37th SNF Cost Comparison and Industry Trends Report

AN INDUSTRY AT A CROSSROADS

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Executive Summary

Executive Summary

Skilled nursing facilities (SNFs) perform a distinct and valuable role in the overall health care system, providing care to both short-term episodic care patients and long-term care residents. Years of compounding policies have increased the heavy regulatory burden on SNF operations and have made it exceedingly difficult to achieve positive financial margins — which are necessary for sustainability, investment, and innovation.

As this competitive landscape alters the profile of patients and residents being admitted to SNFs, the reality is that these SNF admissions are entering the system with increased medical complexity. While we're seeing a reduction in SNF beds nationally, there is also a diverging trend in national demographics that projects an increasing demand on overall senior living and care, including SNF care — further complicating the situation.

The inflationary economic environment post-pandemic has amplified the economic challenges that have faced the SNF industry for decades:

- Labor
- Tightening reimbursement
- Financial viability

These issues are not new; however, various regulatory and reimbursement policies have significantly influenced the operational and financial trends highlighted in this year's report. Despite increasing demand, many SNF operators have been forced to shift from "occupancy growth mode" to "no margin, no mission."

Sustainability of the mission requires both strategy and an intense focus on the fundamentals that drive margins. Capturing the long-term demand and opportunities within the industry requires financial sustainability in the short-term.

Methodology

This publication provides benchmarks and ratios calculated using annual SNF cost report data released by the Centers for Medicare and Medicaid Services (CMS) as of July 2022. That release included approximately 10,000 cost reports for fiscal years ended 2021, representing approximately two-thirds of Medicare-certified nursing facilities. For purposes of comparability, especially as it pertains to increases and decreases from 2020 to 2021, amounts presented for 2017 through 2020 only include the performance of facilities with a 2021 cost report.

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

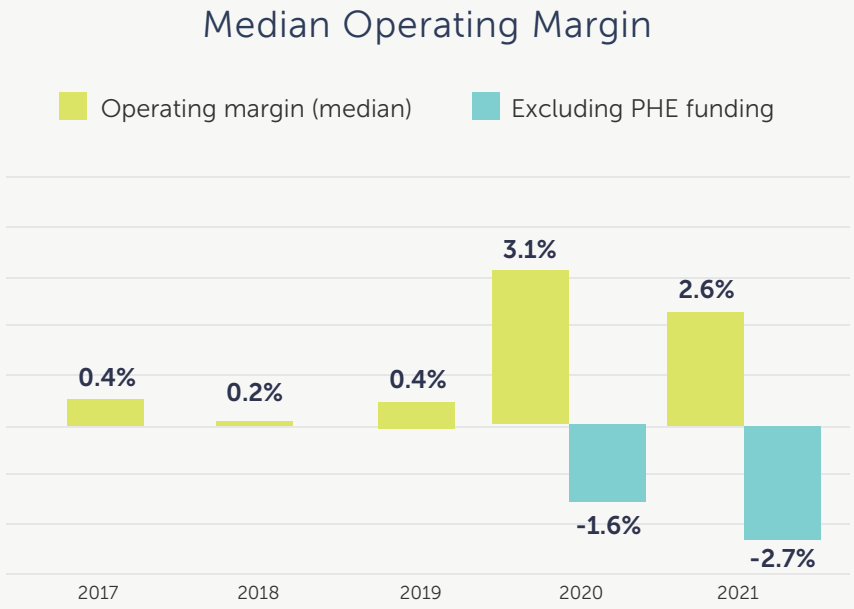
This publication also utilizes data sources for trending beyond fiscal year 2021, which include the Nursing Home COVID-19 Public File for occupancy and Payroll Based Journal (PBJ) Nurse Staffing for contract labor utilization.

Ratio Analysis

Operating margin

Excluding the impacts of public health emergency (PHE) funding, the median operating margin of SNFs decreased in 2021 to a negative 2.7%. The 2021 median operating margin, both including and excluding recognized PHE funding, decreased substantially from 2020 medians. Recapture of occupancy stagnated by availability and affordability of direct care nursing staff, and inflation escalating at the fastest pace in 40 years is putting significant pressure on the economics of operating SNFs.

SNFs predominantly rely on government payors whose reimbursement does not adjust in correlation with the cost inputs of operating a SNF. The headwinds SNF providers navigated through 2021 continue to pressure operating margins. PHE funding allowed SNFs to overcome some challenges; however, with the expiration of the majority of PHE funding programs, SNF providers will likely face continued financial strain. We covered the impact of the various PHE funding sources thoroughly in our 36th SNF Cost Comparison and Industry Trends Report.

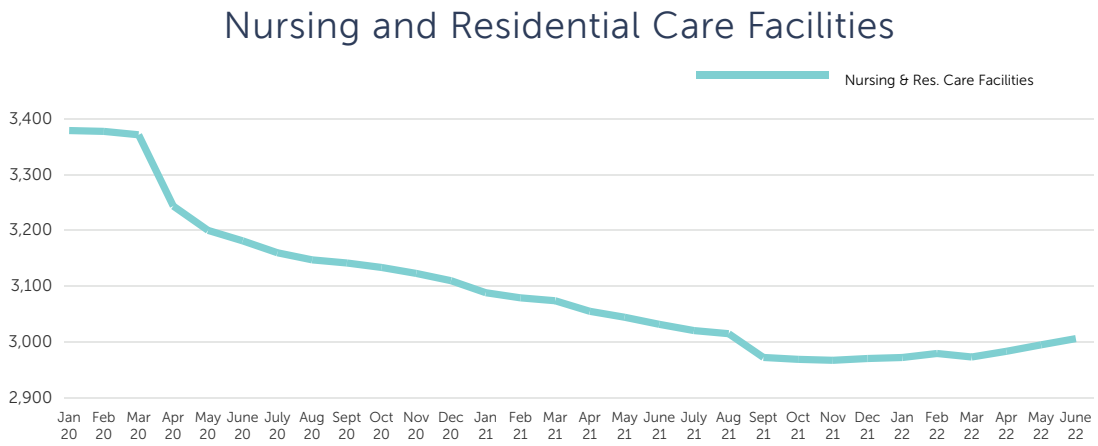


Labor and workforce

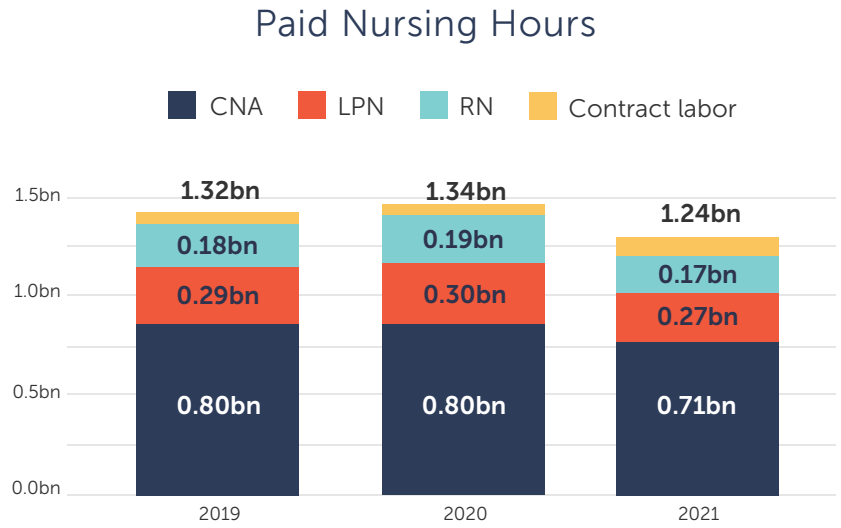
Labor has been one of the forefront headwinds of the SNF industry for years. Pre-COVID, SNF operators would have listed access to permanent direct care nursing as a top-three priority and concern, and the post-COVID environment escalated this pressure point significantly. The SNF industry has a tougher time accessing labor and maintaining their workforce compared to other sectors of health care.

As a comparison, for total employment between January 1, 2020, and December 31, 2021, the ambulatory health care setting increased 2%, hospitals decreased 2%, and nursing and residential care facilities decreased 12%. Hospitals and ambulatory settings generally pay higher wage rates; therefore, the demand for nurses in these settings, which all recruit from the same general pool of nurses, has put increased pressure on SNF operators in hiring and retaining direct care clinical staff. The availability of nursing staff has impacted SNF occupancy across the country as providers are being forced to limit admissions due to constraints on direct care nursing labor supply.

Approximately 100 million fewer nursing hours were paid within the SNF industry from 2020 to 2021 — a 7.5% reduction. This measure includes hours of employed nursing staff as well as hours filled by contract labor.



Source: U.S. Bureau of Labor Statistics as of August 2022 "Employment, Hours, and Earnings from Current Employment Statistical Survey (National)"



RATIO ANALYSIS

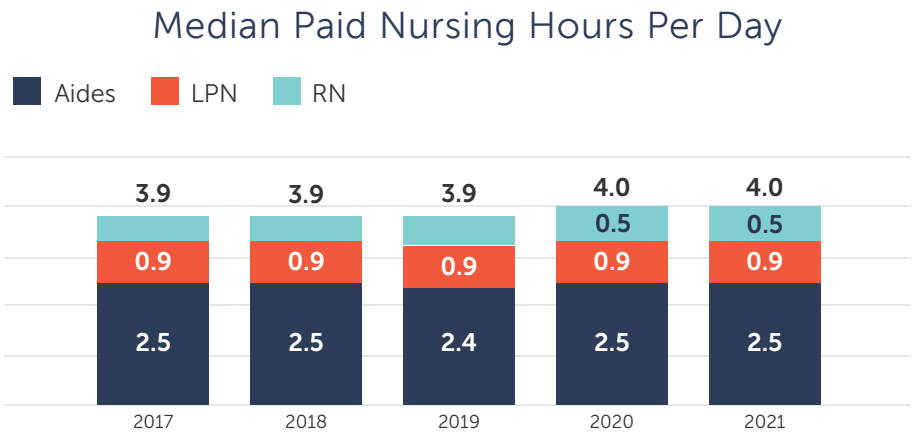
Despite the significant reduction in access to direct care nursing labor, the SNF industry maintained consistent nursing hours per day in 2021 compared with the preceding four years. Unfortunately, this was achieved through significantly higher utilization of costly contract labor. The economics in balancing reimbursement with escalating staffing costs have forced many SNF operators to take a more methodical approach to recapturing lost occupancy — effectively resulting in lower median occupancy than pre-COVID levels.

Proposed minimum staffing mandate

The Biden administration has proposed a federal minimum staffing requirement, with no mention of the economic considerations or increasing funding to support implementation or compliance.

With proposed minimum staffing mandates of approximately 4.1 productive hours per day:

- 94% of nursing homes that care for more than 900,000 residents would need to increase staffing levels to be in compliance
- It would cost $10 billion a year and require hiring more than 187,000 nurses and nurse aides to meet the standard

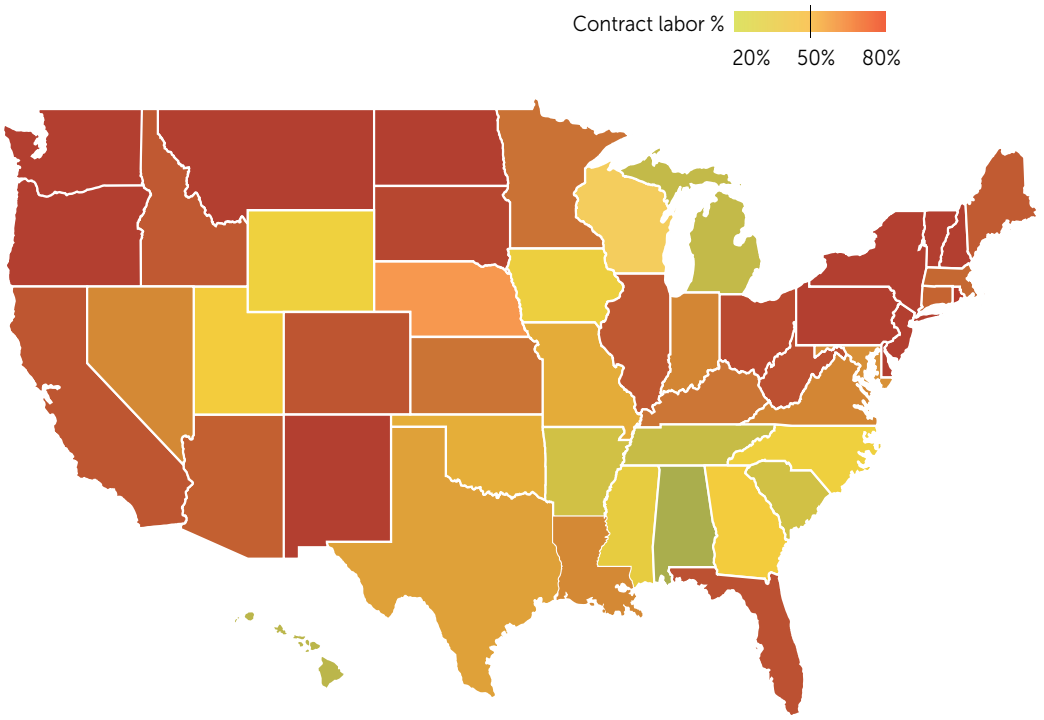


RATIO ANALYSIS

Pre-COVID, the SNF industry was already feeling the pressure of attracting and retaining nurses. The trend of nursing contract labor utilization increased 19% between 2017 and 2018 and increased 24% between 2018 and 2019. COVID and the pursuing inflationary economic environment significantly accelerated that trend.

In 2021, 5.5% of all nursing hours were filled by contract labor, which is an 83% increase from the median 2020 contract labor utilization. Varying levels of reliance on contract nursing staff to fill nursing positions throughout the country are evidenced in the heat map below.

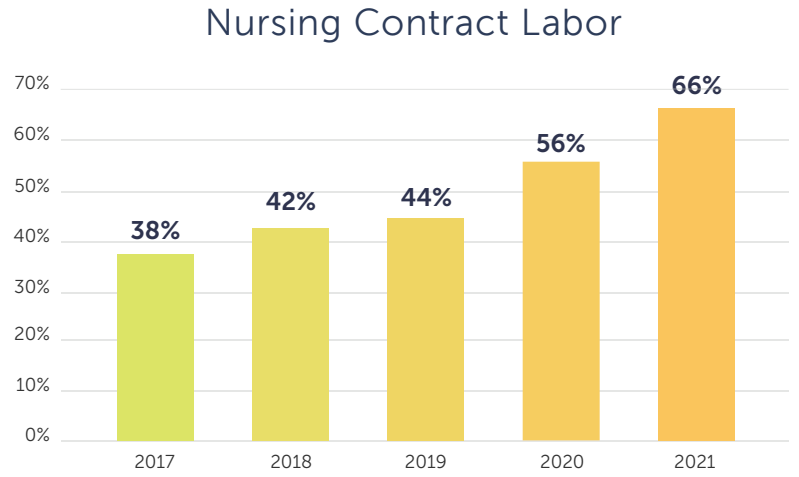
% of SNFs Utilizing Contract Labor in 2021



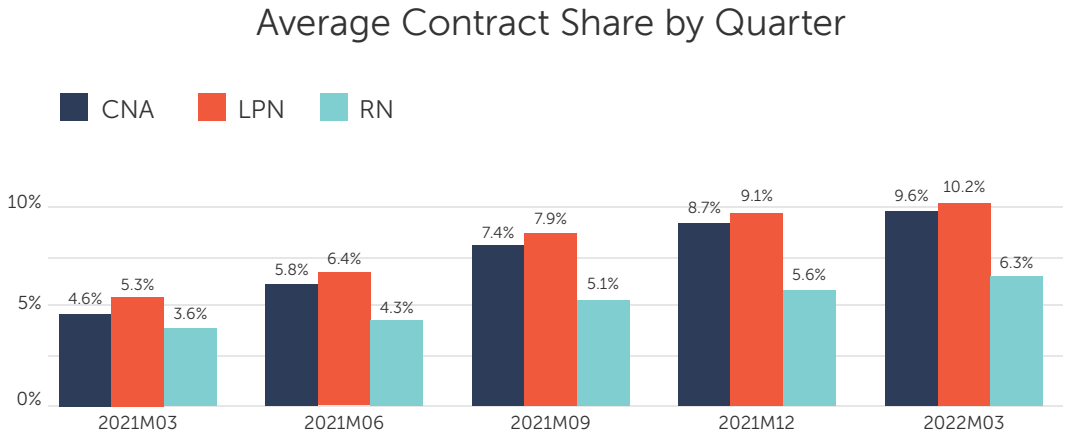
RATIO ANALYSIS

The decreased supply of direct care nursing resulted in approximately two-thirds of SNFs across the country utilizing nursing contract labor to care for their patients and residents in 2021 — about a 50% increase compared to 2019. With an accelerating trend of reliance on nursing contract labor staff, it elevates the concerns of policy makers potentially imposing an unfunded minimum staffing mandate, rather than focusing on the larger issue of enticing direct care nurses to the geriatric population, increasing funding, and supporting care delivery innovation.

As SNFs began rebuilding lost occupancy during 2021, the utilization of nursing contract labor to fill staffing needs grew exponentially. Contract nursing productive hours increased among all levels of direct care nursing throughout 2021 and into 2022. Utilization of contract CNAs, for example, comprised approximately 4.6% of all CNA productive hours in Q1 2021. The utilization of contracted CNA hours increased approximately 110% by Q1 2022.



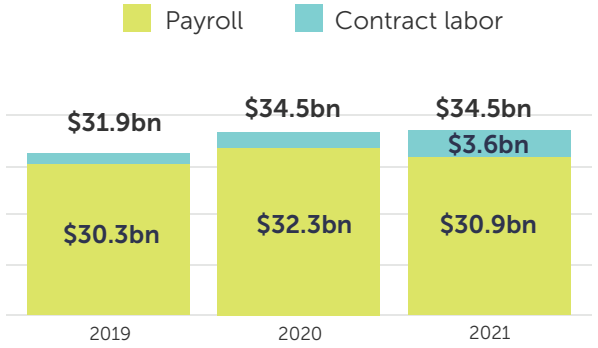
25th	0.4%	0.6%	0.7%	0.7%	1.4%
50th	2.1%	2.5%	3.1%	3.0%	5.5%
75th	6.4%	7.8%	8.7%	9.1%	13.8%
Providers with contract labor	38%	42%	44%	56%	66%



RATIO ANALYSIS

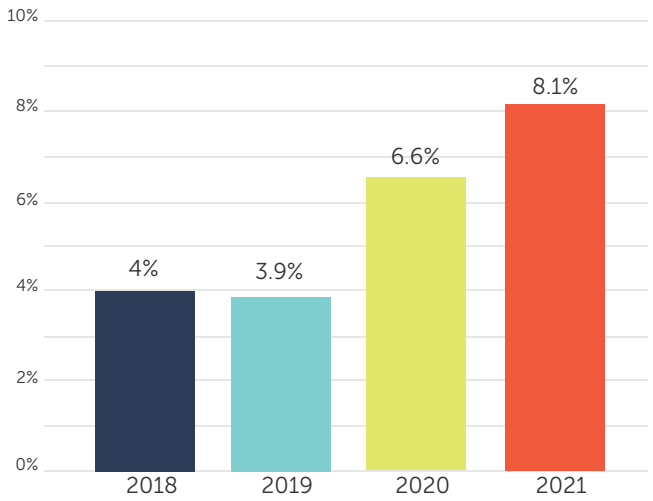
Despite national median occupancy levels in 2021 being approximately 16% below 2019 levels, the overall industry direct care nursing expense is approximately 8% higher in 2021 compared to 2019, even with approximately 100 million fewer nursing hours paid in the industry. Nursing contract labor expense increased approximately 64% from $2.2 billion in 2020 to $3.6 billion in 2021. SNFs increased average wage rates for employed nursing staff at more than double the rate increases as previous years, with CNAs experiencing the largest average hourly increase in 2021 (8.8%).

Direct Care Nursing Expense by Source



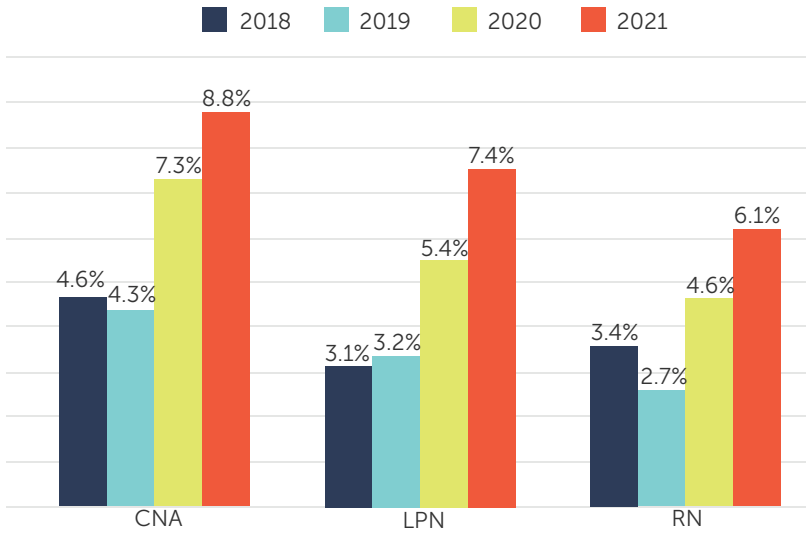
Overall Nursing

Growth rate in average overall nursing hourly wages



Nursing by Discipline

Growth rate in average hourly wages by nursing discipline



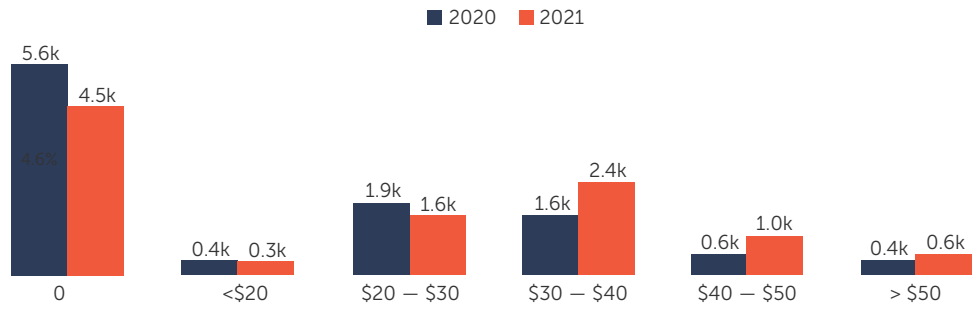
RATIO ANALYSIS

The hourly rates SNFs pay for contracted labor are substantially higher than the average hourly rates of employed staff. The following graphics represent the number of facilities that reported nursing contract labor rates for CNAs and RNs in 2020 and 2021. Approximately 15% (1,600) of facilities with 2021 cost reports were paying more than $40 per hour for contracted CNAs in 2021. For contracted RNs in 2021, approximately 30% of SNFs were paying more than $70 per hour for these services.

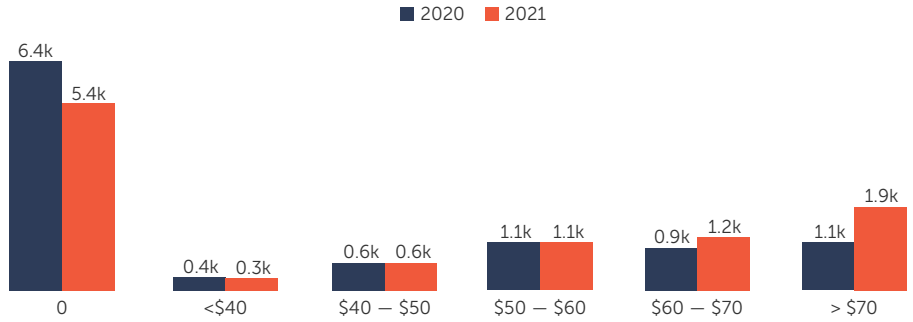
The temporary increases in direct care nursing wage rates, through shift-differentials, hero-pay, etc., were funded by temporary PHE funding sources. As these funding sources expire, wage rates continue to climb.

The compounding effects of workforce availability and cost, along with the economics of how SNFs are reimbursed, directly impacts a SNF operator's ability to recapture lost occupancy. This survey conducted by the AHCA illustrates how most nursing homes are limiting new patients due to staffing shortages.

Facilities Reporting Contract Labor CNAs by Avg. Hourly Rates



Facilities Reporting Contract Labor RNs by Avg. Hourly Rates

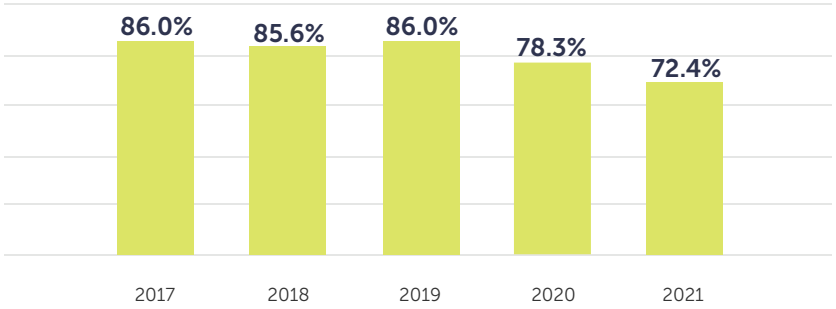


Occupancy

At the beginning of 2021, the national median SNF occupancy had hit bottom and COVID-19 infection rates were quickly declining, providing optimism for a recovering census. Over the next seven months, national median occupancy increased to 73.9%. However, occupancy from July 2021 through the remainder of the year was effectively stagnant, closing the year at a median of 74.2%.

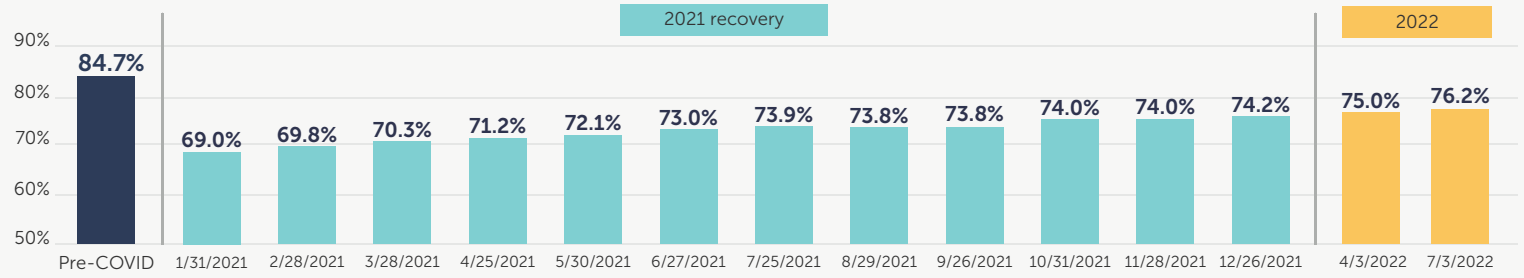
Rebuilding occupancy had a disproportionate impact on labor utilization. Occupancy was so suppressed in January 2021 that operators could rebuild some occupancy without significantly increasing staffing needs. However, as occupancy rebounded, operators realized they were unable to secure workers back into the SNF. Many nurses had left SNFs for other care settings, to pursue different career paths, or left the workforce altogether, which created a significant nursing deficit. Nursing contract labor was utilized as a perceived temporary fix until SNF operators could recruit nurses back to their organizations.

Median Occupancy Rate



As inflation drove up wage rates and staffing agencies were in control of market prices, operators realized using staffing agencies was not financially sustainable. In addition to wage increases, the predominantly government payor mix, which does not adjust reimbursement in correlation with operational costs, contributed to financial burden. Inflation put further pressure on the financials through increased support and administrative costs.

Median Occupancy

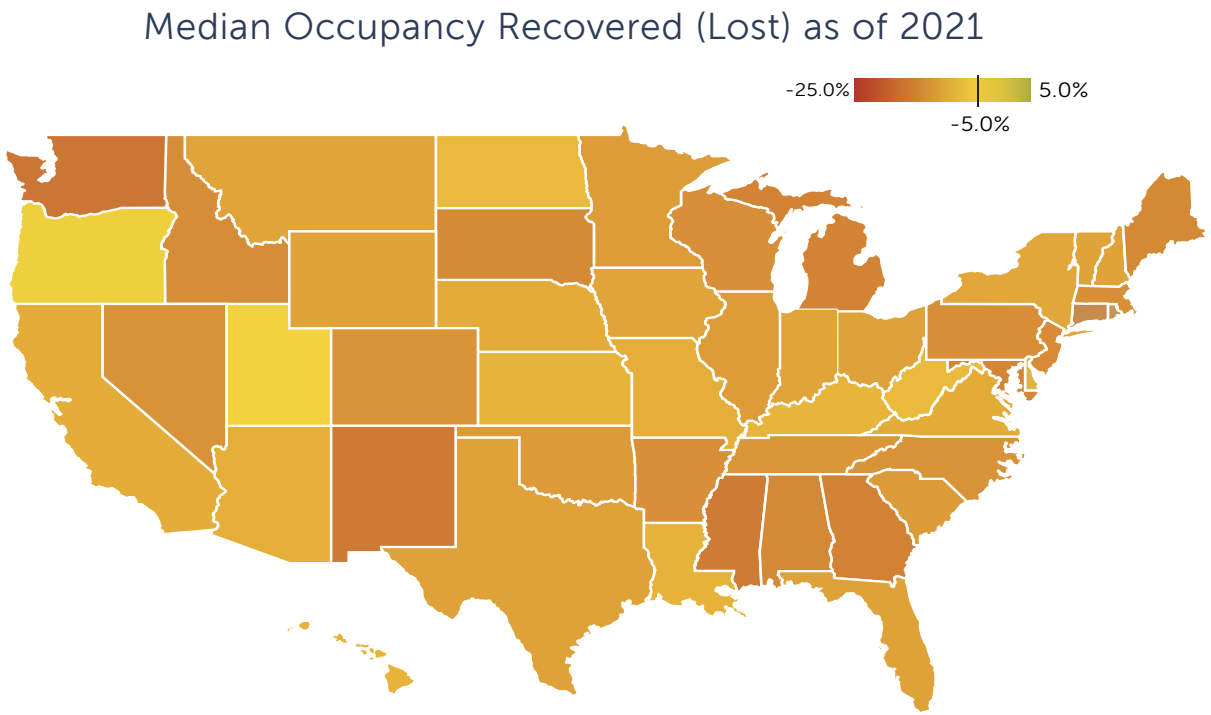


RATIO ANALYSIS

The profile of residents and patients at the start of 2021 greatly impacted reimbursement. Due to various COVID policies such as hospitals suppressing non-emergency surgeries and SNFs not being allowed to accept new admissions for periods of time, many SNFs experienced a disproportionate decrease in higher reimbursed episodic patients and effectively saw a greater concentration of long-stay, predominantly Medicaid residents.

Notably, Medicaid systems in many states do not fund the actual cost of care (see operations cost and reimbursement sections below). Therefore, with labor and supportive services costs increasing, limited staffing, and a shift to predominantly Medicaid residents, increased occupancy cannot be supported. As Medicaid residents slowly attrition, they can be replaced with patients with higher reimbursed Medicare or Medicare Advantage, but that takes time — which many operators may feel they do not have.

This median occupancy heat map represents the degree to which states have experienced decreases in median occupancy from pre-pandemic levels through 2021. Every state is still below their pre-pandemic occupancy levels and there are varying levels of recovery happening nationally and at local levels. In many instances, using SNF data analytics and insights, we have noted an operator's workforce, referral relationships, and quality are the distinguishing factors in capturing local market census share.

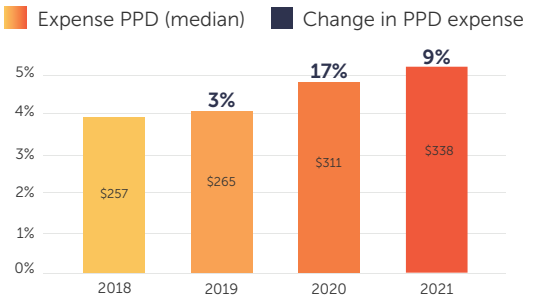


Cost structure and inflation

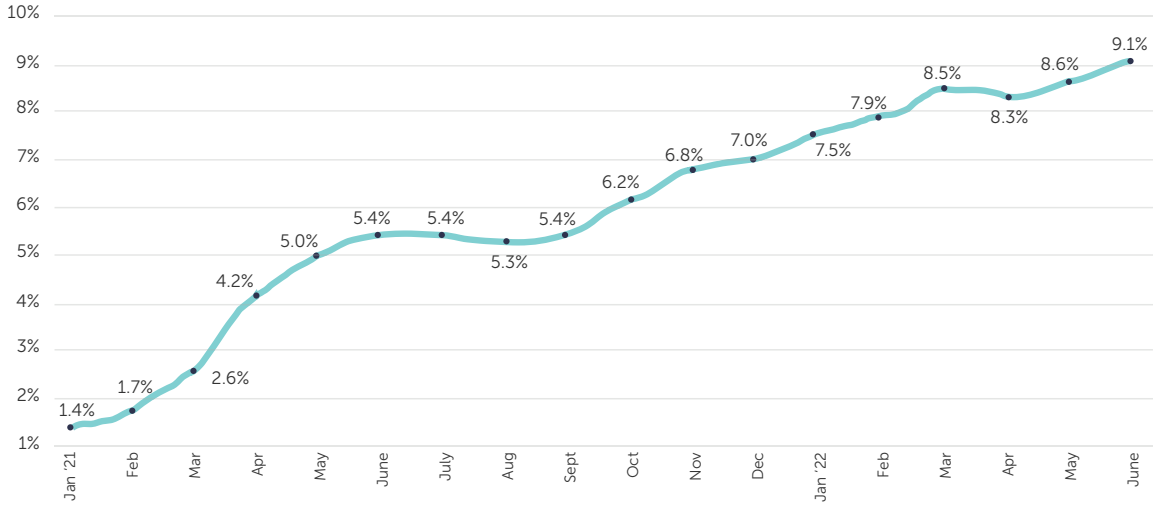
The total cost per patient day from 2019 to 2021 has increased 28% or $73 per day. Compared to the predictable 3% increase between 2018 and 2019, these rising costs are significantly impacting margins, regardless of the operator's market.

Most SNFs have a largely governmental payor mix, such as Medicaid and Medicare. Therefore, they cannot institute price increases to soften the blow of inflation. With inflation at a 40-year high, the Federal Reserve is raising interest rates to cool the economy. However, quickly rising wage rates are still not resulting in enough labor capacity to increase occupancy without costly nursing contract labor hours.

Expense PPD (Median) and Change in PPD Expense



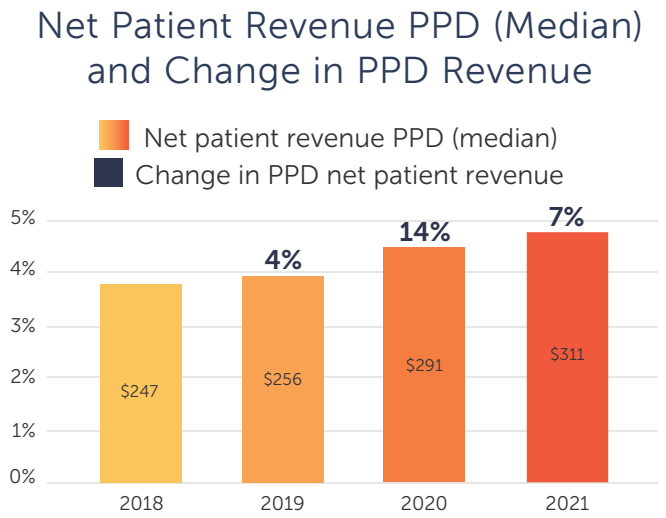
All Item Inflation Trend: Jan. 2021 – June 2022



Source: U.S. Bureau of Labor Statistics as of July 2022 Press Release for Consumer Price Index – June 2022, dated July 13, 2022

Reimbursement and revenue

Net patient revenue per patient day (PPD) between 2019 and 2021 has increased 21%, excluding grant-related revenue sources such as provider relief funds or forgiveness of PPP loans. Included in this figure are Medicaid rate add-ons — which many states enacted and still have in effect (sunsets are tied to the expiration of the national PHE). Some positive revenue enhancements still exist; however, many SNF operators anticipate that PPD expenses will continue to far exceed reimbursement as additional funding is removed with the inevitable end of the PHE.



The SNF PPD reimbursement environment continues to tighten:

- **Traditional Fee-For-Service (FFS) Medicare** — CMS provided updates in its FY 2023 Final Rule for Skilled Nursing Facilities
  - CMS finalized a 5.1% market basket update. CMS estimates the result will be an increase of $904 million in rate increases to SNFs in FY 2023.
  - CMS finalized a 4.6% Patient-Driven Payment Model (PDPM) parity adjustment through a two-year phase-in period. The recalibration of the PDPM parity adjustment will include a 2.3% reduction in FY 2023 ($780 million) and a 2.3% reduction in FY 2024.
  - CMS finalized various changes to the value-based payment and quality reporting programs.
- **Medicaid** — Systems vary significantly among all 50 states. However, nationally speaking, Medicaid reimburses less than half of Medicare FFS on a PPD basis. Rate-setting cycles significantly impact a SNF operator's ability to adjust operational economics to a rapid inflationary environment.
- **Medicare Advantage** — Increasing in prevalence, it comprises 45% of Medicare beneficiaries, with an estimated 50% penetration rate by 2030. Intense focus on medical utilization drives continued pressure on shorter lengths of stay. Medicare Advantage typically reimburses at a lower PPD than traditional FFS Medicare.

Conclusion

Conclusion

Long-term care demographics are projected to shift significantly as the landscape of the senior living and care industry changes. Data from the U.S. Census Bureau determined there will be a 115% increase in individuals 85+ years of age from 2020 to 2040. We are also seeing that this population is less capitalized for retirement, has longer life expectancies, and brings increased medical complexity.

Though long-term opportunity exists, SNF operators need short-term sustainability. This can be accomplished with a strategic vision and intense focus on fundamentals like labor, revenue, occupancy, and operating expenses. Recognizing the value SNFs create, many owners and operators are meeting these challenges by proactively participating in risk-based payment models (e.g., I-SNP or ACO), penetrating and scaling in core markets, and embarking in new strategic partnerships.

SNF operators must know their key performance indicators and use actionable financial data to identify and measure opportunities. Investment in workforce, care coordination, advances in care delivery, and the ability to care for increasingly medically complex patients and residents are key elements helping to produce quality outcomes and create significant value.

We are here to help

Turning challenges into opportunities takes balance: balance of margins, mission, and regulations. The environment may not be easier, but we can help shoulder some of your burden and position you for greater strategic focus:

- Data-driven insights
- Reimbursement advisory and cost report preparation
- Outsourced accounting
- Patient-Driven Payment Model (PDPM) assessments
- Operations and clinical performance improvement
- Strategic planning and financial modeling (CLA Intuition®)
- Transaction support
- Tax strategies and incentives
- Financial audits and internal audit
- Risk-based payment advisory
- Wealth advisory

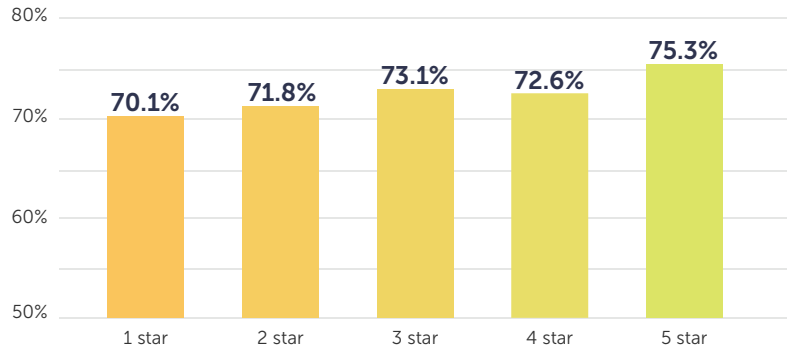
Appendix

APPENDIX

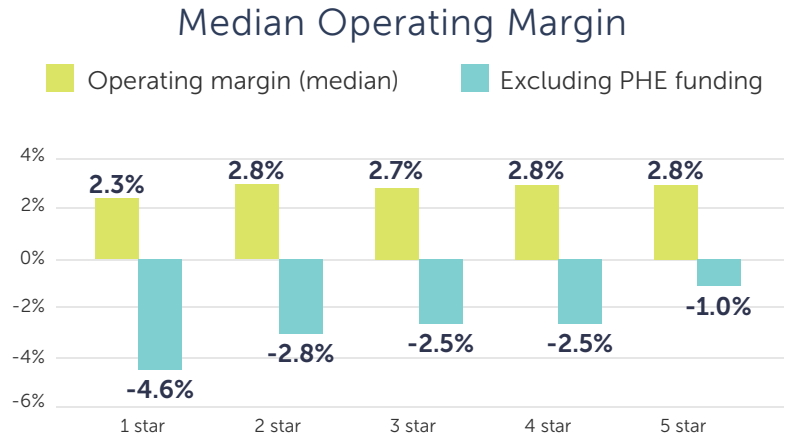
Skilled nursing facility snapshot by star rating

The following graphics display key performance metrics of SNFs grouped by overall star rating. Across these performance indicators, the higher overall star-rated facilities had better performance.

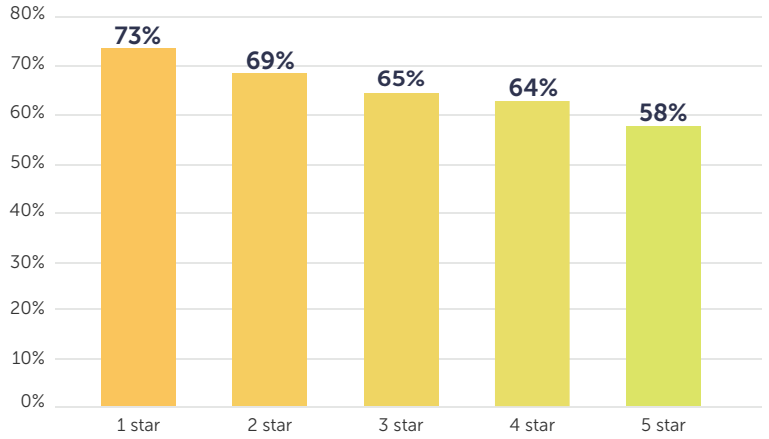
Median Occupancy Rate



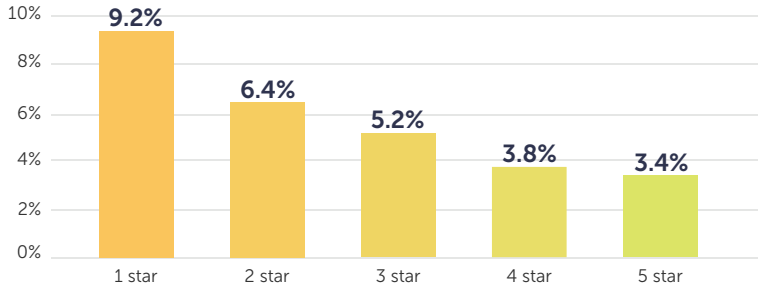
Median Operating Margin



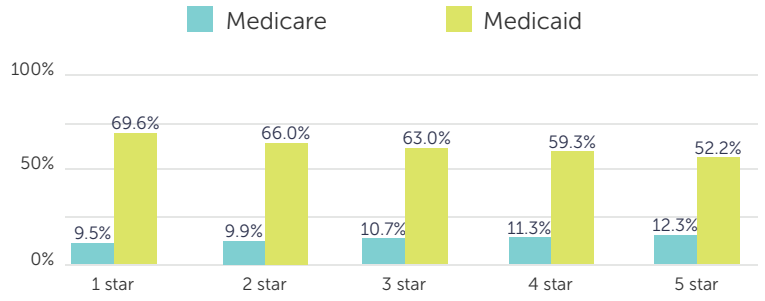
% of Providers Using Contract Labor by Star Rating



Median Contract Labor Utilization by Star Rating



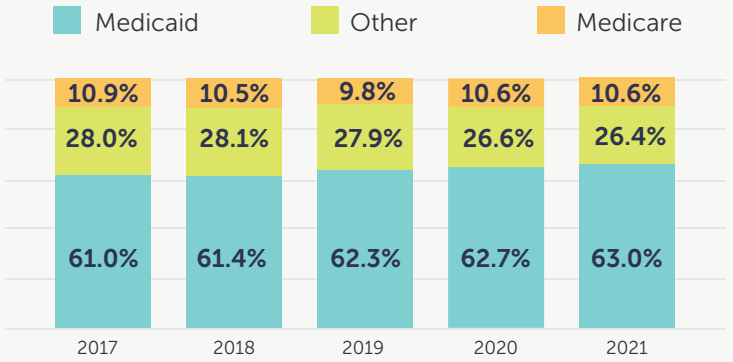
Payer Mix by Star Rating



APPENDIX

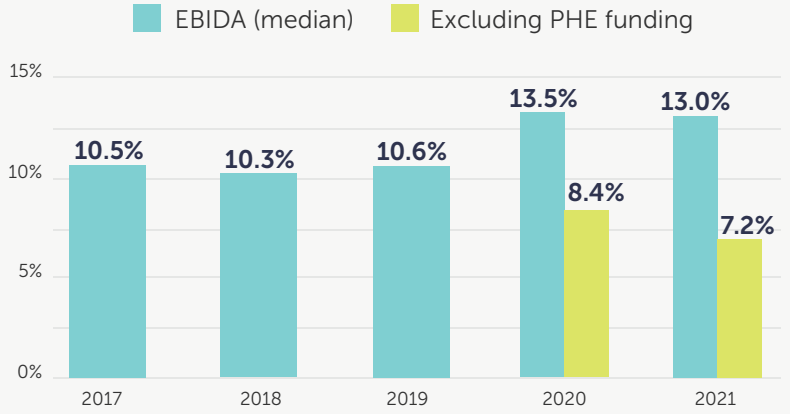
Payer mix

The average payer mix measures the percentage of occupied resident days paid by various payer sources. The percentage of resident days being paid by Medicaid has increased each of the last five years.



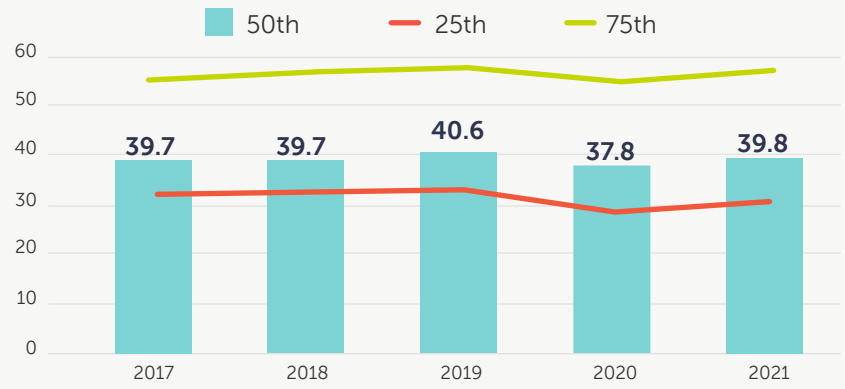
Earnings before interest, depreciation, and amortization (EBIDA)

EBIDA is a commonly used profitability measure because it eliminates capital-related costs. It is a rough measurement of cash flow for skilled nursing operators, so changes measured in this ratio provide a sense for how providers generate cash. The 2020 and 2021 numbers present the EBIDA margin both including and excluding the impact of PHE funding recognized by SNFs.



Days revenue in accounts receivable

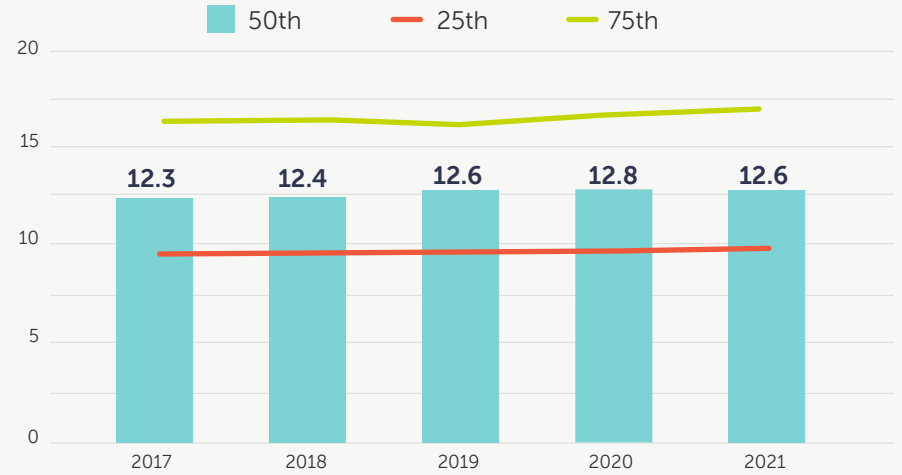
This ratio calculates the average number of days that receivables are outstanding, or how quickly a facility converts its receivables to cash. A lower value of days revenue in accounts receivable is desirable, as it indicates that a facility takes less time to convert its receivables to cash.



	2017	2018	2019	2020	2021
25th	30.3	30.2	31.0	27.4	29.3
50th	39.7	39.7	40.6	37.8	39.8
75th	52.5	53.7	54.4	52.1	54.2

Average age of plant

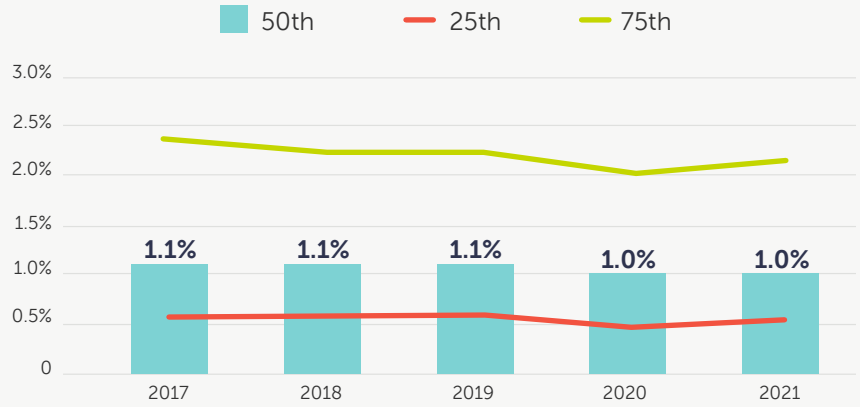
This ratio measures the average age of a facility by estimating the number of years depreciation has been realized for a facility by dividing accumulated depreciation by depreciation expense.



	2017	2018	2019	2020	2021
25th	9.5	9.5	9.5	9.5	9.5
50th	12.3	12.4	12.6	12.8	12.6
75th	16.1	16.1	16.0	16.3	16.6

Capital spending ratio

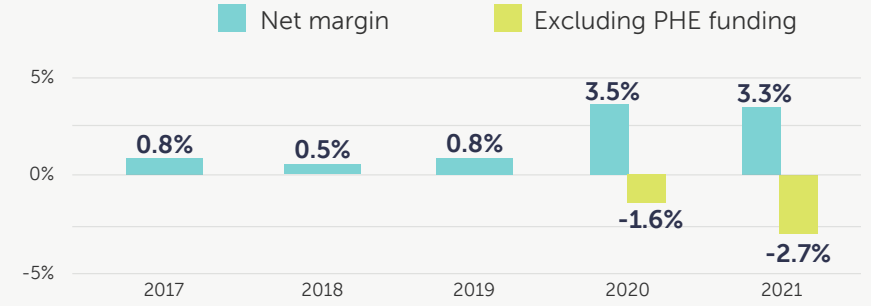
This ratio measures the capital spending of a facility as a percentage of annual operating revenues and indicates how aggressively a facility reinvests its revenue back into its facility.



	2017	2018	2019	2020	2021
25th	0.6%	0.6%	0.6%	0.5%	0.6%
50th	1.1%	1.1%	1.1%	1.0%	1.0%
75th	2.4%	2.2%	2.2%	2.0%	2.2%

Net margin ratio

This ratio measures a facility's efficiency in controlling costs in relation to its total revenue. This profitability measure is calculated by comparing a facility's net income or loss to its total revenue. An organization's ability to maintain its net margin ratio is vital for long-term sustainability. The 2020 and 2021 numbers present the net margin ratio both including and excluding the impact of PHE funding recognized by SNFs.



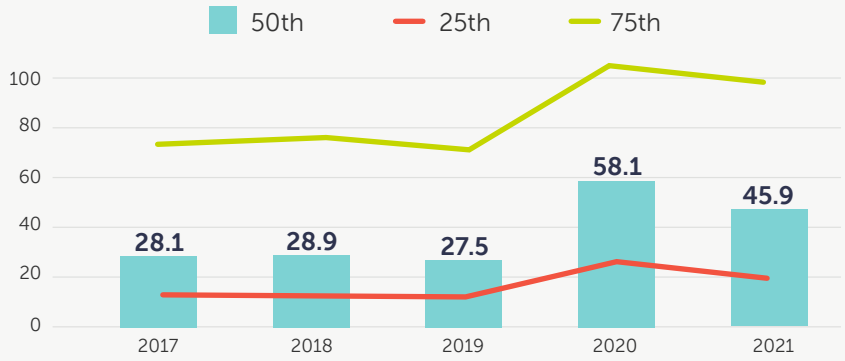
	2017	2018	2019	2020	2021
25th	-4.6%	-5.3%	-4.5%	-2.6%	-5.4%
50th	0.8%	0.5%	0.8%	3.5%	3.3%
75th	5.7%	5.0%	5.6%	9.7%	10.6%

APPENDIX

Days cash on hand

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

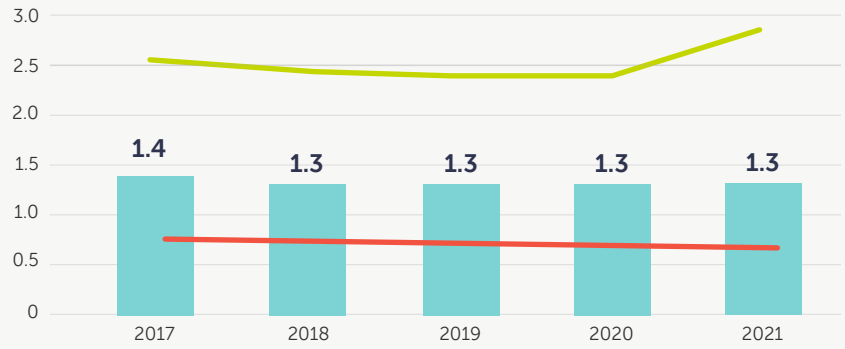
The PHE funding that became available to SNFs provided temporary cash infusions during the pandemic. The continued strain on operations throughout 2021 and into 2022 — labor challenges, inflation, and low occupancy — is causing SNFs to burn through this one-time cash infusion rather quickly.



25th	13.3	13.3	12.8	24.9	18.9
50th	28.1	28.9	27.5	58.1	45.9
75th	71.1	72.9	68.6	102.2	93.4

Current ratio

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

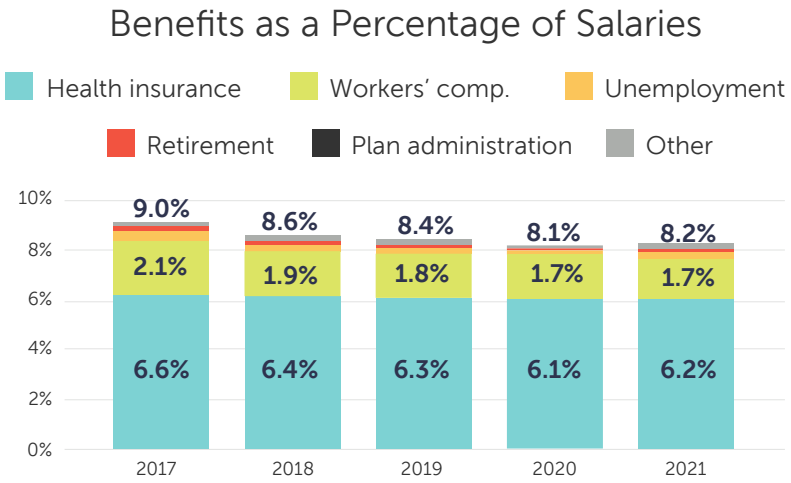


25th	0.7	0.7	0.7	0.7	0.7
50th	1.4	1.3	1.3	1.3	1.3
75th	2.5	2.4	2.4	2.4	2.8

Fringe benefits

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

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

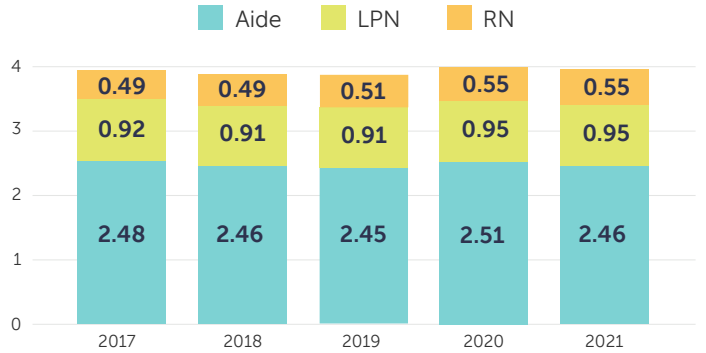


APPENDIX

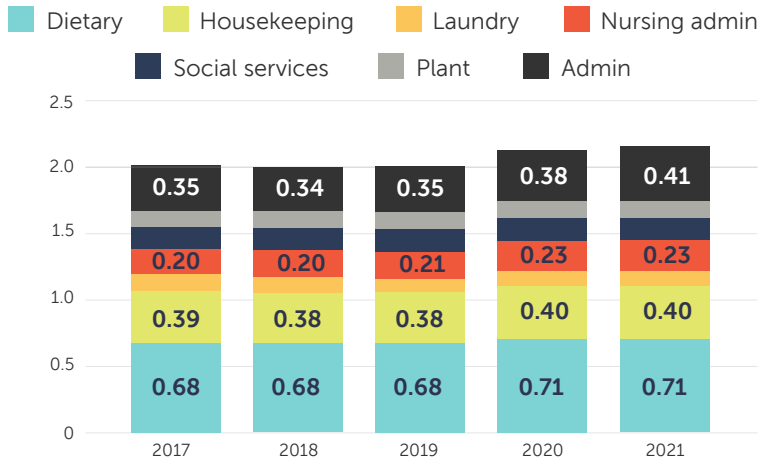
Hours per resident day

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

Median Paid Hours Per Resident Day



Median Paid Hours Per Resident Day (Excluding Nursing)



APPENDIX

Total costs per resident day

Percentile	Nursing	Social services	Ancillary	Plant	Housekeeping	Laundry	Dietary	Admin	Benefits
25th	$92.66	$2.35	$16.24	$11.26	$5.74	$2.04	$18.54	$47.68	$14.67
50th	$117.19	$4.31	$22.43	$14.06	$7.54	$3.17	$22.19	$62.26	$23.32
75th	$147.77	$7.05	$31.10	$18.33	$10.05	$4.47	$27.78	$80.02	$35.43

Salaries per resident day

Percentile	Nursing	Social services	Plant	Housekeeping	Laundry	Dietary	Admin
25th	$73.21	$2.32	$2.12	$2.43	$0.00	$7.78	$9.34
50th	$93.05	$3.98	$2.91	$5.42	$1.38	$11.02	$12.53
75th	$118.84	$6.47	$4.33	$7.62	$2.57	$14.96	$17.92

Salaries per compensated hour

Percentile	Nursing admin	RN	LPN	Aide	Total nursing	Social services	Plant	Housekeeping	Laundry	Dietary	Admin
25th	$35.03	$36.32	$28.01	$16.45	$21.29	$19.48	$18.89	$12.02	$11.32	$13.44	$26.08
50th	$40.41	$42.07	$32.39	$19.71	$24.07	$23.36	$21.71	$13.79	$13.37	$15.56	$30.72
75th	$47.70	$48.49	$37.42	$22.89	$27.05	$28.03	$25.05	$15.85	$15.67	$17.89	$36.44

Indicator formulas

Page 7

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

Page 14

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

Page 22

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

Page 22

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

Page 23

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

Page 23

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

Page 24

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

Page 24

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

Page 25

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

Page 25

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

Page 26

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

Page 27

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

About CLA

The CLA Promise

CLA exists to create opportunities for our clients, our people, and our communities through our industry-focused wealth advisory, digital, audit, tax, consulting, and outsourcing services. With more than 7,500 people, 121 U.S. locations, and a global vision, we promise to know you and help you. For more information visit CLAconnect.com.

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The four essential elements of the CLA Promise

Driven by **Our Values**

Curious
We care, we listen, we get to know you

Collaborative
We help you seamlessly, bringing innovative teams to the table

Transparent
We communicate clearly and authentically

Inclusive
We embrace all voices and create opportunities for you in an energetic and inspiring environment

Reliable
We respond in hours, not days; we follow through, protect our client data, and produce quality results

Our dedication to health care

CLA has developed one of the nation's largest health care practices. Our team includes CPAs and a diverse range of experienced professionals. By working together, we help our clients build enterprise value through strategy, operations, finance, and compliance services. Develop a personal connection with a team of people dedicated exclusively to the senior living and care field. You can benefit from original research, statistics, and techniques developed specifically for senior living and care providers. Committed to helping shape the future of health care, our professionals have offered valuable insights to organizations like yours for more than 60 years.

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

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Our health care network

Our practice consists of
470+
health care professionals

90+
health care principals

We currently serve
10,100+
health care clients

which includes
3,200+
aging services providers

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

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

5,800+
physicians, dentists, and medical practices

Services for SNF operators and owners

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

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

We can help

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