital-based units, (a hospital and nursing home combination), had over 60 percent higher average costs than free-standing homes. In the city, the difference may have been 85 percent and in the rural areas it may have been over 50 percent. In a 1980 study conducted in Colorado, it was determined that hospital-based nursing homes had $10 more average costs per patient day than free-standing homes (674).

Chain ownership is a type of nursing home that treats costs a little differently than proprietary, non-profit, or government homes. Vogel suggests that the assumption that members of nursing home chains will enjoy lower costs because of presumed economies of scale

is just the contrary. In some cases chain membership had a significant downward influence on costs (675).

Other facility characteristics have often been cited as influencing costs, Vogel reported. For example, changes in the number of beds, percent of services provided under external contracts, in-house training programs, and average number of beds per room may or may not influence costs. On the other hand, location and related input price differentials do appear significantly related to cost differences. Mostly due to wage rate differences. Wage rates are found in various parts of the country, on rural versus urban sites, and on population size (676).

Besides location, certified level of care can also increase costs significantly at a nursing home. States use certification standards subject only to imprecise Federal guidelines. States use certification (SNF or ICF) as the basis for rate-setting for reimbursement purposes. Medicare certification accounts for costs 5 percent higher than those for Medicaid certified SNFs and 15 percent higher than for Medicaid certified ICFs. Meiners reported that convalescent or rest homes (RCFs) have costs not appreciably different from those of ICF and SNF nursing homes (677).

The costs of providing services to a patient or resident must be considered. As Vogel points out, volume of services provided per patient should be positively related to average operating costs. This is important because more services per patient means more staff time used, which in turn implies a larger wage bill, more fringe benefits, and more complementary factors of production. Service intensity is directly tied to patient characteristics and the quality of care to which the facility aspires. There is a link between service provision and costs but it may be spurious (677).

When estimating the costs of services it is necessary to distinguish between the availability of service and the amount actually offered or provided. The type of service must be identified as routine (e.g. meals served, medication administered) or special (e.g. rehabilitation, physical therapy, psychiatric care). Lastly, there should be a clear distinction between high quality and waste. It is apparent that different types of people require different types of care, may need different nursing home products, and account for different levels of costs (678). In other words, a "basic" patient requires basic services and the more difficult patient cases requires add-ons which augment costs (684).

Admission rate or resident turnover rate is yet another source of cost variation which can be related to resident characteristics. Vogel states that turnover rate may reflect discharge policies of the facility, source of patient funding, or hospitalization. Regardless of what type of combinations the turnover rate variables consist of, most studies show high positive cost effects associated with high turnover (684).

Private funding versus public funding can also have an effect on nursing home costs. In some cases private pay facilities (residents pay out of pocket) cost more to operate than public pay (Medicare, Medicaid, and charities paying for the resident's stay). On the other hand, some private pay facilities cost less to operate than the public pay facilities. According to Vogel, one must consider various factors, such as payment source, services, quality, and patient characteristics when analyzing nursing home operating costs (686).

If a home wants to attract private pay residents it would have to be price competitive and cost-efficient. The incentive to go after private pay residents is greater but the home should provide more lavish nursing services and amenities. In Vogel's analysis of nursing home costs he concluded that if one assumed a constant level of

amenities in both types of facilities and the same reimbursement and regulatory environment, the private pay-oriented homes would find themselves having to be more efficient and less costly on an average cost basis (686).

Specific state or "internal" regulations also help to determine nursing home costs. State reimbursement programs, enforcement of life safety codes, absolute staff requirements, and low occupancy penalties can exert higher costs to a facility (686). On the other hand, flat rate reimbursement systems, rate limit systems, and administrator salary limits can produce lower costs. If a reimbursement program has a ceiling to limit costs then the ceiling will bind constraints on the home's costs (687).

The key variables that influence costs in nursing homes are occupancy rate, ownership and provider type, location, certified level of care, resident mix (condition and characteristics), and by services offered (687). When determining cash inflow, the lagtime between the billing of services and receipt of payment is calculated. If a nursing home has both public-pay patients and private-pay patients then the percent of total revenues that will be received from each payer in each month is budgeted (Kotler 314). The monthly revenues from the

revenue budget can also help determine the cash receipts for each month. When cash inflows from patient services are known, monthly cash receipts from non-operating sources are computed to give total cash receipts for each month (315).

Cash outflows are somewhat easier to estimate than cash inflows. Using the expense budget and the nursing home's experience with suppliers and other creditors, the amount of cash disbursements can be determined for each month. Cash inflows are compared to cash outflows each month and noted as part of the cash budget. The cash budget can be updated during the year for whatever reason (315).

To estimate cash flow, a pro forma cash flow analysis should be performed. The first step in a cash flow analysis is to summarize the investment outlays required to start a nursing home business (Brigham 295). Table 4 gives an example of a typical nursing home's investment outlay.

After estimating the capital requirements, the cash flow that will occur once production begins can be estimated. Additionally, the sales price and fixed costs should be projected to increase each year by an estimated percent inflation rate. The analysis should also include additional investments that are expected to be made in

Table 4

Investment Outlays, 1991 - 1993

Fixed Assets	1991	1992	1993	Total Cost[1]	Depreciable Basis
Land	$ 325,000	$ 0	$ 0	$ 325,000	$ 0
Building	0	1,255,000	1,255,000	2,510,000	2,510,000
Equipment	0	0	315,000	315,000	315,000
Total fixed assets	$ 325,000	$1,255,000	$1,570,000	$3,150,000	
Net working capital[2]	0	0	320,128	320,128	
Total investment	$ 325,000	$1,255,000	$1,890,128	$3,470,128	

[1] Total costs were projected for 1991-1993.
[2] 12 percent of first year's sales, or 0.12 ($2,667,729) = $ 320,128

SOURCE: Brigham, Eugene F., Louis C. Gapenski. Financial Management. Orlando: Dryden Press, 1988.

support of sales increases (295).

Brigham suggests summarizing the cash flow data by combining all of the net cash flows on a time line. The evaluation shows the payback period, the internal rate of return (IRR), the modified internal rate of return (IRR*), and the net present value (NPV). Brigham warns that if the firm has a relatively long life, and an IRR or IRR* which is significantly above the firm's cost of capital, it might attract other firms into the market. If more firms come into the market the actual cash flow may fall far below the levels originally estimated (298). Table 5 is an example of a cash flow summary for a typical nursing home business.

The third step in the budget process is development of the capital expenditures in the budget year. When a nursing home decides on a capital project, a capital budget is formed to explain how the project will be financed (298). Table 6 gives an example of a capital budget for a typical nursing home.

The budget process concludes with the development of the pro forma financial statements. The pro forma statements are preliminary financial statements based on budgeted amounts. The pro forma income statement is derived from the operating budget and

Table 5

Cash Flow Summary

Sources and Uses of Funds	1991	1992	1993
Cash Receipts			
Cash on Hand January 1	$ 300,000	$ 36,836	$ 370,476
Excess of Revenue over Expenses	(274,533)	173,020	229,913
Depreciation	81,535	156,837	134,787
Amortization	4,834	9,342	8,652
Non-operating Incomes	-	-	-
Less Borrowing Discounts	-	-	-
Other Sources: Mortgage Loan	$ 1,500,000	$ -$	-
Total Cash Available	$ 1,611,836	$ 376,03	$ 743,828
Cash Disbusements			
Payments on Existing Debts	$ -	$ -	$ -
Routine Equipment Replacement	-	-	-
Other Scheduled Projects	-	-	-
Disbursement on This Project	1,500,000	-	-
Interest During Construction	75,000	-	-
Payments on New Borrowings	$ -	$ 5,559	$ 11,465
Total Cash Disbursements	$ 1,575,000	$ 5,559	$ 11,465
Ending Cash Balance	$ 36,836	$ 370,476	$ 732,363

SOURCE: Certificate of Need. Jefferson City: Missouri State Department of Aging, 1990.

Table 6

Capital Budget

Description		Dollars
Costs:		
1.	General Construction Costs	$ 2,150,000
2.	Site Work	275,000
3.	Total Construction Costs	2,425,000
4.	Architectural/Engineering Fees	85,000
5.	Fixed Equipment (not in construction contract)	100,000
6.	Movable Equipment	215,000
7.	Land Acquistion Costs	325,000
8.	Consultants' Fees/Legal Fees	10,000
9.	Interest During Construction	100,000
10.	Other Costs of Financing	25,000
11.	Contingencies	75,000
12.	Total Non-construction Costs	-
13.	Total Project Development Costs	$ 3,360,000

Total Square Footage of New Construction	37,500
Total Square Footage of Renovated Space	-
Total Square Footage of the Project	37,500
New Construction Costs per Square Foot	64.66
Renovated Costs Per Square Foot	-

Funding:		
14.	Unrestricted Hospital Funds for Project	-
15.	Funds Provided Through Fund Raising Activities	-
16.	Short Term Loans (Less than 5 years)	-
17.	Long Term Loans	$ 3,035,000
18.	Bonds	-
19.	Other Methods - Land Already Purchased	325,000
20.	Total Project Development Funds	$ 3,360,000

SOURCE: Certificate of Need. Jefferson City: Missouri State Department of Aging, 1990.

shows the net income (or loss) expected under the budgeted expenses and revenues (Kotler 316). Table 7 gives an example of a typical nursing home's pro forma income statement for the first three years of operation. Table 8 gives a financial summary of the industry norms for a typical skilled nursing home in the United States.

In a 1988 financial study conducted by Financial Research Associates, 28 nursing homes having total assets between $10,000 and $1,000,000 were analyzed. The number of firms that were corporations, proprietorships, and partnerships in the study were 21, 3, and 4, respectively (Financial S-39).

The overall financial analysis for small business nursing homes contained a "typical" composite balance sheet (Table 9) and an income statement (Table 10). The study also gave sixteen financial analysis ratios, arranged in the order of liquidity, leverage, activity, and profitability (Table 11). Finally, in Table 12, a financial analysis was conducted for a breakdown by sales.

The composite balance sheet and income data reflect median values. The ratios show median values, as well as upper and lower quartile figures. The upper quartile represents the value halfway between the median and the best of all ratios. The lower quartile

Table 7

Pro Forma Income Statement

	1991	1992	1993
Revenue			
Daily Patient Care	$ 533,600	$ 2,400,678	$ 2,658,879
Ancillary Services	1,880	7,550	8,850
Total Patient Revenue	535,480	2,408,228	2,667,729
Total Revenues	$ 535,480	$ 2,408,228	$ 2,667,729
Less Deductions			
Uncompensated Care (Title VI)	-	-	-
Charity Care	-	-	-
Third Party Loss	-	-	-
Bad Debts	1,334	6,000	6,650
Total Deductions	1,334	6,000	6,650
Net Operating Revenues	$ 534,146	$ 2,402,228	$ 2,661,079
Expenses			
Labor Costs	$ 343,857	$ 1,172,521	$ 1,362,454
Supplies	13,353	60,056	66,527
Other Expenses	215,100	488,600	522,800
Depreciation	86,369	166,179	143,439
Interest	150,000	341,852	335,946
Total Expenses	$ 808,679	$ 2,229,208	$ 2,431,166
Excess (Shortage) of Revenue Over Expenditures	$(274,533)	$ 173,020	$ 229,913

SOURCE: Certificate of Need. Jefferson City: Missouri State Department of Aging, 1990.

Table 8

Industry Norms and Key Business Ratios For Skilled Nursing Facilities

	Dollars
Total Current Assets	562,641
Total Assets	1,589,381
Total Current Liabilities	386,220
Total Liabilities and Net Worth	1,589,381
Net Sales	2,295,499
Gross Profit	1,163,818
Net Profit After Tax	71,160
Working Capital	176,421
Solvency	
Acid Test	1.1
Current Ratio	1.5
Current Liabilities to Net Worth (%)	39.4
Current Liabilities to Inventory (%)	464.6
Total Liabilities to Net Worth (%)	113.2
Fixed Assets to Net Worth (%)	102.5
Efficiency	
Collection Period (days)	24.8
Sales to Inventory (times)	133.3
Assets to Sales (%)	86.3
Sales to NWC (x)	10.5
Accounts Payable to Sales (%)	2.8
Profitablility	
Return on Sales (%)	3.4
Return on Assets (%)	3.7
Return on Net Worth (%)	10.7

SOURCE: Dun and Bradstreet. Industry Norms and Key Business Ratios 1987-88. Dun and Bradstreet, Inc. 1988.

Table 9

The Financial Study of A Typical Nursing Home's Balance Sheet

Assets

	As a % of Current Assets	As a % of Total Assets
Cash	32.55	11.96
Accounts receivables	45.15	19.25
Inventories	0.51	0.48
Other current assets	1.13	0.61
	As a % of Fixed Assets	**As a % of Total Assets**
Land, Buildings, lease-hold improvements	45.87	21.02
Equipment	22.86	9.23
Other fixed assets	0.00	0.00

Liabilities and Capital

	As a % of Current Liabilities	As a % of Total Liabilities
Accounts payable/trade	30.56	9.98
Short term bank loans	0.00	0.00
Other current debt	59.44	29.66
	As a % of Long Term Debt	**As a % of Total Liabilities**
Long term debt:		
Notes payable	0.00	0.00
Mortgages payable	0.00	0.00
Long term bank loans	0.00	0.00
Stockholder loans (due to owners)	0.00	0.00
Other long term debt	0.00	0.00

SOURCE: 1988 Financial Research Associates. 261.

Table 10

The Financial Study of A Typical Nursing Home's Income Statement

Income Data	As a % of Net Sales
Net sales - gross income	100.00
Cost of sales	0.00
Gross profit	100.00
General/administrative expenses	91.75
Operating profit	8.25
Interest expense	0.51
Depreciation	1.88
Profit before taxes	5.85
Additional Operating Items	
Labor	46.44
Advertising expense	0.33
Travel expense	0.24
Rent	11.10
Insurance	1.53
Officer/executive salaries	7.01

SOURCE: 1988 Financial Research Associates. 262.

Table 11

The Financial Study of A Typical Nursing Home's Financial Analysis Ratios

	Median	Upper Quartile	Lower Quartile
Current(x)	1.9	3.0	0.9
Quick(x)	1.8	2.8	0.7
Current assets/total assets(%)	48.1	77.9	25.5
Short term debt/total debt(%)	75.8	99.3	32.9
Short term debt/net worth(%)	38.2	93.1	11.4
Total debt/net worth(%)	51.2	329.7	17.9
Short term debt/total assets(%)	26.3	35.1	12.8
Long term debt/total assets(%)	6.7	55.2	0.0
Total debt/total assets(%)	49.9	92.4	28.0
Sales/receivables(x)	13.1	19.7	8.8
Average collection period(days)	22.0	33.0	11.0
Sales/inventory(x)	8.9	163.4	0.0
Sales/total assets(x)	3.4	4.8	1.7
Sales/net worth(x)	4.8	14.7	2.5
Profit (pretax)/total assets(%)	16.3	36.8	5.0
Profit (pretax)/net worth(%)	46.9	75.9	11.1

SOURCE: 1988 Financial Research Associates. 262.

Table 12

The Financial Study of A Typical Nursing Home's Financial Analysis Breakdown by Sales

Total Sales (in thousands)	250-500	500-1000	1000+
		(As a % of Sales)	
Net sales	100.00	100.00	100.00
Cost of sales	0.00	16.58	0.00
Gross profit	100.00	83.42	100.00
General/administrative expenses	84.69	73.40	94.46
Operating profit	15.31	10.0	25.54
Interest expense	0.00	0.78	0.32
Depreciation	0.00	2.87	1.21
Profit before taxes	15.30	16.37	4.01
Additional Operating Items			
Labor	36.52	.	.
Advertising and travel expense	.	.	.
Rent	.	.	.
Insurance	3.66	.	.
Officer/executive salaries	9.58	.	.
Ratios			
Current	1.8	2.2	1.4
Quick	1.4	2.2	1.4
Current assets/total assets	51.3	36.4	60.9
Short term debt/total debt	76.9	41.1	95.2
Short term debt/net worth	40.9	25.4	47.9
Total debt/net worth	57.3	44.9	51.7
Short term debt/total assets	32.1	15.5	33.8
Long term debt/total assets	0.01	5.5	1.7
Total debt/total assets	72.7	31.0	60.7
Sales/receivables	15.5	13.6	12.7
Average collection period	16.0	14.0	28.0
Sales/inventory	13.0	57.8	36.6
Sales/total assets	4.6	2.3	3.8
Sales/net worth	2.4	5.1	5.9
Profit (pretax)/total assets	21.0	9.7	14.1
Profit (pretax)/net worth	58.3	36.9	75.9

SOURCE: 1988 Financial Research Associates. S-39.

represents the value halfway between the median and the worst of all ratios. The upper and lower quartiles include 50% of all the firms analyzed. Values higher or lower than upper and lower quartile figures would tend to be extreme (iii). The study results are summarized in Tables 9 through 12, below (S-39, 261-262). Additionally, Appendix B lists the 1990 industrial standards for nursing homes, convalescent homes, and rest homes in the United States (Morris 664-5).

The budgeting process can be costly in terms of time involved in development. However, thorough investigation of the home's finances familiarizes the administrator with the costs of running the facility. A carefully planned budget maximizes the administrator's ability to manage its finances successfully (316).

When developing a business plan the type of accounting method to be used should be described. There are six generally accepted accounting principles which are used by nursing home businesses: the entity concept, ongoing concern concept, consistency concept, concept of full disclosure, time period concept, and the objective evidence concept. The entity concept is a basic concept of accounting, under which the nursing facility is regarded as a whole,

entirely separate from the owners, managers, or other employees. For example, when the owner withdraws from or adds to the funds of the facility the monetary transfer is recorded in the books. The transaction documentation reflects the effect on the facility's finances (Allen 231).

The ongoing concern concept is where the facility is regarded as an ongoing operation. Thus the assets of the facility are not recorded in the books at their value (as if they would be sold tomorrow). All of the facility's bills and other obligations are recorded in the financial records because they will at some point be paid (231).

The consistency concept is another basic rule of accounting. This concept requires that the financial records be prepared in the same way each year. This method is useful when trying to compare records from year to year. It is suggested that if a report is changed, it be done infrequently, if at all (231).

The concept of full disclosure means that all money spent, earned, invested, or owed by the facility be shown in the financial records. Documentation of all transactions allows for an accurate representation of the facility's financial standing. As Allen explains, the concept of full disclosure has significant legal implications. If the

facility fails to disclose all of the financial information then the amount of taxes owed by the facility, or reimbursement from insurance companies, may be affected (231).

The time period concept, also known as the accounting period, is the interval of time shown in the financial reports (usually one year). The accounting period should be the same each year and begin on the same date every year. Accounting records can be prepared more than once a year, usually monthly, to provided management with current information. The shorter reporting periods should also be on the same date year after year (232).

The sixth accounting principle is called the objective evidence concept. This concept requires that the accounting records be prepared with documentable records archived by the facility. Every transaction should have a piece of paper to confirm it. The piece of paper is the objective evidence of the transaction. When objective evidence is available estimates need not be used (232).

There are two systems of accounting: cash and accrual. The difference between the two is basically the time period in which expenses and revenues are recorded in the books. Revenues can be recorded in the period when the money was earned or in the period

when the money was actually received by the facility. Expenses can be recorded when payment was made for the items purchased or when the items purchased were used up by the facility (233).

In cash accounting, expenses are recorded when the cash is actually disbursed and revenues are recorded when the payment is actually received (233). Therefore, the cash system of accounting records the actual flow of cash out of and into the facility as they occur. Noncash expenses are not included in cash accounting systems such as depreciation and prepaid insurance. The money owed to the facility for services already provided would count as accounts receivable only after payment for the services was received (234).

The chief advantage to using the cash accounting approach is simplicity. Revenues are recorded when payment is received and expenditures are recorded when payment is made. Although using the accrual accounting approach is not as easy, the cash accounting method has several disadvantages that make it not appropriate for use in the nursing home business. For one thing, expenses and revenues for a single time period are not attributed to that same period. Thus, total costs and revenues and the real profit and loss for those periods cannot be accurately measured. Secondly, the cash

accounting system does not recognize important asset and liability values such as depreciation of capital items, debt owed to creditors by the facility, money owed to creditors by the facility, or money owed to the facility by patients for services provided. Lastly, since the cash accounting approach requires expense and revenue transactions to be recorded when they are incurred and earned, respectively, the accounting records can be easily mismanaged (234).

Nursing home professionals prefer the accrual system of accounting, because revenues are recorded when they are earned or incurred, regardless of the time the cash transactions took place (234). Expenses in the accrual accounting method are more specifically defined as a cost that is used up, or "expensed." The complexity of the accrual approach is the main disadvantage but is far outweighed by the advantages. It allows the facility to measure the revenues earned after the expenses have been paid or losses incurred. This is done by matching the revenues and expenses for each time period. The accrual system includes depreciation, accounts payable, accounts receivable, and prepaid expenses. When the accounting records include all of these transactions it provides the administrator a more accurate picture of the home's financial

position. Finally, accrual accounting is hard to tamper with because expenses and revenues are usually backed by several forms of "objective evidence" (235).

Marketing Plan

In 1977, the U.S. Supreme Court ruled it legal to advertise health services. Health care professionals, led by hospitals, spent 3.7 million dollars on television spots in 1977 and by 1983 the amount increased to $41 million. Hospitals began marketing because the occupancy rates across the U.S. continued to drop. To increase their occupancy rates, hospitals began competing for patients by distinguishing themselves from their competitors (Allen 559). In the late 1980's competition for patients among public, not-for-profit and for-profit hospitals was a new experience. By 1988 nursing homes began to feel the need to market their services. Today marketing is considered a major component of health care management (560).

Marketing is a process of planning and executing the conception, pricing, promotion, and distribution of ideas, goods, and services to create exchanges that satisfy both individual and organizational objectives (Kinnear 10). The nursing home is in the

business of marketing services. A nursing home is classified as a service because it offers a benefit (and activity) to another that is essentially intangible and does not result in the ownership of anything (Allen 574). The marketing effort is to improve the interaction between the nursing home's goals and the people whose needs the home wishes to serve (560).

In the past, the focus of health care providers has been on designing a quality hospital or nursing facility, assuming that if it is built it will become filled to capacity with patients. This is recognized as a "seller's" market thinking. Marketing health care today is becoming increasingly a "buyer's" market because consumers are more interested in looking for a facility that will best fit their needs (561).

There are six basic steps in marketing a nursing home: auditing, market segmentation, market mix, implementation, evaluation, and control. Allen describes "auditing" as the process of identifying, collecting and analyzing information about the external environment. Market segmentation uses the audit information to divide the potential residents into subgroups. Market mix is where the decision to choose what type of potential residents to seek and in

what proportions is made. Implementation is the process of managing organizational behaviors and outreach activities to attract potential residents in the proportions desired. Evaluation and control of the marketing program involves assessment of the results achieved and the ability to meet organizational goals (561).

When planning the marketing strategy deciding who the facility will serve is critical. There are a variety of different organizational goals a facility may choose from. For instance, the administrator may seek longer-term care patients or shorter-term care patients. An administrator may look for short-term rehabilitation, light care or heavy care patients, or any mixture of the three. The facility may choose to serve an entirely private-paying patient population, an entirely public-paid patient population, or any ratio of the two. The size and characteristics of markets to be served will be a major consideration in choosing a location for a nursing home (562).

Demographic data and economic information for nursing homes are needed to appropriately estimate a business' market (Starting 10). The administrator of the facility must set organizational marketing goals as to the type of patient population (market segmentation) it

wants to serve (Allen 562). Table 13 shows the total number of nursing and related care homes in the United States in 1986.

There are very many market segments in the long-term care field. The market ranges from home health care to life care communities. After estimating the market potential the entrepreneur should estimate what share of the market can be reasonably gained. One must take into account the number and size of competitors and the amount of time it will take to reach the entrepreneur's goals (Siropolis 169). Appendix B gives information about the competition in the area where this report's business will be located.

Implementing a marketing plan can best be accomplished by creating awareness among potential customers that the services exist, assisting customers in deciding to buy the service, and assuring that the customers are satisfied with the quality of services provided by the facility (King 39).

"One of the major trends in America has been the dramatic growth of services" says Kotler (574). In the mid 1980s, 47 cents out of every dollar spent by U.S. consumers was spent on services (Berkowitz 608). In the late 1980's service jobs accounted for 77% of total employment. It is expected that by 2000, the service industry

Table 13

Total Number of Nursing and Related Care Homes In 1986

Type of Facility	# of Facilities	# of Beds	# of Residents	Occupancy Rate
Nursing Homes[1]	16,388	1,507,392	1,380,777	92%
Residential[2]	9,258	201,831	172,476	90%
Hospital-Based	734	60,983	56,166	92%
All Facilities	26,380	1,770,206	1,609,419	.

[1] = SNF or ICF
[2] = RCF

SOURCE: Vogel, Ronald J., Hans C. Palmer. Long-Term Care: Perspectives From Research and Demonstrations. Washington D.C.: U.S. Department of Health and Human Services, 1983.

will be providing 90% of all new jobs (Kotler 574).

Services are classified as people-based (provided by people) or equipment-based (provided by automation or monitored by people). Nursing homes are considered people-based services since the service is provided by unskilled, skilled, and professional workers (576). The characteristics of services and their marketing implications should be considered when planning a marketing strategy. Since services are intangible, buyers look for signs of service quality. Conclusions will be drawn about quality from the place, people, equipment, communication material, and price that they see. Businesses that offer services should make the intangibles into tangibles. This can be done by the physical setting of a nursing home, the furnishings, the staff's appearance, even the home's advertising brochures (577).

Besides services being an intangible product, services are also inseparable from their providers, variable in quality, and perishable (they cannot be stored). A nursing home staff attendant is part of the service, thus having a provider-client interaction. Nursing homes are somewhat variable in the quality of the services they provide. Perishability of services in nursing homes comes when demand and supply are unbalanced. For example, nursing homes are required to

maintain a ratio of personnel to residents, however, when the home loses employees or residents, then the service can become compromised (578).

Service firms need not only the traditional marketing strategies (product, price, promotion, and place) but also internal and interactive marketing strategies. Nursing home management must effectively train and motivate its employees to work as a team to provide customer satisfaction. The nursing home that uses interactive marketing is interested in perceived service quality. Service quality depends on the service deliverer or the buyer-seller interaction (578).

According to Berkowitz, services have four characteristics which differentiate them from durable goods, they are: intangibility, inconsistency, inseparability and inventory (609). As stated earlier, services are intangible because they cannot be touched. The health care that a customer expects to be given in a facility cannot be experienced before entering it. This is why marketing services differs from marketing tangible goods (e.g. a car) because the quality of service can be inconsistent from day to day, depending on the mood of the provider. However, a nursing home can make services appear more tangible by the way they are presented (Kotler 563).

The third characteristic of marketing services is inseparability. Inseparability is where the consumer does not separate the service from the deliverer of the service or from where the service is given. Allen gave an example of how a consumer's perception of the service will have a lot to do with whether a purchase will be made. He described the case where the nursing home gave excellent nursing care, but the bathrooms were smelly and dirty. Hence, the patient's and visitor's perceptions of the facility and quality of care were negatively affected (Allen 235).

Unoccupied beds at a nursing facility are classified as "inventory" and is the fourth characteristic of service marketing. The inventory carrying costs of empty beds is high, as much as 70% of the costs of occupied beds. The nursing home should aggressively market their services to keep the occupancy rate high or else the home can quickly lose profits (Kotler 563).

The nursing facility's business is providing health services to the resident by providing the recipient with performance satisfaction not ownership. Therefore, the nursing home administrator must be aware that customers will base their purchase decisions on the perception of whether the service provided by the nursing home will

meet their needs (564).

"The company's pricing decisions are affected by many internal company factors and by external environmental factors." says Kotler (305). The internal factors such as marketing objectives, marketing mix strategy, costs, and organization for pricing must all be considered before setting the price for the product or service. The external factors affecting pricing decisions include the market and demand, the competition, and other environmental factors such as the economy, resellers, and the government (305).

Kotler suggests that before setting prices the marketer must understand the relationship between price and demand for its product. The competitors' prices and offers will affect the strategy of a company's pricing moves. The costs to operate set the floor for the product's selling price. The price must cover all of its cost for producing, distributing, and selling the product, along with a fair rate of return for the effort and risk. Whatever the price may be, pricing decisions must be coordinated with product design, distribution, and promotion decisions to form a consistent and effective marketing program (305).

The common marketing objectives of a company, in addition to

the marketing mix strategy and price, are survival, current profit maximization, market-share leadership, and product quality leadership. Survival objectives assure a business's variable and fixed costs will be covered. If residential capacity becomes too low or competition becomes too heavy, as a short-term measure, prices may be lowered. The low price pay off level must cover variable costs and some fixed costs so the business may stay solvent to survive. The lowering of prices along with other promotions can be used to attract customers and bring the facility back to full capacity (306).

Current profit maximization is where a company sets a price to maximize current profits. The objective is to estimate what demand and costs will be at different prices and then choose the price that produces the maximum current profit, cash flow, or return on investment (304).

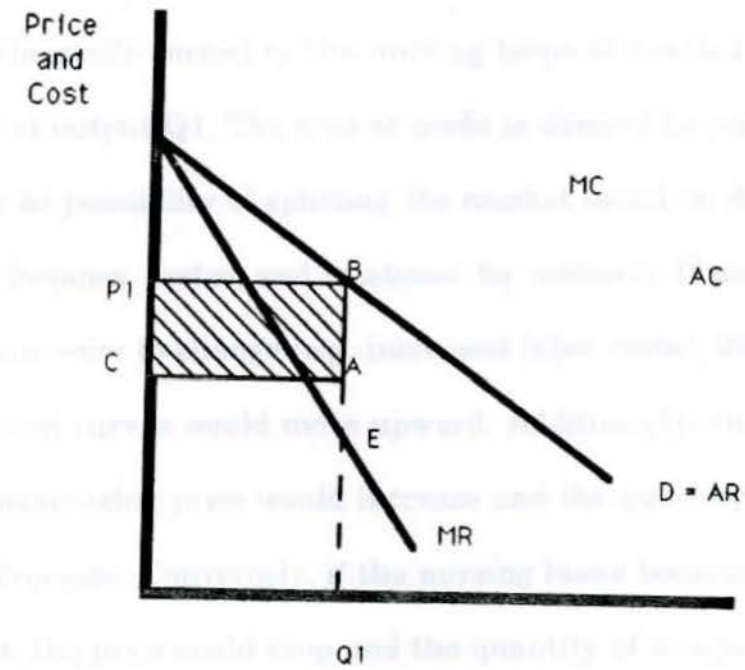
It is estimated that 70 percent of the nursing homes in the United States are profit-oriented, proprietary enterprises (538). These enterprises seek to maximize their profits and the income and wealth of their owners. An economic model of a typical nursing home shows how a nursing home can maximize its profit by matching costs with services. Vogel began the analysis with the assumption that a nursing

home is a profit-seeking imperfectly competitive firm (a market that is neither perfectly competitive nor perfectly monopolistic), offering a specific set of services to clients with similar levels of dependency. Figure 1 shows the demand and cost situation of a profit maximizing home, in the short run. In this figure, all clients in a given type of home are of the same level of disability and receive the same type of care and volume of services, in other words, the product is homogeneous (Vogel 538).

The output of the nursing home is bed days per year (Q), on the horizontal axis. The price (P), average costs (AC), marginal costs (MC), and the marginal revenue are on the vertical axis. At point E the marginal costs equal the marginal revenue. The corresponding quantity of beds would be Q1 and the price of the beds would be P1. If the home produced more bed days than Q1, then the cost of an additional bed day (marginal cost) would be greater than the additional day (marginal revenue). In this situation profit would be reduced (revenues minus costs). Since marginal cost does not equal price, the home is not economically efficient at the margin. On the other hand, if the home produced fewer than Q1 days of care, profit would be decreased. Some profit is lost because marginal revenue

FIGURE 1

Profit Maximizing Nursing Home



Symbol Key

MC : Marginal Cost
E : MC=MR
D=AR : Demand shift
Q_1 : Quantity of beds at point where MC+MR
MR : Marginal Revenue
P_1 : Price where MC=MR
Q : Bed Days
AC : Average Cost
P_1BAC : profit earning area

SOURCE: Vogel, Ronald J., Hans C. Palmer. Long-Term Care: Perspectives From Research and Demonstrations. Washington D.C.: U.S. Department of Health and Human Services, 1983.

exceeds marginal cost up to output Q1. Vogel adds that levels output other than Q1 would not necessarily produce losses, but profits would not be maximized. The nursing home may generate losses if total costs exceed total revenues but a "loss-minimizing" strategy would dictate the same MR=MC type of behavior to the owner (538).

The profit earned by the nursing home is denoted by the area P1BAC at output Q1. The area of profit is derived by assuming that there is no possibility of splitting the market based on differences in clients' incomes, tastes, and locations, for instance. If underlying conditions were to change (e.g. increased labor costs), the nursing homes' cost curves would move upward. Additionally, the profit-maximizing price would increase and the quantity of beds would decrease. Conversely, if the nursing home became more efficient, the price could drop and the quantity of occupied beds could increase. Shifts in the demand (D) and shifts in the marginal revenue curves without any changes in costs would cause similar price and quantity effects. If demand shifts upward, then P and Q would increase. If demand shifts downward then P and Q would decrease (538).

Vogel concludes that profit maximization in a nursing home

requires marginal cost and marginal revenue to be equal. The demand and cost curves are directly related to the ultimate price and quantity of occupied beds per day. They are also affected by changes in the corresponding marginal revenue and cost curves (539).

The type of market in which the nursing home operates in will have a great impact on what profit maximization program it chooses. There are basically four types of markets: pure competition, monopolistic competition, oligopolistic competition, and pure monopoly. With each market a different pricing challenge is presented. With pure competition, the market is made up of many buyers and sellers trading in a "uniform commodity." A uniform commodity, as explained by Kotler, is a product like rice, gold, or stocks. Companies in a purely competitive market sell their commodities at a market price. Sellers won't charge more than the market price because buyers can get the same product elsewhere (310).

When a market consists of many buyers and sellers who trade over a range of prices they are under monopolistic competition. The price range is possible because the seller can offer variations of the same basic product or service (310).

Under oligopolistic competition, the market has only a few sellers. The sellers in this market are different than sellers in pure and monopolistic competition markets because of pricing sensitivity and marketing strategies. Oligopolistic competitors have to be aware of each others moves since these changes can directly impact them (310).

If a market consists of only one seller, as with the government, for example, then it is operating under a pure monopoly. Some monopolies are regulated and some are not. The regulated monopolies must charge customers to get a "fair return." The unregulated monopolies can charge any price for the product or service. However, most unregulated monopolies do not always charge full price for several reasons. Kotler says that a company won't charge full price because it may want to saturate the market quickly, try not to attract new competition, or for fear of possible governmental regulation (311).

Nursing homes operate in a monopolistic competitive market. Nursing homes are varied in price, quality, features, style, and accompanying services, and therefore, buyers see these differences and will pay different prices. In the end, however, the consumers will decide whether the service is right (311).

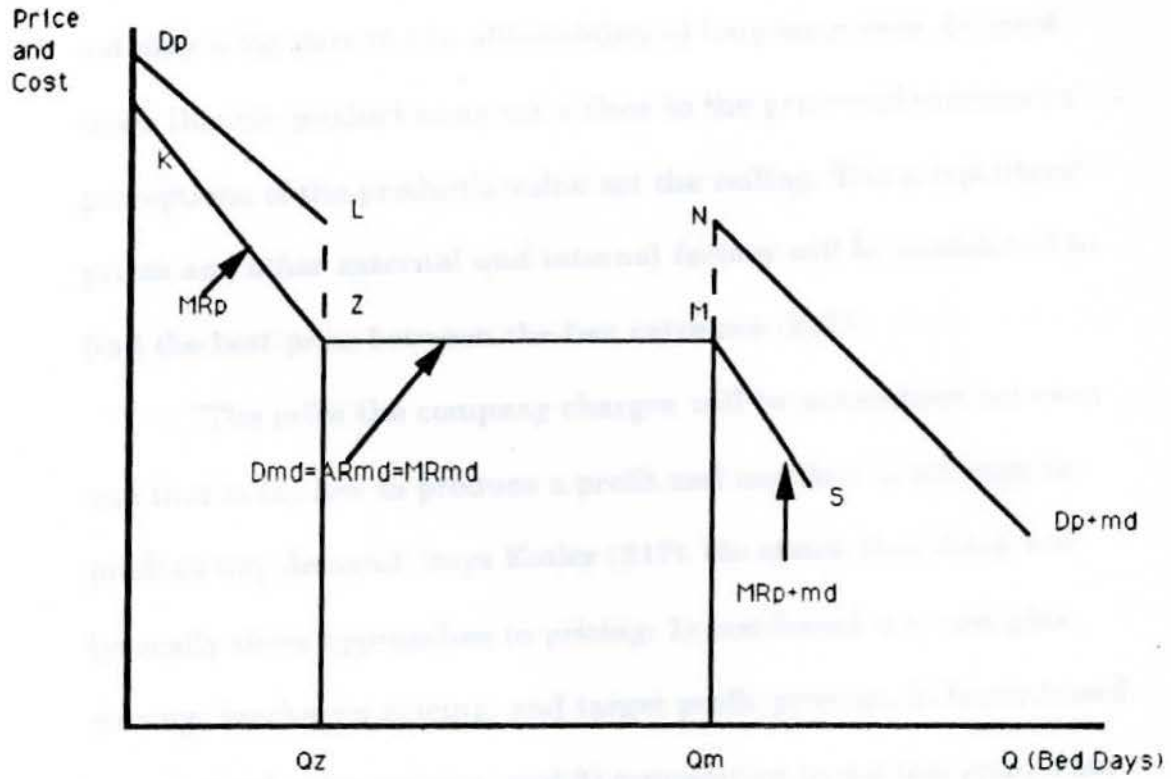
An important part of a business plan is setting the price for the product or service. When deciding on a price the price-demand relationship must be analyzed. Each price a nursing home might charge will lead to a different level of demand. The possible relationship between the price charged and the resulting demand level is shown in the RCF nursing home demand curve in Figure 2. In normal cases, the higher the price the lower the demand. The price elasticity of consumer demand must also be known when determining the pricing strategy (312).

Consumers in the nursing home market are generally slow to change demand when there is a change in price. One reason for the slow response is because most facilities operate on lease-term contracts. Usually the only time price changes are noticed is when residency contract renewals are due. At this time it is important that the increase in price is not too drastic or the demand may drop significantly. Even though the drop in contract renewals may be short-term, where new residents are able to sign on, the period of time between the two can cause a significant loss of profit (312).

Another external factor to consider when setting a price for a nursing home is the economy. Economic conditions can have a strong

FIGURE 2

A Typical Nursing Home Demand Curve With Private Pay and Medicaid Pay Clients



Symbol Key D_PLZMND_{P+MD} : Demand curve in combined market
KZMS : Marginal revenue curve
MR_P : Marginal revenue private pay market
Q : Bed days
Q_Z to Q_M : Marketing area (total # of Medicaid clients) where marginal revenue functions
$D_{MD}=AR_{MD}=MR_{MD}$: Demand and marginal revenue curve for Medicaid bed days
MR_{P+MD} : Marginal revenue private pay + Medicaid
D_{P+MD} : Demand curve of private pay and Medicare pay markets

SOURCE: Vogel, Ronald J., Hans C. Palmer. Long-Term Care: Perspectives From Research and Demonstrations. Washington D.C.: U.S. Department of Health and Human Services, 1983.

impact on the business's pricing strategy. There are several economic factors that can affect the elderly's purchasing ability, such as inflation. The government is another important external influence on pricing decisions for the nursing home industry. Federal and State aid play a big part in the affordability of long-term care. In most cases though, product costs set a floor to the price and consumers' perceptions of the product's value set the ceiling. The competitors' prices and other external and internal factors will be considered to find the best price between the two extremes (317).

"The price the company charges will be somewhere between one that is too low to produce a profit and one that is too high to produce any demand" says Kotler (317). He states that there are basically three approaches to pricing: 1) cost-based (i.e. cost plus pricing, breakeven pricing, and target profit pricing); 2) buyer-based or perceived-value pricing; and 3) competition-based (i.e. going-rate and sealed-bid pricing) (317).

Cost-plus pricing is a cost-based pricing method where a standard markup is added to the cost of the product. Cost-plus pricing is popular among construction companies and professional service businesses (e.g. doctors, lawyers, accountants) (317).

The second cost-based pricing method companies use is called breakeven pricing. Breakeven pricing is where a company determines the price at which it will break even. A helpful planning-and-control tool is the breakeven chart. The breakeven chart allows the entrepreneur to determine how many items must be sold to make a profit. The chart can also give visual answers to questions like: what will happen to the profits if only fixed costs increase by 10%; or sales volume drops off by 10% but prices, fixed costs, and variable costs stay the same; or sales volume increases 10% and variable costs rise 5% (Siropolis 370).

Not all entrepreneurs use breakeven charts. Some find the point at which the business starts making a profit by a simple calculation. The simple calculation is called breakeven analysis. Breakeven analysis is used to analyze past accounting periods and for planning future operations (Warren 724). The computation gives the breakeven point but does not provide the versatility that the breakeven chart does (Siropolis 372).

When analyzing the breakeven point, another area that should be considered is the "margin of safety." The margin of safety is the difference between the sales revenue and the sales at the breakeven

point. The margin of safety represents the possible decrease in sales revenue that may occur before an operating loss occurs. The margin of safety value can be measured in terms of dollars or as a percentage of sales. The decrease in sales percentage formula is: sales minus sales at the breakeven point divided by sales. Using the margin of safety formula helps the manager evaluate past operations and plan for future operations. If the margin of safety is low, then management must plan carefully because even a small decline in sales will result in an operating loss (Warren 735).

Target profit pricing is another cost-based pricing approach that can be used. Target profit pricing is where a company determines the price where it will make the profit goal (Siropolis 318). For buyer-based pricing or perceived-value pricing a company bases its price on the product's perceived value. The buyers' perception of value is considered when setting the price instead of the seller's cost (320).

Going-rate pricing, a competition-based approach to pricing, is when a firm bases its price mostly on others' prices. The company's own costs or demand are not considered. Going-rate pricing is popular where demand elasticity is hard to measure. The second

competition-based pricing approach, sealed-bid pricing, is used when firms bid for jobs. In sealed-bid pricing, a company bases its price on how it thinks competitors will price. The company can't set its price below a specific level, or below cost. Additionally, the company can't set the price too high or there will be a chance of loosing the contract (321).

Consumers' needs and wants change with age. Some companies offer different products or use different marketing approaches for different age and life-cycle segments. Not only is age important but also are family life-cycle and psychological life-cycle stages. People's tastes change over time as well as their family status and psychological stage in life (Allen 126).

Service and products have a life cycle marked by five stages 1) product development, 2) introduction, 3) growth, 4) maturity, and 5) decline. Product development is when a company finds and develops a new product idea. Introduction stage is when there is a period of slow stage growth as the product goes on the market. There is usually no profit during this stage because of the prior expenses. When the product is in the growth stage it is obtaining rapid market acceptance and increasing profits. Once the sales growth slows down the product

is in the maturity stage. Profits level off or drop because of increased marketing expense to ward off competitors. Decline is the period when the sales and profits drop quickly (Kotler 289).

There is an emergence of new sales strategies used by the long-term health care industry. Nursing homes are offering special services and amenities to patients. Nursing home care is transforming from a "hospital-like" setting to a "hospitality" type setting. The hotel chains entering the field of long-term care services practice "aggressive hospitality." Aggressive hospitality is a sales strategy which assures that all employees of the facility play active roles in positive patient relations (Allen 565).

Special services and amenities being made available in nursing homes are cable television, recreational activities, varying levels of accommodations, and special meal services. Some nursing homes are updating and renovating existing facilities to attract larger portions of private-pay clients. Other homes are offering different levels of care within the same facility, according to the ability and willingness of the patient to pay. There is also a trend for new facilities to be built in affluent areas of towns instead of less desirable neighborhoods because the affluent are more likely to have larger

proportions of private-paying clients (565).

When considering ethical concerns regarding sales strategies, Allen indicated that as facilities cater to the growing private-paying patient population, classes of care are emerging (565). A major study conducted by Scanlon concluded that in states with larger numbers of beds available per 1000 older persons, more than 90% of people most in need of nursing facility care were being admitted to nursing homes. In states where beds were in short supply, only half of those most in need, most of whom were Medicaid patients, were being admitted to nursing facilities. Scanlon's study showed that if there were more beds to accommodate the growing number of elderly in need, more elderly would choose long term health care (28).

Problem Statement

Based on the information given in this chapter, there seems to be a need for long-term health care for the elderly now and even more so in the future. It is also apparent that, if managed properly, a long-term health care operation can be a profitable business venture. After researching the various aspects involved with starting a long-term health care operation, an actual business plan can be

developed. In this report, a business plan for a residential care facility (Appendix C), includes all of the necessary components discussed in this chapter.

Chapter III

METHODS AND EVALUATION

The methods by which the proposed project, a business plan for a long term health care facility, (Appendix C), will be prepared and evaluated are discussed under the section headings of subjects, instruments, materials, and procedures. In the subjects section, the evaluators of the project are described. In the instrument section, the instrument used to evaluate the project is described.

In the materials section, a complete description of the project is given. Lastly, in the procedure section, the methods of evaluation are explained.

Subjects

There are three project subjects, or evaluators. The first evaluator, John Elsuffer, is a retired businessman, currently employed by the U.S. Small Business Association's Score Chapter servicing Missouri's St. Charles, Lincoln, and Warren counties. Elsuffer has been a chairman of this Chapter for one year. The major

responsibilities in this position are to lead all activities of Score Chapter #443. The job's duties include developing small business seminars, teaching business planning, and providing counsel to small business clients. Prior to Score, Elsuffer was an owner and manager of three small businesses. He wrote business plans which were used to acquire capital ranging from $ 150,000 to $ 500,000.

An SBA representative was selected because of the experience in business plan evaluations, consultations, and financial advice.

The second evaluator, Ralph Wehrmann, Ph.D., is employed at the University of Missouri Extension Center, in Clayton, Missouri. Wehrmann is a business specialist who, for the last 20 years, arranges and presents educational conferences concerned with most aspects of business. Wehrmann specializes in small business planning and also provides individual counseling. Previous to the University position, he had 30 years of experience in private business.

A business specialist was chosen for expertise in starting a new business in Missouri. The specialist will be able to understand the business planning process, and review the plan for organization, administrative and legal aspects.

The third evaluator, Dick Ford, has been the Director of

Community Relations at Parkside Meadows, Incorporated, for the last 15 years. Parkside Meadows is a residential care facility II (RCF II) in St. Charles, Missouri. Ford's major job responsibilities include marketing the apartment units, and acting as a liaison between Parkside Meadows, state and federal government agencies, and related political lobbyists. He also participates in programming activities for residents, serving as a public relations representative for the facility, and acts as a resource person to the facility's board of directors regarding issues in law, lobbying, policies and procedures, budgeting, and long-range planning.

Ford's previous experience, in relation to reviewing the business plan for Woodbine Retirement Home, includes social and recreational activities for older adults, licensed nursing home administrator, familiarity in compliance with affirmative action, OBRA, (Omnibus Budget Reconciliation Act), and OSHA, (Occupational Safety and Health Administration), resource person to MHCA, (Missouri Health Care Association), concerning legislation affairs effecting nursing home regulation, and planning two building expansions (apartment and RCF II).

A current long-term health care employee was chosen as an

evaluator because this person should be able to advise on current practices in the health care industry. The State laws and regulations required to run a long-term care facility are extensive and confusing. This evaluator will be able to identify discrepancies or inadequacies the plan may have in relation to these laws. A long-term health care facility employee will also know the daily routine that is involved with running this type of business.

Instrument

The instrument used to evaluate the business plan will be a questionnaire, (Appendix D). The questionnaire, like the business plan, is divided into six categories, 1) description of the business; 2) the market; 3) the competitors; 4) business location; 5) management; and 6) application and expected effect of funds.

The questions asked in each section will help identify where the business plan's strengths and weaknesses may lie. At the end of the questionnaire there is a section for the evaluators to add their own comments. The individual's comments should not only help the prospective entrepreneur improve the business plan, but should also help in the decision of whether go into business at all.

Materials

The materials in the proposed project include the actual business plan and the evaluators' questionnaire. The format for the business plan is provided by the University of Missouri and Lincoln University. The SBA recommends using this format for small business owners in Missouri. The business plan includes a description of the business, a marketing analysis, a competition analysis, the business location analysis, management analysis, and the application for finances and expected effects of funds.

Through evaluation of the materials section of the project, an evaluator will be able to assess whether the proposed business plan is thorough and sound. One will also be able to indicate whether they feel the prospective owner has a sufficient amount of education and experience to operate this type of business.

While reviewing the business plan, the evaluators will be asking themselves questions such as: 1) is there a need for this type of business, 2) is this a good location, 3) will the business be profitable under the proposed plan 4) are the goals obtainable, and 5) are the personnel needs sufficiently addressed?

Procedures

The methods of evaluation, as discussed earlier, include a questionnaire completed by three experienced business evaluators. The questionnaire will be mailed to each subject. The cover page to the questionnaire gives instructions on how to complete the questionnaire. The instructions include a brief explanation as to why the proposed project was written and why they were selected to evaluate it. A telephone number will be given in case there may be questions. A request for comments concerning the business plan itself will also be made to help improve the project's chance for success.

The cover page also indicates clearly that all items in the questionnaire must be answered for the project to be adequately reviewed and analyzed. If there are any unanswered items or if additional comments are added to the business plan or questionnaire that are unclear, the author of the business plan will contact the evaluator so the information can be addressed appropriately.

The business plan and the questionnaire will also be accompanied by a self-addressed stamped envelope for easy return of the project evaluation response. If a response has not arrived within

three days past the deadline, a phone interview will be conducted. If for some reason the pre-selected subject cannot or decides against participating in the project evaluation, another subject with similar credentials will be selected. The substitute subject will be treated in the same way the previous subjects were. Complete details concerning the substitution of a subject, if necessary, will be given in Chapter IV.

Once the business plan (with evaluator comments) and the questionnaire are returned, both will be reviewed by the author for clarity and completeness. If questions arise from the author's review, the subject(s) will be contacted by telephone to resolve the issue. After a resolution has been attained, the results will be compiled and summarized in Chapter IV of this report. The comments and suggestions about the project, which each subject may have added to the business plan and to the appropriate sections of the questionnaire, will be interpreted and discussed in Chapter V.

Chapter IV

RESULTS

Evaluation of the business plan for a retirement facility, (RCFI), Appendix C, was conducted. Three evaluators were chosen based on their experience and education. The evaluators were asked to review the business plan and answer the accompanying questionnaire, Appendix D. Additionally, each evaluator was asked to add any comments about the plan that may help strengthen the business's chance for success.

The results and comments from the business plan review and evaluation are presented in this chapter.

Questionnaire Results

Results of the questionnaire for business plan evaluation will be presented in six different categories, 1) description of business, 2) the market, 3) competition, 4) business location, 5) management, and 6) application and expected effect of funds (finance).

Description of Business

Elsuffer, Wehrmann, and Ford felt that the decision to incorporate Woodbine was sound. Ford recommended more detailed data be gathered and that an adequate familiarity with regulations would be helpful to give the owner's presumptions more credibility. Elsuffer and Wehrmann felt that the plans for additional consultant needs were adequate. Ford answered "no" and recommended an administrator-in-training course certified by the University of Missouri, as well as licensure for the owner/administrator, with continued on-going education.

All evaluators felt that the plan had a sufficient number of employees to start the business, however, Elsuffer stated that a full-time bookkeeper may be needed. Ford commented that without knowledge of nursing personnel turnover the owner/operator may "plug in finances for one to two more people."

Elsuffer rated the "description of the business" portion of the plan, in support of the total plan's chance for success, as "good." Wehrmann rated it as "very good." Ford rated it as "fair."

The Market

Elsuffer did not feel qualified to state whether or not there was a market in the O'Fallon area for a retirement facility. Nor did he feel qualified to remark if he felt Woodbine would fill a niche not yet filled in the O'Fallon area. However, Elsuffer did rate the "market" category of the business plan as "good."

Wehrmann stated that he did not have sufficient information to make a judgment as to the market for a retirement facility in O'Fallon.

Ford believed that there is a market in the O'Fallon area for Woodbine but the data in the business plan does not fully support the owner's assumptions. He claimed that the target market was more likely to be in the 80 plus age range. He added that he felt a very small majority of the 65-79 year age group would be interested. Ford did not think that this business will fill a niche not yet filled in the O'Fallon area because other RCF I's provide the same services as Woodbine would.

Overall, Ford rated the "market" portion of the plan in support of the total plan's chance for success as "fair." He commented that the

high quality care should not only include room, board, and security, but also recognition to provide services that will afford residents to maintain and even improve their psychological, physical, social, and spiritual well-being.

The Competition

Elsuffer did not feel qualified to answer the questions whether the price for residency in Woodbine was too high, reasonable, or too low. Nor did he feel qualified to remark if he felt Woodbine would be able to successfully compete with other facilities in O'Fallon and nearby. However, Elsuffer did rate the "competition" category of the business plan as "very good."

Wehrmann felt that the price for residency was reasonably competitive. He also felt Woodbine would be able to successfully compete. Wehrmann rated the "competition" portion of the business plan as "good."

Ford suggested not to set pricing on a yearly basis because in future economic times an unanticipated increase due to change in regulatory requirements, utility costs, wages, or supplies, may occur.

Ford stated that the monthly price for residency in Woodbine

seemed reasonable but commented that it may not be realistic. He suggested that more data is necessary to qualify the business plan's assumptions on revenues and expenses when judging whether or not Woodbine would be able to successfully compete with other facilities in the O'Fallon area.

To add to the intimacy of the home's atmosphere, Ford suggested to make the home architecturally warm, allow the residents to decorate their own units and use some of their own furniture, and allow staff to dress in street clothes for a non-institutional effect. Ford further warned that when analyzing the competition's strengths and weaknesses, formal business backgrounds may not be as important as years of experience. Additionally, word-of-mouth advertising is a rather formidable competition.

Overall, Ford rated the "competition" portion of the plan as "fair."

The Business Location

Elsuffer did not feel qualified to answer the questions about the location for Woodbine but rated the "business location" category of the business plan as "good." Additionally, Elsuffer commented that the plan to locate the facility walking distance from the downtown area of O'Fallon was a "very good specification."

Wehrmann felt that the location for the business was good and that the location should serve its customers conveniently. He did suggest that prior to purchasing any property to be sure there will be no zoning problems. Wehrmann rated the "business location" portion of the plan, in support of the total plan's chance for success, as "good."

Ford stated that although the exact location in O'Fallon was not given, O'Fallon is a fine community of choice. Ford suggested information about acreage, square footage of living space, ratio of parking spaces to residents, staff and visitors needs to be added to the business plan. He also suggested to get two or three estimates from contractors when renovating or remodeling the facility. "Location is very important, for instance, should the business be in

the heart of a high traffic volume area, near a park, medical facilities, shopping centers, doctors, ambulances, or fire departments?" asked Ford, rhetorically. Ford suggested that a couple of locations should be chosen and obtain quotes from the sellers of the property before deciding on one.

When discussing services, Ford suggested that the plan also include transportation for shopping, doctor visits, field trips, dining out, senior center, and trips the facility will provide. Ford rated the "business location" portion of the business plan as "poor."

The Management

Elsuffer did not feel qualified to answer the questions about the management plans for Woodbine but rated the "management" category of the business plan as "very good" based on "clear objective thinking."

Wehrmann answered "yes" to the question about whether he felt the owner had sufficient educational experience to operate Woodbine successfully. He also felt that the owner had the ability to manage a retirement facility using the amount of time planned per week. Wehrmann felt the skill level for the employees was sufficient

for Woodbine. Overall, Wehrmann rated the "management" portion of the business plan as "good."

Ford felt that the owner does not have enough education in geriatric care or nursing home care. He commented that nursing homes are highly regulated and the liability is great to the owner, administrator and staff. "It's imperative that on-going education be guaranteed to providers of care (i.e. administrator and staff) for the facility to reduce its liability and continue to operate in the future," he advised. Ford felt that if the owner attains education in health care administration and geriatric care, then the owner would have the ability to manage this type of business effectively. He also suggested that the level of skill planned for the employees of Woodbine should include use of CMT's, (certified medical technicians), and CNA's, (certified nurses aides). Although CMT's and CNA's are beneficial and cost efficient in nursing home care, on-going training will be necessary.

Ford suggested to add to the plan the prospective owner's past experience that related to elderly care, relationships with supervisors, peers and others. He also suggested that the owner's personal philosophy in operating this type of business should be at the top of

the business plan. To improve the owner's chance of success in the residential care facility, Ford suggested to not only enroll in continuing education but to conduct personal research by reading industry materials, and conversing with the Division of Aging staff and fellow health care providers.

When discussing related work experience, Ford advised that the owner should give a more detailed list of previous job duties, the length of time spent in those jobs, professional enhancement course titles and even grade point averages (if above 3.5) when discussing managerial experience. Ford rated the "management" portion of the business plan as "poor."

The Application and Expected Effect of Funds

Elsuffer felt that this section of the business plan needed more work, specifically, a three-year pro forma cash flow statement, a start-up section from "funds acquisition to doors open," and a more detailed capital equipment list. Overall, Elsuffer rated the "financial" portion of the business plan as "fair."

Wehrmann felt that the business plan's building renovation costs may be higher than anticipated. However, the pro forma income statement was accurate for planning this type business. Wehrmann rated the "financial" portion of the business plan as "good."

Ford believed that more data is necessary to qualify the business plan's assumptions for start-up funds. He suggested obtaining operation reports or studies done by the Division of Aging on neighboring facilities may be helpful. Ford felt that the pro forma income statement was not accurate for planning Woodbine. He rated the "financial" portion of the business plan as "poor."

Evaluator Review Comments

Overall, Elsuffer commented that the business plan was a good draft. The required data seemed to have been researched and fairly evaluated. He also thought a "hard-hitting concise expository statement to capture the attention of the lender/investor" would be helpful. Additionally, Elsuffer thought the whole business plan should be expository in format, instead of the "question and answer" format suggested by the University of Missouri Extension Center in Business.

Wehrmann did not have additional comments for the business plan. Ford stated that the format of the business plan was good. The plan, however, does not qualify any assumptions made or figures attained. He wondered how the figures compared with other facility revenues and expenses and their resident to staff ratios, for example.

Ford instructed that anticipated expenses should be thoughtful and qualified. "How has the competition increased in cost?" he asked. More importantly, "what made those increases necessary, wages, benefits, regulation, profit margin, and/or taxes?" He advised that the prospective owner qualify assumptions with facts from the past and if

possible, with competition.

Although the plan is aimed at RCFI facility operation, Ford claimed there are other services that will effect the business's target market, namely home health services and retirement apartments. If more apartments are constructed and home health services are provided in the O'Fallon area, it will directly affect occupancy. He suggested that this possibility be addressed, to some degree, in the business plan.

Care for the geriatric is changing by leaps and bounds. Ford cautioned to not let the "niche" of today stymie long-range plans for tomorrow.

Chapter V

DISCUSSION

The results, as presented in Chapter IV, were from a business plan evaluation made by three qualified business people. Each evaluator reviewed the business plan and then completed a questionnaire. The questionnaire was provided to uncover weaknesses in the business plan. Each evaluator completed the questionnaire and, in some cases, added suggestions to further strengthen the business plan.

The business plan was divided into six areas of importance, 1) description of the business, 2) market, 3) competition, 4) location, 5) management, and 6) application and expected effect of funds. In almost all of the categories an evaluation was made. The discussion of the evaluation results will be presented by category.

Description of the Business

When writing a business plan, Elsuffer suggested using a prose approach. When a business plan is written in prose, instead of question and answer, he thought the plan would be easier to read

and have a stronger impact. However, Wehrmann and Ford both thought the plan format was fine. The business plan format will remain as is.

Ford recommended that the prospective owner take additional courses in health care before starting the retirement care facility. The business plan did call for at least one course, so two more courses (administrator-in-training and regulatory compliance) were added. The plan will also include a statement that the owner will conduct personal research in retirement care operations by reading industry materials, and interacting with governmental agencies and fellow health care providers, as recommended by Ford.

Elsuffer thought that a full-time bookkeeper should be added to the plan, but as explained, the prospective owner will provide this service. As Ford suggested, two more people were added to the staff as a buffer in case of unexpected personnel turnover.

The Market

The marketing section of the business plan will have additional information as suggested by Ford. First, there will be the acknowledgement of other types of competition (but not to the degree

as with the discussion on RCFs) such as home health care, and retirement apartments. This information will be included to point out that if more of these type of services are provided in the O'Fallon area, the occupancy at Woodbine may be directly affected. Second, the business plan target market will be changed to the "80 plus age range," since Ford explained that a small majority of the 65-79 year age group would be interested in this type of facility.

Third, the plan will also include, in the "services offered" discussion, a recognition to provide services that will afford residents to maintain and even improve their psychological, physical, social, and spiritual well-being. Additionally, the plan will state that residents may bring certain items from home to furnish their rooms. The plan will include, under the advise of Ford, provisions for the transportation of residents for shopping, doctor visits, field trips, dining out, senior center, and others. Finally, to add to the "noninstitutional" effect there will not be a uniform dress code for the staff.

The Competition

As Ford suggested, the once-per-year pricing schedule will be

removed from the plan. No schedule will be stated because there may be unanticipated cost increases which may directly affect pricing of services. If a there is a price increase, residents will be notified 30 days prior to the increase.

To satisfy Ford's recommendation that a comparison of Woodbine's revenues and expenses to its competitors is needed, the revenue and expense industry standards for tables used in Chapter II will be added to the business plan. The competition would not release their financial records for the study so their data were not included.

The Location

When discussing the location, the acreage, square footage of living space, and parking spaces needed will be added to the business plan, as recommended by Ford. The estimates needed for building renovation or remodeling will be increased to at least three within the plan. Additionally, when selecting a location for the facility, at least two sites will be chosen and quotes obtained, before deciding on one.

The Management

In the business plan, the skill level for nurses aides will be specified to state they must be either a certified medical technician or a certified nurses aide. The past experience in elderly care, relationships with supervisors, peers and others will be included in the business plan for the prospective owner qualifications. The owner's personal philosophy in operating a retirement facility will be rearranged so that it is included at the beginning of the plan, instead of the middle.

Ford's suggestion about giving a more detailed list of previous job duties, length of time spent in the jobs, titles of the courses completed in professional enhancement, and managerial course work grade point averages (if available) will now be included in the management section of the business plan.

The Application and Expected Effect of Funds

A three-year pro forma cash flow statement, and a more detailed start-up budget (including a capital equipment list) was added to the financial section of the business plan as suggested by

Elsuffer. The Division of Aging would not release operation reports for compilation of data in the financial section of the plan, however, the data in the pro forma income statement was obtained from studies conducted by the agency. No further adjustments were made to this section of the plan.

Summary

Starting a new retirement care facility in O'Fallon, Missouri in 1993 can be accomplished, according to three business plan evaluators. With the addition and changes recommended by the evaluators the business plan contains all of the necessary components to show whether the business has a chance for success. Since some of the suggestions will add cost to the operating budget, it was revised. Alternatives may be needed if, once in operation, the returns are not attractive.

The prospective owner has sufficient qualifications to manage the retirement facility, but additional training in health care administration and operations is needed prior to opening the facility. Continuous education in the health care field will also be required to give the owner the edge needed in this ever-changing industry.

A facility's location can sometimes make or break the business. Once the exact location for Woodbine is selected, more information about the location should be added to the plan. For example, information about living space estimates, parking availability, shipping and receiving accessibility, and distance to other services (e.g. hospitals, doctor offices, entertainment) is important to the client and to the success of the business.

There seems to be a market for a retirement facility in the O'Fallon area, now and in the future. The profitability of the business will depend a lot on occupancy, service costs, employee turnover, and competition. If the owner is highly cost-effective, has a quality reputation, and treats employees well, the business should have a very good chance of surviving and turning a profit.

Limitations

The problems encountered when completing the expository project were mainly found in obtaining financial and operational data from local retirement health care facilities. The health care industry is becoming increasingly competitive, and therefore, local competitors were not willing to give out information about their operation, except

pricing. The State of Missouri's Division of Aging, however, conducts a periodic study that reports various health care financial and operational data. Therefore, cumulative data was located to help support this project's conclusions.

Suggestions for Future Research

As a suggestion for future research, more evaluators in the health care business would have been beneficial. The retirement care facility is a very specialized business. People in other types of businesses, such as retail, may not fully understand all of the requirements involved with operating a health care facility. If the business plan lacks the specific needs in this type of business, the chance for success may be severely impaired.

APPENDIX A

INDUSTRIAL STANDARDS FOR NURSING, CONVALESCENT, AND REST HOMES

	0 - 500M	500M - 2MM
ASSETS	%	%
Cash and Equivalents	14.9	9.2
Trade receivables - (net)	31.2	22.9
Inventory	1.0	1.1
All other current assets	2.9	3.1
Total current assets	50.0	36.2
Fixed assets (net)	38.9	50.5
Intangibles (net)	1.6	2.4
All other non-current	9.5	10.9
Total Assets	100.0	100.0
LIABILITIES		
Notes payable short term	11.5	7.8
Current Mat. L/T/D	4.3	4.9
Trade payables	11.8	9.2
Income taxes payable	1.9	0.8
All other current liabilities	21.2	14.4
Total current liabilities	50.8	37.1
Long term debt	18.7	36.7
Deferred taxes	0.0	0.2
All other non-current	3.7	3.8
Net worth	26.7	22.3
Total liabilities and net worth	100.0	100.0

APPENDIX A

INDUSTRIAL STANDARDS FOR NURSING, CONVALESCENT, AND REST HOMES (Continued)

	0 - 500M	500M - 2MM
INCOME DATA	%	%
Net sales	100.0	100.0
Gross profit	.	.
Operating expenses	95.2	94.5
Operating profit	4.8	5.5
All other expenses (net)	0.8	3.2
Profit before taxes	4.1	2.2
	0 - 500M	500M - 2MM
RATIOS	%	%
Current	1.11	.1
Quick	1.5	1.4
Sales/recievables	35.2	14.1
Cost of sales/inventory	.	.
Cost of sales/payables	.	.
Sales/working capital	136.2	122.1
EBIT/interest	4.2	2.6
Net profit and deprec., dep., amort/cur.mat. L/T/D	4.6	3.4
Fixed/worth	4.1	7.8
Debt/worth	19.8	9.9
% profit before taxes/tangible net worth	40.7	31.0
% profit before taxes/total assets	11.1	5.3
Sales/net fixed assets	21.5	6.5
Sales/total assets	4.3	2.0
% depr.,dep.,amort/sales	2.0	3.2
% officers' comp/sales	11.5	7.3
Net sales ($)	117,683M	388,429M
Total Sales ($)	29,373M	186,317M

Number of Statements for "0 - 500M" = 111; "500M - 2MM" = 16.

SOURCE: Morris, Robert. 1990 Industrial Standards. Robert Morris Associates: 1991:664-5.

APPENDIX B

NURSING HOMES IN O'FALLON AND SURROUNDING AREAS

Beds	Type	Name of Facility	Location	Organized
11	RCF I	The Stress Farm	Foristell	Corp
30	ICF	Four Season	Moscow Mills	Corp
46	RCF II	Twin Oaks Estate	O'Fallon	Corp
15	RCF I	The Pathway Program*	O'Fallon	Corp
125	SNF	Charlevoix	St. Charles	Corp
17	RCF II	Charlevoix	St. Charles	Corp
180	SNF	Claywest House	St. Charles	Prtr
21	ICF	Colonial Rest	St.Charles	Prop
22	RCF I	Harvestor Rest	St. Charles	Prop
10	ICF	Jefferson Street	St. Charles	Prop
6	RCF I	L.T.C. Boarding	St. Charles	Prop
30	RCF II	Parkside Meadows*	St. Charles	Prop
120	SNF	St. Charles Health Care	St. Charles	Corp
103	ICF	St. Joseph's Home*	St. Charles	Corp
100	RCF II	Camelot RCF	St. Peters	Corp
102	ICF	St. Peters Manor Care	St. Peters	Corp
27	RCF I	Wimer Boarding Home	St. Charles	Corp
17	RCF I	M&M Rest Home	Troy	Prop
120	SNF	Medicalodge of Troy	Troy	Corp
19	RCF I	Pink Home of Angels	Troy	Prop
19	RCF II	Troy House	Troy	Corp
120	SNF	Fellowship	Warrenton	Corp
75	ICF	Katie Jane Memorial	Warrenton	Prop
34	RCF I	West Boarding Home	Warrenton	Prop
196	SNF	Wentzville Park	Wentzville	Corp

* = Not for profit; Corp= Incorporated; Prtr = Partnership; Prop = Proprietorship

SOURCE: Licensed Skilled Nursing, Intermediate Care, Residential Care II and Residential Care I Facilities In Missouri. Jefferson City: 1987: 118.

APPENDIX C

A BUSINESS PLAN FOR A LONG-TERM HEALTH CARE FACILITY

I. DESCRIPTION OF THE BUSINESS

1. Type of business? Service

2. Status of the business? A start-up business

3. The business form? The residential care facility will be named "Woodbine Residential Home." Woodbine will be organized as a for-profit standard C corporation, and comply with the State of Missouri's Long-Term Care Facility Regulations and Licensure Law as a "Residential Care Facility I."

4. Why is the business going to be profitable? There is a need for this type of service in O'Fallon and the surrounding areas. The marketing research evaluations have indicated a real need for this service. The home will be properly positioned against competition so it will return a profit.

5. Why are you going to be successful in this venture? Long-term health care is a business that is increasingly in demand and has the potential for profitability. Although I have not worked directly in a residential health care operation, I feel I have the necessary skills to manage this type of business. Moreover, my motivation, organization, and ability to work well with others will enable me to successfully own and operate the residential home.

6. When will the business open? 1993

7. What hours of the day and days of the week will the business be

in operation? 7 days a week, 24 hours a day

II. THE MARKET

1. Who is the market? The RCF will serve 12 residents who are over the age of 55, ambulatory, and in generally good health. Both men and women will be allowed to reside at Woodbine. The target market for the facility, however, will be those who are 80 years old and over.

2. What is the present size of the market? In St. Charles County, where O'Fallon is located, there were 13,559 people over 65 in 1988.

3. What percent of the market will the business be able to capture? Approximately 0.5%

4. Is this market growing or declining? What will it do in the future? The market is growing. It is expected to increase by 20-40% by the year 2025.

5. Will the business's share grow or decline as the market grows? The initial business should reach and maintain a level of full occupancy but the business share will have the ability to grow if another branch is open or if more rooms are added. The share of the business may decrease if additional businesses open in the O'Fallon area, such as home health care or retirement apartments.

6. How will the business satisfy its market? What is the business's strategy? The business will satisfy its market by providing room, board and 24-hour security for older adults who do not want to live alone or have the burden of maintaining their own home.Woodbine will provide services that allow residents to maintain and improve their psychological, physical, social, and spiritual well-being. Transportation will be provided to residents for shopping, doctor visits, field trips, dining out senior center, and others. The business's strategy is to promote high quality

care, in a small town environment, at affordable and competitive prices.

7. How will the product be priced to make a profit and be competitive? The types of costs Woodbine will expect to incur in the first three years of operation (not including start-up costs) are in Attachment 1. At best, the price for residency at Woodbine should cover the total costs at any given level of capacity, however, this may not be the case for several years of operation.

   As shown in Attachment 2, Woodbine must remain at 75% capacity (9 residents) to break even. Calculations given in Attachment 2 were only for the first year of operation since this year is assumed to be the worse case for profitability. The amount of revenue needed to break even was calculated by dividing fixed costs ($106,751) by the gross profit margin (55%). To calculate the gross profit margin, the operating profit ($143,649) is divided by the revenue ($259,200). The margin of safety is 25%, calculated by subtracting the break even point revenue from revenue and dividing the difference by revenue.

   The owner will set the prices according to costs. Residents will be notified 30 days prior to a price increase. When setting the price, the consumer's perception of price must be considered.

   The image of Woodbine, "provider of secure, quality care" will be supported by the price. The benefits the residents received from living in a boarding home must be in line with their values. If the consumer perceives the price is greater than the product's value, the consumer may not buy the product.

   The price will be buyer-oriented, since the price is considered along with the other marketing mix variables before the marketing program is set. The general pricing approach that will be used is target profit pricing. The price at which the company will make the profit goal will be determined. The target price will be set to eventually achieve a profit margin on sales of 20% (net income/sales).

The image Woodbine would like to convey to potential residents is that of a residential care facility that provides security, high quality care, a home-like atmosphere, and is reasonably priced. The residents can feel comfortable, secure, and cared for. They can be assured that their basic needs will at all times be met. The residents will be able to bring cetain items from home to furnish their rooms. The staff will not wear uniforms to give a noninstitutional feel at the home.

Many times relatives or close friends help the buyer choose a long-term care facility and for those people the image will be "a home that loved ones can feel good about." Residential fees for those living in the home will be billed on a monthly basis. The fees are competitive as shown in Attachment 3.

To reduce the chance for bad debts, each potential resident will be screened prior to admission into the home. The client will be asked to complete an application for credit history (Attachment 7), agree to a personal interview (Attachment 8), read and sign the residential admission agreement (Attachment 9), the resident's rights statement (Attachment 10), and the facility policy (Attachment 11). The client will also be asked to submit a letter of recommendation from a licensed geriatric physician.

Once a client has been approved they must sign a one year lease and pay a one month deposit (plus first month's fee) before moving in.

III. COMPETITION

1. Who are the five nearest competitors? Twin Oaks and Caregivers Inn in O'Fallon; West Boarding Home in Warrenton, Camelot in St. Peters; and Diane's Home Care in St. Charles.
2. How will this operation be better than theirs? The service provides an atmosphere that is more intimate and home-like than the competitors.

3. How are their businesses doing? All are doing well and some of the facilities have added additional beds. Currently none of the facilities have waiting lists for occupancy.

4. How are their operations similar/dissimilar to this operation? They are similar in that they offer the same basic services as this business will, however, their facilities are much larger than this one.

5. What are their strengths and weaknesses? Because they have larger operations they have the ability to reduce their variable expenses when purchasing in large quantities. Their employee staff is larger. They are well established and people in the area know them and their good reputation. They are operated by people who are knowledgable about the nursing care business.

   One of the weaknesses is that most of the competitor's facilities are older (except for the new additions) and the costs of renovating or updating are high. They do not market their services heavily but instead put more reliance on word-of-mouth advertising. Some of the competitors' owners do not have formal business backgrounds so in these cases they may not be as thrifty when it comes to reducing costs and wastes.

   Another weakness is because their homes are larger than Woodbine, they loose some of that home-like atmosphere.

6. What can be learned from watching their operations? How to fulfill the needs of older people; what do people expect in terms of services; why occupancy rates are where they are; how to treat residents (and how not to treat residents) in a nursing home environment.

7. How will the competitors react to this business's plans? They will probably welcome the new business since the market is far from saturated.

IV. BUSINESS LOCATION

1. What is the business address? The location of Woodbine will be in a residential-type home walking distance from downtown O'Fallon. The residents and visitors will have easy access to the home, however, resident parking will be limited. Expansion of the business, as a long-term goal, will be focused on opening another residential care facility (a branch). The company's short-term goal will be expansions within the home, such as adding a recreational room to the house.

2. What are the physical features of the building? The location is planned for a residential area. It must be large enough to house 12 people comfortably and comply with governmental regulations (square footage of living space). It must have adequate storage space for supplies. It must have adequate parking for employees, visitors, and residents. It must have adequate grounds for outside entertainment (e.g. gardening, visiting, walking). The acreage of the location must be large enough for future expansions. It must be walking distance from downtown O'Fallon for residents who do not have a car or want to exercise.

3. Is the building leased or owned? The plan is to own the building and property. At least two sites will be chosen and quotes obtained before deciding on the location for the home.

4. Are renovations needed? The bedrooms will need to be a specific size, with emergency call systems installed. There will need to be an adequate number of bathrooms (with emergency call systems installed) to accomodate the number of residents. Safety equipment will be installed throughout the home (e.g. lights, alarms, handrails). The home will probably need remodeling (e.g. painting, carpeting, bathrooms, walls moved). Since many of these procedures can be done by the owner, the total expected costs of renovations/remodeling is planned at $20,000. At least three estimates will be obtained before purchasing supplies or hiring help.

5. What is the neighborhood like? Does the zoning permit this kind of business? Is the neighborhood changing? The exact location has not been chosen yet, but in O'Fallon a zoning permit is needed (cost $300 and a one month waiting period) for a residential area business. A permit from the neighborhood of choice (no cost) may be needed. The City of O'Fallon is proactive in renovating existing uildings rather than demolishing and building new ones, so welcoming this business into O'Fallon is expected. The neighborhood is changing by improving existing homes and attracting family-type residents.

6. What type of businesses are in the area? Is the mix changing? There are many service and retail-oriented businesses in O'Fallon. There are several fast-food chain resurants, as well as full service resturants. There is a large shopping mall seven miles east of O'Fallon (Mid Rivers Mall) and a medium-sized shopping mall 8 miles west of O'Fallon (Belz Factory Outlet Mall). There are also several manufacturing companies in and around O'Fallon. There are hospitals and medical centers nearby. The town is growing, mainly in residential areas, but more businesses are also coming into the area, hence the business mix is slowly changing.

7. What are the characteristics of other areas you have considered? Wentzville and St. Peters were also considered as a location for the business for most of the same reasons O'Fallon was. However, Wentzville is not as large and doesn't have near as many businesses or conveniences as O'Fallon or St. Peters has. St. Peters is similar to O'Fallon in the growth pattern, but the cost of starting a business in St. Peters would be marginally higher. Additionally, there is more competition within St. Peters than there is in O'Fallon.

8. Why is this the right building and location for you? Will you need to change in the future? O'Fallon, Missouri has been chosen as the location for three reasons. First, there are not many RCF facilities in or nearby O'Fallon. Second, the elderly population in the area is disproportunately large compared to the amount of

long-term care facilities available. Third, the potential owner lives in O'Fallon and wants to support the small town's economic growth and development by opening the business within the city limits. Moreover, the convenience of O'Fallon as the location is good. It is close to two interstate highways, several full service hospitals, medical centers, senior citizen activity centers, and is less than an hour from downtown St. Louis.

9. How does this location affect your operating costs? The operating costs should not be affected since the home is close to suppliers, services, and entertainment. Taxes should be relatively low since the home will be located in a residential area within O'Fallon. The costs of renovations in the home should be lower than building a new home, since most can be done by the owner.

10. Do customers need and have ready access to your location? Residents will need access to the home and this is accomplished by utilizing a large driveway and by parking on the street. There will also be a limited amount of space for carport parking.

11. Are you well situated to receive inventory shipments? The home should be well situated to receive inventory shipments since it will be located on a residential street. However, no large trucks will be permited to travel on residential streets. This should not be a problem because most inventories utilized by the home will come in relatively small packages.

V. MANAGEMENT

A. Personal History of Principles

1. What is your business background? While growing up, I had the opportunity to work in two of my family's businesses: a gas station and an automobile dealership. These jobs provided me with useful knowledge and experience about what it takes to run a business. See attachment 14 for resume.

In the gas station business, I assisted my father (the owner) in daily operations. The daily duties included: opening the business (e.g. prepare the cash register for customer transactions, prepare the gas pumps, restrooms, and the repair and service shop for usage, and prepare the accounting books for the daily activities), providing customer service (e.g. cashier and gas pump attendant), and closing the business at the end of each day (e.g. sum the customer receipts, cash and credit, clean the facility, lock-up the gas pumps and facility, and make the bank deposit).

In the automobile dealership, I assisted my parents (the owners) as the office administrator. The job duties included: accounts payable and receivable transactions, payroll, monthly profit and loss statements, and customer service. I have held other types of jobs over the years which provided me with experience in food service, sales, marketing, bookkeeping, accounting, animal research and quality assurance. The experience I gained from food service included meal preparation, service, and cleanup. The marketing experience was obtained primarily through a marketing assistant position I held in an agricultural company. The job duties included assisting the editors of a monthly agricultural research magazine. I assisted in print typesetting, editing, paste-up, and general clerical duties. The sales, bookkeeping, and accounting experience has been obtained through these and several other jobs I have had in the past.

2. What management experience have you had? Currently, I am in my ninth year of service at Monsanto Agricultural Company. For the first six years I worked as a research biologist. The responsibilities included training and supervising research technicians. I performed experimental and toxicological studies on small animals (e.g. mice, rats, rabbits, guinea pigs) and large animals (e.g. dairy cows, calves, goats, sheep) under governmental regulations. I have also gained technical expertise in clinical laboratory functions (e.g. microbiology, hematology, bioassay, radioimmunoassay) and am able to operate several pieces of laboratory equipment.

In the last two years of employment at Monsanto I have held the position of Quality Assurance supervisor for the Research and Development department of the Animal Sciences Division. My current position provides me with the opportunity to supervise administrative employees and interface with different levels of management, operating groups, and the government.

3. What education have you had which would have a bearing on your managerial ability (both formal and informal)? My educational background consists of a Bachelor of Science in Agriculture with a minor in Business Administration and courses working towards a Masters in Business Administration. In addition, I have received informal training in management, communication, computer programming, and various governmental regulation procedures in seminars and short courses.

4. Personal data: age, where you live and have lived, special abilities and interests and reasons for being in business or going in business.

   Born 12/21/59 in Carbondale, Illinois. Lived in Carterville, Illinois for 4 years; Florissant, Missouri for 16 years; Albuquerque, New Mexico for 1 year; Perryville, Missouri for 3 years, Cape Girardeau, Missouri for 4 years; and O'Fallon, Missouri for 8 years.

   My hobbies and interests include sports, camping, raising domestic animals for sale, horseback riding, fishing, and arts and crafts.

   The reason I would like to start a business is because I enjoy administrative work. I look forward to being my own boss. I feel owning this type of business would be a good investment. Finally, I enjoy the company of elderly people and sincerely care about their well-being.

5. Are you physically up to the job? Yes, I am in excellent health.

B. Related Work Experience

1. What is your direct operation experience in this type of business? I have had many administrative, accounting, and recordkeeping duties in past jobs, as well as formal training in school.

2. What is your managerial experience in this type of business? I have had several managerial positions in the past, as well as formal training in school.

3. What managerial experience did you acquire elsewhere? Besides the actual work-related experience in managing, I have taken several managerial-focused courses while employed at Monsanto. Additionally, I have completed managerial coursework in undergraduate and graduate school.

C. Duties and Responsibilities

1. What experience have you had planning and reviewing plans? The experience I have had in planning and reviewing business plans is limited to my MBA courses.

2. What experience have you had in the major operating duties (purchasing, sales, personnel, promotion, recordkeeping, payroll, etc.)?

   I feel I have had sufficient experience in all of the major operating duties.

3. What experience have you had in budgeting and management control? I have had 16 years of experience in management control and almost three years of experience in budgeting.

D. Salaries

1. What are the salaries? See Attachment 4 for the employee work schedule and salary.

E. Resources Available to the Business

1. What are your resources for the business? A social worker, registered or licensed practical nurse, geriatric physician, physical therapist, dietitian, lawyer, accountant, insurance broker, University Extension agents in business, SBA or financial representative from a local bank, clergy, and a Department of Aging representative will be consulted when necessary.

F. Personnel

1. What are your personnel needs now, in the near future and in the next five years? The Woodbine employee staff will include the owner, (as health care administrator and manager), four full-time cerified nurses aides, and three part-time certified nurses aides. Additionally, a geriatric physician, a dietician, a social worker, a physical therapist, an accountant, a licensed nurse, and a lawyer will be hired as consultants, when needed.

   The owner will serve as the president of the corporation. According to the Division of Aging, the education required for managing an RCF I consists of having completed at least one continuing education course offered or approved by the Division of Aging. The owner will enroll in at least one course before opening the business.

   Work experience in all facets of business is helpful, but not necessarily required. The owner's primary duties will include setting company policies and ensuring that they are upheld. The owner will be responsible for developing and implementing a marketing strategy to promote the business. The other primary duty of the owner will be to perform recordkeeping tasks and enlist professional consultants (accounting, legal, medical) when necessary. The owner is responsible for the planning and assurance that an in-service nurse training program is implemented. The owner will work closely with other employees to ensure operations are running smoothly, that the facility is in

compliance with state and company policies, and that the residents are receiving appropriate care.

The personnel needs for the first three years are set at 3 full-time nurses aides, 2 part-time nurses aides, and one part-time manager. In five years two more part-time assistants may be hired.

2. What skills must they have? The nurses aides have administrative overview of the medical care at the residential home. Medical administrative overview includes obtaining vital signs, administrating medications, performing enemas, monitoring intravenous fluids, and limited assistance in bathing, dressing, and feeding. The nurses aides have clinical training in elderly care and are personally committed to the care of the elderly. The nurses aides report each resident's health status periodically to a licensed practical nurse (LPN) or registered nurse (RN) consultant. The LPN/RN will visit the home at least eight hours each week. The LPN/RN must be able to develop a nursing treatment plan for the residents and ensure that the plan is implemented by the home's staff.

   The operations portion of the residential care facility include housekeeping and cooking. The housekeeping duties include keeping the facility neat, clean and attractive in appearance at all times. Cleaning residents laundry and linens, maintaining adequate supplies on hand and reporting needed repairs to the manager.

   To perform the cooking duties the nurse's aides must have health certificates which claims the individual is free from communicable diseases, as shown by physical examination and blood tests. The cook's duties include planning menus, estimating requirements, ordering food from suppliers, food preparation and service, and cleanup. Cooking duties also include preparing and serving three meals daily, and cleaning up afterwards.

3. Are the people you need available? Where? Yes, nurses aides from St. Charles County and St. Louis County will be considered.

4. Will full-time or part-time employees meet your needs? Both full-time and part-time employees will be needed.

5. What will be your salary and wage scale? Will you include a stock ownership plan for certain employees or some other sort of incentive plan? See Attachment 4. No stock ownership plan will be offered for at least the first five years of operation. A medical benefits plan will be offered where the company pays 75% of the monthly premium.

6. What fringe benefits do you plan to offer? Medical benefits will be offered to the employees. Paid vacation and sick days will also be offered.

7. Do you expect to pay overtime? The employees will be expected to work the set hours but in case of emergency they will be paid time and one-half for overtime (after they have met their set amount of hours for the work-week).

VI. APPLICATION AND EXPECTED EFFECT OF FUNDS

1. See Attachments 1, 2, 5, and 6.

ATTACHMENT 1

Pro Forma Income Statement

Revenue and Expense Categories	1993	1994	1995
Revenues:			
Revenues from residents	$259,200	$285,120	$313,632
Ancillary services	1,000	1,110	1,210
Total resident revenue	$260,200	$286,230	$314,842
Net operating revenues	$260,200	$286,230	$314,842
Expenses:			
Salaries	$ 81,120	$ 84,366	$ 87,862
Supplies	6,600	7,260	7,986
Other expenses	14,550	16,005	17,606
Depreciation	6,320	11,112	8,667
Interest	$ 29,365	$ 29,365	$ 29,365
Add deductions			
Bad debts	$ 400	$ 443	$ 480
Total Expenses	$138,355	$148,551	$151,966
Excess (shortage) of revenue over expenditures	$121,845	$137,679	$162,876
Less employment taxes	$ 17,441	$ 18,139	$ 18,890
Net Income (Loss) before taxes	$104,404	$119,540	$143,986
Less income tax	$ 17,749	$ 20,322	$ 24,478
Net Profit (Loss)	$ 86,655	$ 99,218	$119,508

ATTACHMENT 2

Breakeven Analysis for 1993

FIXED COSTS		
Utilities		$ 5,750
Notes payable		29,365
Depreciation		6,320
Salaries		81,120
Insurance		8,775
Property taxes		1,500
Total		$132,830
VARIABLE COSTS		
Supplies		6600
Other expenses		2200
Total		$ 8,800
Revenue	$259,200	
Expenses		
Fixed cost	$132,830	
Variable cost	8,800	
Operating profit		$117,570

Gross profit margin = 45% [$117,570/$259,200]
Breakeven point** = $295,178 [$132,830/.45]
Margin of safety = 14% [$259,200 - $194,093] / $259,200

* Analysis does not include start-up costs.
** Breakeven point accounts for approximately 12 residents/year.

ATTACHMENT 3

Competition Analysis Of Similar Care In O'Fallon And Surrounding Areas

Beds	Type	Facility	Location	Price/Month
30	RCF II	Caregivers Inn	O'Fallon	$2400
46	RCF II	Twin Oaks Estate	O'Fallon	$1950
30	RCF II	Parkside Meadows	St. Charles	$1500
100	RCF II	Camelot RCF	St. Peters	$1600
12	RCF I	Woodbine Residential	O'Fallon	$1800
27	RCF I	Diane's Home Care	St. Charles	$ 800
19	RCF I	Pink Home of Angels	Troy	$ 600
34	RCF I	West Boarding Home	Warrenton	$1100
23	RCF I	Winfield Residential	Winfield	$ 700

Note: The price/month was the highest price each facility charge (as of 1/92).

ATTACHMENT 4

Employee Work Schedule and Salaries

Title	Hours	Days	Shift	Salary Range
Manager	*	Sun-Sat	Variable	$8.00-9.00
Nurses Aide(2)	40	Mon-Fri	7:00 am - 3:00 pm	$6.00-7.00
Nurses Aide	40	Mon-Fri	3:00 pm - 11:00 pm	$6.00-7.00
Nurses Aide(2)	40	Mon-Fri	11:00 pm - 7:00 am	$6.00-7.00
Nurses Aide	16	Sat-Sun	3:00 pm - 11:00 pm	$6.00-7.00
Nurses Aide	16	Sat-Sun	11:00 pm - 7:00 am	$6.00-7.00

Consultant Fees: RN 24 hours per month = $480; Lawyer 8 hours per year = $800; Social Worker 4 hours per month = $40; Accountant 8 hours per year = $240; Dietician 2 hours per month = $20.

* A minimum of 21 hours per week including the Sun and Sat shift 7:00am-3:00pm.

ATTACHMENT 5

Proposed Capital Budget

Description	Dollars
Costs:	
Building and land acquisition	$150,000
Renovations	20,000
Equipment	11,100
Vehicle	8,000
Consultant fees/legal fees	1,000
Other costs of financing	
Salaries for two months	$ 9,600
Supplies for two months	1,135
Utilities for two months	1,067
Employment taxes	3,088
Corporate fees, licenses, and permits	1,200
Advertising	200
Total project development costs	$206,390
Funding:	
Owner Investment	6,390
Long-term loan 12%, 15 year fixed rate	200,000
Total project development funds	$206,390

ATTACHMENT 6

Calculations to Support Financial Data for Business

REVENUES (assumed a 10% increase per year)

Sales $259,200 (1993) $285,120 (1994) $313,632 (1995)
[12 residents x $1800/month x 12 months = Sales for 1993; 12 residents x $1980/month x 12 months = Sales for 1994; 12 residents x $2178/month x 12 months = Sales for 1995]

Ancillary Services: Estimated

Bad Debts: $ 400 (1993) $ 443 (1994) $ 480 (1995)
[$50/resident 1993; $55/resident 1994; $60/resident 1995]

EXPENSES (assumed a 10% increase per year, except salary at 4%)

Salaries: $ 81,120 (1993) $ 84,366 (1994) $ 87,862 (1995)
[1993 = 5 Nurses aides x 6.00/hr x 40 hr week x 52 weeks = $62,400; 2 Nurses aides x 6.00/hr x 16 hr week x 52 weeks = $ 9984; 1 Administrator x 8.00/hr x 21 hr week x 52 weeks = $ 8736; 1994 = 5 Nurses aides x 6.24/hr x 40 hr week x 52 weeks = $64,896; 2 Nurses aides x 6.24/hr x 16 hr week x 52 weeks = $10384; 1 Administrator x 8.32/hr x 21 hr week x 52 weeks = $ 9086; 1995 = 3 Nurses aides x 6.50/hr x 40 hr week x 52 weeks = $67,600; 2 Nurses aides x 6.50/hr x 16 hr week x 52 weeks = $10816; 1 Administrator x 8.65/hr x 21 hr week x 52 weeks = $ 9446]

Employment Taxes: $ 18,530 (1993); $ 19,342 (1994); $ 20,216 (1995)
[21.5% (15.3 + 6.2) 0-50,000 15%, 51,000-75,000 25%, 76,000-100,000 34%, 101,000-up 5%]

Supplies: $ 6,600
[Office $100; Food $6000 ($500 x 12 months); Cleaning $500]

Other Expenses: $ 13,300
[Advertising $200; Insurance $8700 (company pay 75% of cost); $189 Life + $12 Dental + $124 Maj. Medical; Utilities $5750 ($100 gas + $100 water + $200 elec + $50 phone + $25 cable + $50 misc); Property Tax $1500; Consultant Fees $2000]

Depreciation: $ 6,320 (1993); $ 11,112 (1994); $ 8,667 (1995)

Depreciation Schedule

Deprec Type/Yrs	Unit	Book Value	1993	1994	1995
MACR/5	Equipment	$ 19,100	$3,820	$6,112	$3,667
S.L./30	Building	$150,000	$2,500	$5,000	$5,000

[Equipment includes: 12 beds $1600; 16 tables $800; 2 TV $500; washer/dryer $500; couch $1000; 1 loveseat $500; 4 chairs $800; kitchen set $2000]

Interest expense: $ 29,365 per year

Loan Amortization Schedule

Year	Beginning Amount	Payment	Interest	Repayment Of Principal	Remaining Balance
1993	$200,000	$ 29,365	$ 24,000	$ 5,365	$194,635
1994	194,635	29,365	23,356	6,009	188,626
1995	188,626	29,365	22,635	6,730	181,896

[interest is calculated by multiplying the loan balance at the beginning of the year by the interest rate (e.g. in 1993 $200,000(0.12) = $24,000); payment is calculated by the amortization formula PMT(PVIFA 12%, 15 years) or $200,000 = PMT (6.8109); PMT = $200,000/6.8109 = $29,365; repayment of principal is equal to the payment minus the interest charge for each year]

ATTACHMENT 7

Credit History For Admission

1. Name
2. Social Security number
3. Medicare number
4. Present residence
5. Date of birth
6. Place of birth
7. Marital status
8. Bank account number(s)
9. Credit card accounts
10. Monthly income
11. Additional income
12. Outstanding loans (name of institution and loan account number)

ATTACHMENT 8

Personal Interview Questionnaire

Background Information

1. Name
2. Social Security number
3. Medicare number
4. Present residence
5. Date of birth
6. Place of birth
7. Marital status
8. Who are the family members or friends who should be contacted in case of emergency?
9. What is the name, address and phone number of your current physician?
10. Do you wish to retain that physician after moving into Woodbine?
11. Which local hospital would you prefer if the need should arise?

Medical History

12. Height
13. Weight
14. What is your general physical condition?
15. What illnesses do you currently have?
16. What is the immediate reason that residing here is being considered?
17. Are you able to walk alone or with help from a walker?
18. Have you been hospitalized recently? If so, where and for what reason?
19. Do you have any permanent physical disabilities such as those which might result from a stroke?
20. Do you have control over bowel and bladder functions?
21. Do you have any psychological disabililities such as chronic depression?

22. Are there any recurrent behavioral problems such as abusive or violent behavior, alcoholism or drug addiction?
23. Are you mentally alert?
24. Do you have any allergies?
25. Are you sensitive to any drugs?
26. What prescription drugs are you currently taking?
27. At what pharmacy do you purchase drugs?
28. What over-the-counter drugs do you currently take?
29. Do you have special dietary needs or preferences?

Financial Considerations

30. What is your monthly income from pensions?
31. What is your monthly income from savings?
32. What is your monthly income from Social Security?
33. What are your current monthly debts?
34. Do you own your own home?
35. What is the value of the home?
36. Do you have any other real estate?
37. Do you have any other assets such as stocks or savings?
38. Are assets available to pay for boarding home residency?
39. Who is responsible for managing your financial affairs?

Personal Considerations

40. What is your religious background?
41. What are your recreational and leisure interests?
42. What other social or psychological information would be helpful for the staff to know?

SOURCE: Pieper, Hanns G. The Nursing Home Primer. Crozet: Betterway Publications, Inc., 1989.

ATTACHMENT 9

Residential Admission Agreement

1. The management of this facility agrees to exercise such reasonable care toward this person as his or her known condition may require.

2. The facility provides nursing care on a non-discriminatory basis. All residents are admitted and recieve services without regard to race, religion, color, sex, age, handicap or national origin.

3. All residents must have a physical examination within thirty days prior to admission into the facility. The examination must state the individual is in good physical and mental health. The individual must be able to walk alone or with the assistance of a walker.

4. The facility requires that each private pay patient be examined at least annually by his or her physician and a report be provided for the resident records.

5. The facility will not admit or retain addicts, alcoholics, persons having or suspected of having communicable diseases or mental or physical conditions endangering others or themselves.

6. The facility reserves the right to limit admissions or recommend discharge if administration deems the resident requires social, emotional, medical and nursing care that cannot be adequately provided by the staff of this facility.

Except in an emergency, the facility will provide 10 days written notice to appropriate parties, (i.e. resident/responsible party, attending physician) when such care can no longer be provided. The notice will specify the following: reason for proposed discharge, effective date of transfer, and other facilities that may be available.

7. Charges for all services or supplies will be itemized on monthly billing. Payment due by the 10th of every month. Any willful destruction of facility property will be charged by separate billing.

8. The resident will be notified at least thirty days in advance of the effective date of any changes in the rates or services that these rates cover.

9. If at any time the resident feels they are not being treated fairly or if they feel an employee has mistreated them in any way, they may take the following steps without restraint, coercion, discrimination, or reprisal:

a. Notify the administrator who should be able to resolve the problem.

b. If a solution is not reached after taking this action, the resident may take the grievance to an outside representative of their choice.

Agreement of Resident and Responsible Party

1. To arrange for the services of an attending physician and a designated alternate to be contacted in the event the attending physician is unavailable. The arrangements will include a commitment to see the resident either by visitation in this home or through office visits.

2. To provide written inventory of personal belongings and valuables, in duplicate, on forms furnished by the residential home, properly signed by the resident or responsible party at admission.

The resident is responsible for their personal belongings and valuables.

3. The home is not responsible for holding any personal funds or money for the resident unless authorized in writing by the resident or responsible party. The resident or responsible party will be allowed access to their personal possessions and funds during regular business hours, Monday through Friday.

4. All personal fund transactions will be documented and records maintained at the home. A receipt of the transaction will be given to the resident or responsible party for their records.

Residential Admission Agreement

_____ _____

Staff Member's Signature Date

I/We sign this acknowledgment with the understanding that the Resident's Rights benefit the resident's interest and individuality, and further, that they have been explained to me orally and that I have received a copy for my future reference. I have no further questions with regard to the rights of residents in this facility.

_____ _____

Resident's Signature Date

_____ _____

Responsible Party Signature Date

SOURCE: Kane, Rosalie A., Robert L. Kane. Long-Term Care: Principles, Programs, and Policies. New York: Springer Publishing Company, 1987.

ATTACHMENT 10

Residents Rights

This rule has been established by the State of Missouri's Long-term Care Facility Regulations and Licensure Law. The rule protects resident rights in all types of licensed long-term care facilities in Missouri. For readability, only the highlights of the resident rights (13 CSR 15-18) have been described below. A complete set of the regulations are available upon request.

1) A list of names, addresses and occupations of all of the individuals who have property interest in the facility will be available for public inspection.

The facility will keep a copy of official notifications from the Division of Aging of violations, deficiencies, licensure approval and/or disapprovals and responses.

2) Notices of noncompliance will be posted in a conspicuous location along with a copy of the most recent inspection reports.

3) A copy of the most current Division of Aging's rules governing the facility shall be kept available to all interested.

4) Each resident admitted to the facility will be fully informed of their rights and responsibilities as a resident.

5) All new and present residents will be given statements of their rights, responsibilities, and conduct and be expected to understand them.

6) The facility will document that they gave the resident resident rights information.

7) Information regarding resident rights and facility rules will be posted in a conspicuous location within the facility. Copies will be available to anyone interested.

8) Upon admission, the resident will receive information, in writing, about services (on and off-site), costs, and procedures followed in case of medical emergency.

9) Each resident will be informed fully about their medical condition by their attending physician. This prognosis will be documented on a medical record, signed by the physician.

10) Each resident will participate in planning their medical treatment. If they refuse treatment it will be documented in their medical record.

11) Residents will have the priviledge of selecting their own physician. The physician is responsible for their total care.

12) Each resident can be transferred or discharged for medical reasons, or health or welfare or that of other residents, or for nonpayment for stay.

13) Transfer or discharge reasons will be documented in the resident's medical reasons. The resident must be first informed of the rules before transfer or discharge.

14) An advance notice of ten (10) days will be given to the resident before transfer or discharge, except in an emergency situation.

15) If the resident is transferred or discharged from the facility, a reasonable effort will be made to arrange for another facility.

16) Each resident will be encouraged to voice their rights as a resident and as a citizen to facility staff or to outside representatives.

17) Exercising residents' rights by the residents will be free from restraint, interference, coercion, discrimination, or reprisal.

18) Each resident will be free from mental and physical abuse.

19) Residents will be free from chemical and physical restraints except when authorized in writing by a physician for a specified period of time.

20) A physical restraint, used by authorized personnel, will be used in an emergency to protect the resident from injury or injuring others. The physician will be immediately notified. The physician will order how long the restraint will be used, what type of restraint should be used, and what action to take.

21) If a restraint is used on a resident in a residential care facility, the resident placement facility will be immediately reevaluated.

22) All information contained in a resident's medical, personal or financial record (including source of payment) will be confidential. This information will not be discussed in front of other residents or those not involved with the resident's care. Written consent of the resident (or legal guardian) will be required for the release of information to those not authorized by law to receive it.

23) Each resident will be treated with consideration, respect and full recognition of their dignity and individuality. This includes privacy in treatment and care of personal needs.

24) No resident will be required to perform services for the facility.

25) Each resident will be permitted to visit, associate, and meet privately with anyone unless to do so would infringe upon the rights of other residents.

26) The facility will permit residents to meet alone with anyone and provide an area which assures privacy.

27) Telephones will be accessible at all times to residents. Privacy will be provided when using the telephone.

28) If the resident cannot open mail, written consent by the resident (or legal guardian) will be obtained to have all mail opened and read to the resident.

29) Each resident will be permitted to participate as well as not participate in activities of social, religious, or community groups at their discretion, both within the facility, as well as outside the facility.

30) Each resident will be permitted to keep and use personal clothing and possessions as space permits. The facility will maintain a record of these possessions.

31) Married residents will have privacy for visits by the spouse. The private area will include comfortable arrangements.

32) If both husband and wife are residents, they shall be allowed the choice of sharing or not sharing a room.

33) Each resident will be allowed to purchase or rent goods or services not included in the facility's service program. These purchases/rentals must meet the reasonable standards of the facility.

34) Residents will not have their personal lives regulated or controlled beyond meal schedules and other written policies necessary for orderly management of the facility and personal safety of the residents.

_____ _____

Signature of Resident/or Responsible Party Date

SOURCE: Long-Term Care Facility Regulations and Licensure Law for Residential Care Facilities I and II, Intermediate Care Facilities, and Skilled Nursing Facilities. Jefferson City: Missouri Department of Aging, 1990.

ATTACHMENT 11

Facility Policy

The residential care facility will follow all of the applicable rules in the State of Missouri "Long-term Care Facility Regulations and Licensure Law." All local laws and regulations for operating a business will also be followed.

Room and board fees are $60/day or $1800/month for a private room. This facility is a non-smoking residence. Services provided at the facility (at no extra cost) are:

* **Certified nurses aides on staff**
* **24-hour security**
* **Visiting licensed nurse once a week**
* **Medication administration**
* **Emergency call systems in each room**
* **Assisted bathing**
* **Visiting Social Worker once each month**
* **Three meals a day, snacks anytime**
* **Housecleaning and laundry**
* **Regularly scheduled transportation for shopping, for professional appointments, for worship services and for entertainment**
* **Activities daily**
* **Social and cultural events**
* **Planned trips**
* **Local telephone**

Prior to admission the resident must complete various forms and pay a one month deposit, in addition to the first month's fee. The deposit will be returned to the resident upon leaving the facility if no:

* Damage assessed at the deposit value was incurred
* Infraction on payment of room and board was made
* Personal charges incurred by resident was billed to facilty and unwillingly paid by facility.

Residents will be asked to read the "Residents Rights" policy upon admission. Each resident will be expected to understand and follow the policy rules. Each resident will be expected to voice their concerns, comments, questions, and suggestions to the facility manager at anytime.

_____ _____

Signature of Resident/or Responsible Party Date

ATTACHMENT 12

Resume
Laura Ellyn Metzger

Education

B.S. Agriculture 1982
Southeast Missouri State University
Cape Girardeau, Missouri

M.B.A. 1992 (GPA 3.8/4.0)
Lindenwood College
St. Charles, Missouri

Employment Record

1982 to Present: Biologist, Monsanto Agricultural Group, Animal Sciences Division
St. Louis, Missouri

1978-1982: Office Manager, Williams Pontiac,Buick, AMC, JEEP
Perryville, Missouri

1976-78: Cashier, K-Mart
Florissant, Missouri

Professional Enhancement Courses

Negotiating Skills
Good Laboratory Practices
Computer Validation
Time Management

Leadership and Supervisory Skills
Communication Skills
Dealing with Difficult People
Statistical Analysis using SAS

FORTRAN, COBOL, VAX, WordPerfect, Windows, IBM PC

Professional Society Membership

Society of Quality Assurance
Association of Laboratory Animal Science

ATTACHMENT 13

Pro Forma Cash Flow

	1993	1994	1995
Cash Receipts	$260,200	$286,230	$314,842
Cash Dispursements	112,276	120,928	124,143
Cash Gain or Loss	$147,924	$165,302	$190,699

ATTACHMENT 14

Capital Equipment

Equipment*	Cost
Van	$ 8,000
Bed	1,600
Table	800
Television	500
Washer	250
Dryer	250
Couch	1,000
Loveseat	500
Chair	800
Kitchen Set	2,000
Microwave	200
Utensils	500
Appliances	200
Dishware	500
Oven/Stove	500
Refrigerator	$ 1,500
Total	$19,100

*Estimated prices for purchase in 1993

APPENDIX D

QUESTIONNAIRE FOR BUSINESS PLAN EVALUATION

Evaluators' instructions for completing the questionnaire:

* After you have reviewed the business plan, please circle the answer to each question on the attached questionnaire.

* Use the comment section to give the owner additional information to help improve the business plan.

* It is important that you answer every question so interpretation will be meaningful.

* If you have any questions or concerns about the questionnaire or the review process please call Laura Metzger.

* **REMEMBER:** Please return the completed questionnaire by July 1 (using the pre-stamped envelope provided).

Your time and comments are greatly appreciated!

QUESTIONNAIRE FOR BUSINESS PLAN EVALUATION

DESCRIPTION OF BUSINESS

1. Do you feel that the decision to incorporate this type of business is sound?

   YES NO

2. Do you feel that the business plans for additional consultant needs adequately?

   YES NO

3. Do you feel the plan has a sufficient number of employees to start the business?

   YES NO

4. On a scale from 1 to 5, how do you rate this portion of the plan in support of the total plan's chance for success?

   1 (Very Poor) 2 (Poor) 3 (Fair) 4 (Good) 5 (Very Good)

THE MARKET

1. Do you believe there is a market in the O'Fallon area for this type of business?

   YES NO

2. Do you think that this business will fill a niche not yet filled in the O'Fallon area?

   YES NO

3. On a scale from 1 to 5, how do you rate this portion of the plan in support of the total plan's chance for success?

   1 (Very Poor) 2 (Poor) 3 (Fair) 4 (Good) 5 (Very Good)

COMPETITION

1. Do you feel the monthly price for residency in the boarding home is:

   1 (too high) 2 (reasonable) 3 (too low)

2. Do you believe this boarding home will be able to successfully compete with other facilities in O'Fallon and nearby?

   YES NO

3. On a scale from 1 to 5, how do you rate this portion of the plan in support of the total plan's chance for success?

   1 (Very Poor) 2 (Poor) 3 (Fair) 4 (Good) 5 (Very Good)

BUSINESS LOCATION

1. Do you feel the location for the business is:

   1 (Very Poor) 2 (Poor) 3 (Fair) 4 (Good) 5 (Very Good)

2. Do you think that the business location will serve its customers conveniently?

   YES NO

3. On a scale from 1 to 5, how do you rate this portion of the plan in support of the total plan's chance for success?

   1 (Very Poor) 2 (Poor) 3 (Fair) 4 (Good) 5 (Very Good)

MANAGEMENT

1. Do you feel the owner has a sufficient amount of education and experience to operate this type of business successfully?

   YES NO

2. Do you feel the owner has the ability to manage this type of business with the amount of time expected to spend per week in the business?

YES NO

3. Do you feel the skill level for the employees is sufficient this type of business?

YES NO

4. On a scale from 1 to 5, how do you rate this portion of the plan in support of the total plan's chance for success?

1 (Very Poor) 2 (Poor) 3 (Fair) 4 (Good) 5 (Very Good)

APPLICATION AND EXPECTED EFFECT OF FUNDS

1. Do you believe there is sufficient funds to start up this business?

YES NO

2. Do you feel the pro forma income statement is accurate for planning this type of business?

YES NO

3. On a scale from 1 to 5, how do you rate this portion of the plan in support of the total plan's chance for success?

1 (Very Poor) 2 (Poor) 3 (Fair) 4 (Good) 5 (Very Good)

ADDITIONAL COMMENTS:

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