Coming of age: Lower reimbursements will limit growth as an older population spurs demand
## About this Industry

### Industry Definition

This industry provides living quarters, inpatient nursing and rehabilitation services for people with a chronic illness or disability. The care is usually provided for an extended period to individuals who require help with day-to-day activities, but who do not need to be in a hospital.

### Main Activities

The primary activities of this industry are:

- Operating convalescent homes or convalescent hospitals (except psychiatric)
- Operating group homes with nursing care for the disabled
- Operating homes with nursing care for the aged
- Operating inpatient-care hospices
- Operating nursing homes
- Operating rest homes with nursing care
- Operating retirement homes with nursing care
- Operating skilled nursing facilities

### Similar Industries

62161 Home Care Providers in the US
This industry includes companies that provide skilled nursing services in the home and other services, such as personal care, homemaker and companion services, physical therapy and medical services.

62211 Hospitals in the US
This industry includes firms that primarily provide diagnostic and medical treatment (both surgical and nonsurgical) to inpatients with a wide variety of medical conditions.

62231 Specialty Hospitals in the US
This industry includes firms that provide diagnostic and medical treatment to inpatients with a specific type of disease or medical condition. Long-term hospitals are included in this industry.

62331 Retirement Communities in the US
This industry includes firms that provide residential and personal care services for the elderly and others who are unable to care for themselves or who do not desire to live independently.

62399 Orphanages & Group Homes in the US
This industry provides residential facilities and camps that allow disadvantaged and disabled youths to receive care and accommodation simultaneously.
About this Industry

Additional Resources

For additional information on this industry

www.aarp.org
AARP

www.ahcancal.org
American Health Care Association

www.leadingage.org
LeadingAge

www.skillednursingfacilities.org
SkilledNursingFacilities.org

IBISWorld writes over 700 US industry reports, which are updated up to four times a year. To see all reports, go to www.ibisworld.com
Industry at a Glance
Nursing Care Facilities in 2013

Key Statistics
Snapshot

Revenue $120.6bn 2.8% Annual Growth 08-13
Profit $8.3bn Annual Growth 13-18
Wages $50.6bn Businesses 8,634

Market Share
There are no Major Players in this industry

Key External Drivers
Federal funding for Medicare and Medicaid
Number of adults aged 65 and older
Federal expenditure on disability benefits
Number of people with private health insurance
Per capita disposable income

Industry Structure
Life Cycle Stage Mature
Revenue Volatility Medium
Capital Intensity Low
Industry Assistance High
Concentration Level Low
Regulation Level Heavy
Technology Change Low
Barriers to Entry Medium
Industry Globalization Low
Competition Level High

FOR ADDITIONAL STATISTICS AND TIME SERIES SEE THE APPENDIX ON PAGE 37
Executive Summary

The Nursing Care Facilities industry has remodeled itself to accommodate for a tough economy, unstable reimbursement rates and costly professional liability insurance. During the five years to 2013, IBISWorld estimates that industry revenue will increase 2.8% per year on average to $120.6 billion. Due to an aging US population and the necessary nature of services provided in nursing care facilities, the industry was able to thrive even while the economy struggled. However, despite favorable demographic trends, operators made adjustments to boost occupancy rates while maintaining profitability, including progressive acquisition strategies and cost mitigation techniques. Furthermore, revenue growth was hindered as private health insurance coverage and per capita disposable income fell during the recession, decreasing nursing care affordability for many individuals. Additionally, reduced Medicare and Medicaid reimbursements are expected to constrain industry growth, with industry revenue expected to rise a moderate 3.3% over 2013.

In response to changing consumer preferences, unfavorable government policies, uncertain reimbursement rates and a down economy, some operators have exited the industry or closed underperforming locations. This trend has caused the number of companies to increase at a marginal annualized rate of 0.5% to 8,634 in the five years to 2013. Additionally, nursing care operators are changing their business models and offering supplementary services to reduce costs, attract residents and help offset lower Medicare reimbursements. Labor, supply and malpractice expenses have stabilized recently, helping firms maintain profit margins at 6.9% in 2013.

Demand is forecast to pick up slightly starting in 2014 and going forward as the economy recovers and the population continues aging. However, recent healthcare legislation will continue to encourage individuals to use at-home nursing care to cut costs. This trend is expected to shift demand away from the industry’s facilities and into patients’ homes. Furthermore, Medicare and Medicaid reimbursements, which account for more than 75.5% of revenue, are expected to decline over the next five years. Both factors will place downward pressure on revenue and profitability and somewhat offset the benefits of an improving economy and an older population. As a result, IBISWorld forecasts that revenue will grow at a moderate average annual rate of 3.6% over the five years to 2018 to $144.0 billion.

Key External Drivers

Federal funding for Medicare and Medicaid
The majority of nursing homes are certified to provide services under Medicare and Medicaid programs. Medicare and Medicaid reimbursements account for about 75.5% of industry revenue. Federal funding of Medicare and Medicaid and the federally determined terms of access to these programs affect demand for skilled nursing services and the price charged for those services. Although federal funding for Medicare and Medicaid is expected to increase during 2013, continuing reimbursement pressure will be a potential threat to the industry.
Industry Performance

Key External Drivers continued

**Number of adults aged 65 and older**
More than 88.0% of all nursing home residents are older than 65, and 45.0% are 85 or older, so the rate of growth in these age groups affects demand for nursing home care. The number of adults aged 65 and older is expected to increase during 2013, representing an opportunity for the industry.

**Federal expenditure on disability benefits**
The US Census Bureau defines disability as a long-lasting sensory, physical, mental or emotional condition. This condition may make it difficult for a person to perform activities of daily living, so individuals may require nursing care in a facility. As disability expenditure increases, demand for industry services also rises. Federal expenditure on disability benefits is expected to increase during 2013.

**Number of people with private health insurance**
Private insurance can reduce patients’ out-of-pocket costs, as people are more likely to use services when they are covered by insurance, therefore boosting demand for industry services. Nonetheless, payments made through private health insurance make up only a small portion of total industry revenue. The number of people with private health insurance is expected to increase slowly during 2013.

**Per capita disposable income**
As household income rises, households are more likely to purchase insurance or afford out-of-pocket expenses. Also, households become more able to afford paying for their elderly members’ stay in nursing facilities. Consequently, a rise in disposable income can result in heightened industry demand. Per capita disposable income is expected to increase slowly during 2013.

![Number of adults aged 65 and older vs Federal funding for Medicare and Medicaid](source:www.ibisworld.com)
Industry Performance

Current Performance

The Nursing Care Facilities industry has remodeled itself to accommodate for a tough economy, unstable reimbursement rates and costly professional insurance. This adaptability has lessened the severity of the economic downturn’s influence on the industry. In addition, an aging population has been the main support for industry growth during the recession. However, despite this favorable demographic trend, industry operators have had to make adjustments to boost occupancy rates while maintaining profitability. These adjustments include progressive acquisition strategies and cost mitigation techniques.

Starting in the last quarter of 2011, reimbursement for nursing care provided to Medicare patients decreased significantly, and this trend is expected to continue in 2013. As a result of these trends, IBISWorld estimates that industry revenue will grow at a temperate average annual rate of 2.8% to $120.6 billion in the five years to 2013. In 2013 alone, despite declining Medicare and Medicaid reimbursement levels, industry revenue is expected to increase a modest 3.3% as a result of rising demand from the aging population. Furthermore, private health insurance coverage and household income that plummeted during the recession are expected to rebound and increase nursing care affordability for many individuals.

Adjusting for age

The aging US population is boosting demand for nursing care as the elderly are more prone to injuries and illnesses that require assistance with activities of daily living. IBISWorld estimates that the number of adults aged 65 and older will increase an average 2.5% per year to total 44.0 million during the five years to 2013. Specialized care for Alzheimer’s disease is also escalating as the population ages. Top industry players, such as HCR ManorCare and Kindred Healthcare, offer specialized programs for residents with Alzheimer’s disease and other types of dementia.

Residents at nursing care facilities arrive with greater medical complexities and require more extensive and costly care than in previous years. The emergence of the US obesity epidemic, which has started to reverse recent declining trends in disability rates among the elderly, presents new demand and challenges for the nursing care system. To appropriately care for a higher-acuity short-stay patient population and a more frail and unstable long-stay resident population, operators are taking steps to improve the delivery of clinical and hospitality services. Firms achieve this by adjusting the level of staffing, assisting physician oversight through the selective use of nurse practitioners, enhancing nursing skills via ongoing education and improving clinical case management through the employment of clinical case managers.
In 2013, revenue growth is expected to be pressured, primarily due to reimbursement cuts brought on by healthcare reform. In addition, nursing care facilities are already losing under federal sequestration, with a 2.0% cut to patients on Medicare. Medicare is a federal system of health insurance for people over 65 years of age and for certain younger demographics with disabilities. Medicaid is a joint state and federal health insurance program that provides health coverage for low-income individuals. Medicare and Medicaid payments to nursing care facilities are based on changeable payment rates determined by the Centers for Medicare and Medicaid Services, which provide various reimbursement levels according to patient acuity (measurement of the types of disorders, their severity and the intensity of the symptoms). Medicaid payments to nursing care facilities have been cut considerably in recent years and are expected to continue to decline over the coming years as elements of reform are implemented and as states face budgetary pressure. In addition, under a corrective proposal issued by the federal government in July 2011, Medicare payments to nursing care facilities were trimmed 11.1% beginning October 1, 2011. Cuts in federal funding for Medicaid and Medicare represent a potential threat to the industry because Medicaid and Medicare make up about 75.5% of industry revenue.

Payments under government programs are subject to statutory and regulatory changes, which may affect the level of program payments to nursing centers. They also may not be sufficient on an overall basis to cover the costs of serving some patients participating in these programs. The recent economic downturn has accentuated state budgetary pressures, further reducing government payments to nursing centers. Furthermore, changes in government requirements for providing therapy services have increased operating costs. While many operators are implementing or examining cost-saving measures to help mitigate a portion of revenue decreases and cost increases, some have not been able to offset these changes. As a result, IBISWorld estimates that operating profit will increase slightly to 6.9% in 2013, compared with 4.6% in 2008.

A long recession, the prospect of changing reimbursement models and shifting consumer preferences have put pressure on nursing care facilities. As a result, providers are rethinking their models and looking for ways to diversify services to maintain profit margins and attract more residents. Some companies have exited the market or closed underperforming locations in states with unfavorable reimbursement rates. Over the past five years, there has been a shift from nursing homes to managed care at home, adult daycare centers and visits to specialists. Many elderly citizens would like to remain in their homes; in fact, many nursing facility residents do not require 24-hour nursing care, and services provided by a home care attendant or nurse several times a week can often suffice. Also, to expand community-based long-term care services, federal resources have assisted states in rebalancing their...
services from institutional to community care. Beginning in October 2011, states have been able to receive a 6.0% increase in federal matching funds for providing community-based attendant services and support to Medicaid beneficiaries with disabilities. These shifts in favor of at-home care represent rising competition and a potential threat to industry operators as they decrease demand for nursing care facilities.

Furthermore, in response to low Medicaid and Medicare compensation, companies are growing other areas of business to diversify revenue streams. For example, operators are offering specialized services that attract patients with workers’ compensation or private insurance and moving into community-based services with multiple funding streams. This strategy, together with company exits, has contributed to sluggish growth in the total number of companies, representing average annual growth of 0.5% to total 8,634 during the five years to 2013. At the same time, the number of facilities has barely increased during the period, at an average annual rate of 0.1% to 16,543 as financing for new construction became more difficult to attain.

In the next five years, an aging American population will stimulate demand for nursing care as people aged 65 and older make up the majority of nursing home residents. The number of individuals over the age of 65 is projected to increase 3.1% per year on average over the same period, according to IBISWorld projections. In addition, personal disposable income is expected to pick up as the economy continues to rebound, thus enabling people to afford nursing care services and private healthcare insurance. However, the positive effect that population aging will have on industry demand will be partly offset by the effects of government reimbursement cuts, an increase in life expectancy, later onset of frailty and a rise in the use of at-home care services. Revenue growth and profit margins will come under pressure as payers seek to contain costs, causing operators to reevaluate business models to boost residency and efficiency. During the next five years, IBISWorld forecasts revenue will increase at an average annual rate of 3.6% to $144.0 billion, including a 4.4% jump in 2014.

IBISWorld forecasts industry consolidation to increase, with the number of operators expected to rise marginally at 0.6% per year on average in the five years to 2018. Companies will merge to take advantage of bundling Medicare payments that result from new reimbursement policies developed under the 2010 Patient Protection and Affordable Care Act. Merged companies
Industry Performance

Fewer beds, shorter stays continued

will have better economies of scale and offer fuller rosters of nursing care services, allowing providers to better serve Medicare patients. For example, Kindred Healthcare, one of the largest industry’s operators, acquired RehabCare Group in 2011, thus illustrating the industry’s efforts to consolidate in order to expand services. The addition of RehabCare significantly boosts Kindred’s long-term acute care hospital business and its number of contracted rehab businesses with hospitals and skilled nursing facilities. IBISWorld forecasts substantial growth in the number of patients who will require multiple sites of services due to very complex health conditions. About 25.0% of Medicare spending is estimated to be consumed by the 15.0% of patients with five or more chronic conditions.

In light of a growing number of elderly people in the population, having fewer beds will help keep occupancy rates high, promote advancement in high-quality treatment and support increasing private fees. Stalled growth in facilities will allow owners, residents and capital markets to focus on strengthening the nursing care model. IBISWorld projects the number of facilities to increase at an annualized rate of 0.7% to 17,104 during the five years to 2018. Operators will also continue to refine their capital structures and residents’ programs.

Hospitals are forecast to reduce the length of patients’ stays to help minimize costs. This reduction will result in more patients with routine rehabilitative needs receiving care at skilled nursing care facilities. Facility operators will continue to modify their services to manage rising acuity levels of residents, mostly by providing a higher degree of care. Kindred Healthcare, one of the largest industry players, is well positioned to meet rising demand for post-acute services. The company, like many of its skilled-nursing peers, has increasingly focused on patients who require rehabilitation, skilled nursing care after surgery or other types of hospital stays. With Medicare and other payers shifting patients away from hospital settings, post-acute care is an attractive growth opportunity for industry operators.

Maintaining fewer beds per facility will help keep occupancy high and support increasing fees

Complications under reform

The 2010 healthcare reform legislation includes a list of changes to nursing services for seniors and the disabled. One provision involves an infusion of federal funding to help state programs provide more care at home, resulting in a shift from nursing care facilities to at-home care. This trend will be moderately offset by an increase in the number of insured individuals; an estimated 32 million people are projected to gain health insurance coverage under healthcare reform.

The legislation also includes
Complications under reform continued

modifications to qualifying for payment, bundling payments to cover acute and post-acute care and imposing enrollment limitations on new providers. In addition, a primary goal of healthcare reform is to reduce costs, which may include reductions in reimbursements paid to industry operators. Medicaid and Medicare cover more than half of nursing home costs. This funding will change with the reform, slashing more than $500.0 billion on planned Medicare payments to nursing care facilities, hospitals, hospices and other providers over the next 10 years.

The law also requires the Health and Human Services Secretary to submit a report on the appropriateness of establishing a healthcare-acquired condition (HCAC) policy relating to nursing homes. While this change is not a direct cut to reimbursement, it strongly suggests cuts. An HCAC policy could potentially decrease payments and encourage Medicaid patients to receive home care, which will likely mean fewer paid patients for nursing home providers.

Reimbursement to tighten

Despite an increasing portion of post-acute patients, profit margins will continue to decline during the five years to 2018 to about 6.6% of revenue. Strong downward pressure on profit will come from decreasing Medicare and Medicaid reimbursement rates and tougher pricing negotiation from private insurance companies. States are planning to trim Medicaid rolls and benefits and are expected to turn to private insurance companies for manage care. Some states are considering introducing or expanding the use of managed long-term care. The trend is sparking opposition from nursing care operators. Traditionally, states pay Medicaid providers, such as doctors and nursing homes, directly for individual services. Under managed care, states pay health insurers a fixed monthly fee for each Medicaid patient. The lump sum is used for all the patient’s costs, including nursing care. Managed care companies will aim to save states money by keeping Medicaid patients who need long-term care at home whenever possible, rather than in relatively expensive nursing homes. Managed care companies are also expected to negotiate reimbursement rates downward, pressuring the industry’s slim profit margin.

Initiatives undertaken by major insurers and managed care companies to contain healthcare costs or to respond to healthcare reform could affect industry profitability. These payers attempt to control healthcare costs by contracting with healthcare providers to obtain services on a discounted basis. This trend may continue or intensify and may limit reimbursements for healthcare services. If insurers or managed care companies, which account for substantial payments into the industry, reduce the amounts they pay, profit margins may decline further than projected.

States are introducing or expanding managed long-term care, sparking industry opposition
Industry Performance

Life Cycle Stage

The industry relies on funding from government programs, which is expected to fall with other spending cuts.

There are cheaper substitutes for nursing home care.

Growth in the aged population will boost revenue.

Nursing care facilities have long been part of US communities; drastic development is not expected.

Key Features of a Mature Industry

- Revenue grows at same pace as economy
- Company numbers stabilize; M&A stage
- Established technology & processes
- Total market acceptance of product & brand
- Rationalization of low margin products & brands

Quantity Growth

- Many new companies; minor growth in economic importance; substantial technology change

Maturity

- Company consolidation; level of economic importance stable

Quality Growth

- High growth in economic importance; weaker companies close down; developed technology and markets

Decline

- Shrinking economic importance

Home Care Providers

Primary Care Doctors

Brand Name Pharmaceutical Manufacturing

Health & Welfare Funds

Nursing Care Facilities
Industry Performance

Industry Life Cycle

IBISWorld estimates that the Nursing Care Facilities industry is in the mature stage of its life cycle. Industry value added, which measures the industry’s contribution to the overall economy, is estimated to grow at an average annual rate of 3.0% during the 10 years to 2018. This growth is slightly higher than the forecast average GDP growth during the same period (2.1%). While demographic trends have been and will continue to promote growth in this industry, nursing care facilities have been part of American communities since the early 20th century. Facilities have undergone various changes in structure, licensing and funding, but the industry has not undergone major transformation. As such, many operators have been growing by acquiring other facilities, because most areas that have resources available to provide nursing care already have an established nursing care facility.

The number of Americans aged 65 and older has been expanding and will continue to make up an increasing portion of the total population. This will bolster continued demand, but it will not cause dramatic growth. This is particularly true in the current environment of new healthcare legislation that encourages individuals to receive at-home care rather than staying at a facility. Also, the effect of a favorable aging demographic will be softened by the following trends: an increase in life expectancy, later onset of frailty, and an increase in the provision and use of home and community care services. Growth in the population of seniors will vary across and within states, and this will produce varying growth profiles across America.
### Products & Markets

#### Supply Chain

<table>
<thead>
<tr>
<th>KEY BUYING INDUSTRIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>52512 Health &amp; Welfare Funds in the US</td>
</tr>
<tr>
<td>Private health insurance funds can help fund nursing home care, and can represent a referral source.</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>62111a Primary Care Doctors in the US</td>
</tr>
<tr>
<td>Doctors are major referrers of patients to nursing homes.</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>62111b Specialist Doctors in the US</td>
</tr>
<tr>
<td>Doctors are major referrers of patients to nursing homes.</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>62211 Hospitals in the US</td>
</tr>
<tr>
<td>Hospitals are major referrers of patients to nursing homes. Hospitals with in-house nursing centers can also represent competition to the industry's operators.</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>99 Consumers in the US</td>
</tr>
<tr>
<td>Individuals with chronic disease or disability requiring help with day-to-day activities are the primary beneficiaries of the industry's services.</td>
</tr>
</tbody>
</table>

#### KEY SELLING INDUSTRIES

| 32541a Brand Name Pharmaceutical Manufacturing in the US |
| This industry supplies pharmaceuticals and medicines, which are required by most nursing home residents. |
| |
| 32541b Generic Pharmaceutical Manufacturing in the US |
| This industry supplies pharmaceuticals and medicines, which are required by most nursing home residents. |
| |
| 33911a Medical Instrument & Supply Manufacturing in the US |
| This industry supplies nursing homes with a range of medical supplies including medical dressings, beds and syringes. |
| |
| 42345 Medical Supplies Wholesaling in the US |
| This industry supplies nursing homes with a range of medical supplies including beds and syringes. |
| |
| 42421 Drug, Cosmetic & Toiletry Wholesaling in the US |
| This industry supplies pharmaceuticals and medicines, which are required by most nursing home residents. |
| |
| 42441 Grocery Wholesaling in the US |
| Nursing homes purchase groceries to feed their patients. |
| |
| 53112 Commercial Leasing in the US |
| Some nursing homes are owned by companies that lease the homes to nursing home operators. |
| |
| 56131 Employment & Recruiting Agencies in the US |
| Recruiting agencies assist with short-term nursing and other staff requirements |

### Products & Services

Nursing facilities provide short-stay patients and long-stay residents a full range of services in addition to basic skilled nursing care and custodial care. Facilities typically supply rooms, meals, social activities, personal care, 24-hour nursing supervision and access to medical services when needed. In addition, most nursing facilities offer respite care (short-term, temporary relief for those who are caring for family members) and interim medical care (after a hospital stay).

Selected services provided to nursing home residents are delivered through formal contracts with outside providers.
According to the Online Survey, Certification and Reporting database of the Centers for Medicare and Medicaid Services, pharmacies and medical direction are the services most commonly provided under contract. Other services commonly provided by outside sources include therapy services, podiatry services, dental and oral services, and diagnostic services.

During the past five years, there has been a shift from nursing facilities to managed care, which allows elderly patients to stay in their homes and receive medical and social services otherwise provided in institutions. Many seniors still prefer to remain in their homes and some nursing home residents in fact do not require 24-hour nursing care. Instead, seniors can receive services like home healthcare or Meals on Wheels.

The major types of nursing facilities are skilled nursing facilities (SNF), nursing homes and inpatient hospices. An SNF is an institution that primarily provides skilled nursing care or rehabilitation services for injured, disabled or sick individuals. Hospitals often have arrangements with SNFs to provide follow-up care after a patient no longer needs the level of services that an acute hospital provides. The patient is sent to an SNF to receive skilled care and rehabilitation until they are able to return home.

**Skilled nursing facilities**

In general, SNF care is covered under health insurance plans and Medicare, and nursing home care is not covered. Medicare is a federal program primarily for those aged over 65 years. With the growing number of elderly in the United States, more facilities are gaining Medicare certification and offering skilled nursing services. SNFs can provide specialized services, including care for patients with Alzheimer’s disease, ventilator and oxygen care, HIV care, intravenous therapy, complex wound care, traumatic brain injury care and post-stroke care.

Medicare and higher-acuity nursing care patients (i.e. those with relatively brief but severe illnesses) generate higher revenue per patient day, but profitability with respect to higher-acuity patients is reduced by the higher costs associated with them. Kindred Healthcare, a large industry player, generates about 34.0% of revenue through Medicare-covered patients, but these patients make up only 17.0% of patient days in the company’s nursing centers. Medicaid accounts for...
Demand Determinants

The demand for nursing care facility services is influenced by the size and age distribution of the population; the level of, and changes in, household incomes and wealth; and the scope, availability, effectiveness and cost of both nursing care facilities and alternative or substitute services.

Catering to a diverse crowd

As the population ages, more individuals require the services of nursing care facilities because aging adults are more susceptible to injuries and illnesses that prevent the performance of activities of daily life. According to the US Census, nearly 75.0% of nursing facility residents are 75 or older. The median age of nursing facility residents is 83.2 years. Based on data from the Centers for Medicare and Medicaid Services, of the 65-and-over population, about 7.0% have a nursing home stay in any given year, and about 21.2% of individuals aged 85 and older have a nursing home stay. As such, an aging population and increased life expectancies can increase demand in the industry.

However, today, many nursing facilities do not cater services exclusively to the elderly patients. During the past five years, resident demographics has changed, with the growing number of younger residents. The percentage of patients under age 65 has been steadily increasing since 2002, according to Skilled Nursing Facilities, a nationwide directory of nursing homes. Younger patients who require a long rehabilitation are placed into nursing homes because they are cheaper than hospitals.
During the past five years, there has also been an increasing availability of alternatives to nursing facilities (e.g. assisted living) and a rising use of community services (e.g. home healthcare), resulting in significant changes to the profile of the typical nursing care facility resident.

**Age**
The proportion of elderly adults over age 65 in nursing homes has declined over the past two decades, most noticeably in the past five years. Reasons for this trend include reductions in disability rates among elderly people, improvements in mechanisms for coping with disability, and changes in the residential and long-term care options available to elderly people with disabilities. Nonetheless, about 47.0% of nursing care residents are aged over 85. In contrast, about 14.9% of residents are aged younger than 65. Americans at high risk for placement in nursing home facilities are typically aged 85 and older, women and African-Americans, who are also more likely to rely on Medicaid as their primary source of payment, according to the Centers for Medicare and Medicaid Services.

Four-fifths of elderly people in nursing care facilities are long-stay residents (90 days or longer) and about half of elderly residents can be considered permanent residents (one year or longer). The typical long-stay resident is over age 85 (53.0%), female (76.0%) and widowed (60.0%). Disease prevalence is higher, and multiple conditions are more common, among elderly nursing home residents in 2013 versus 2008, indicating an increasingly sicker population within facilities. This is likely attributable to the

Consequently, nursing facilities must accommodate needs of patients of different ages and illnesses by training staff and developing age-appropriate services.

**Patients still need to pay**
Demand for nursing care facilities is influenced by the affordability of services. According to information from the Organisation for Economic Cooperation and Development (OECD), wealthier people tend to spend more on healthcare, including nursing care. Therefore, changes in household wealth (i.e. disposable income and job stability) can affect private spending on nursing care facilities. Health insurance can reduce the direct cost of care to patients and can thereby boost demand in the industry. Government health funding for Medicare and Medicaid and other regulatory policies can also affect the out-of-pocket cost for services.

**Where patients go for services**
Nursing care facilities face competition from substitute services, which can sometimes be more cost-effective for patients and payers. Substitute options include facilities located in hospitals, long-term care facilities and at-home programs. According to the American Health Care Association, nursing facility services’ share of long-term care Medicaid expenditure has been declining since 2002. This trend is expected to continue and be furthered by recent healthcare legislation, which includes an infusion of federal funding to help state programs provide more care through home and community settings. Public and privately funded programs can increase the overall level of health by promoting healthy lifestyles. Additionally, advancements in pharmaceuticals and surgical procedures may avert or reduce the need for institutionalization.
rising availability of alternatives to nursing care facilities, which causes people to use nursing care only when it is most necessary. Over two-thirds of long-stay residents have multiple physical conditions, and close to 40.0% have both physical and cognitive conditions. The percentage of long-stay residents who receive help from another person in five activities of daily life (ADLs) has also been on the upswing. A high percentage of these residents do not walk (41.0%) and only 18.0% walk independently without help or supervision.

**Gender**

The proportion of female-to-male residents has been very moderately increasing. Women tend to live longer than men, which means they are more likely to be admitted to a nursing home, and they are also more likely to stay for longer. Overall longevity of stays has increased during the past five years, though at a slower rate for women than men. Additionally, a higher percentage of older women need help with personal care and routine care activities than older men.

Within the nursing home population, substantially more men (42.0% of the population) than women (15.0%) are married, while more women than men are widowed (69.0% compared with 30.0%). Although about 28.0% of residents can perform ADLs, nearly 50.0% have at least four ADL impairments. The percentage of patients with no impairments has been gradually increasing, as has the prevalence of physical restraints. Based on the data, there is a growing acceptance of nursing facilities for purposes other than serious illness.

**Prior care**

Immediately prior to admittance to a nursing home, 36.0% of residents come from an acute care hospital. Other previous locations include a private or semi-private residence (29.0%); another nursing home (11.5%); a hospital-based skilled nursing facility (8.5%); or assisted living, board and care or group home. The number of residents coming from a private residence has increased during the past five years, pointing to the rising use of home healthcare. This illustrates the preference for remaining in a residential setting and presents an opportunity for industry operators to cater to this preference.
Payment
Over 92.0% of nursing homes are certified to provide services under both Medicare and Medicaid programs. Medicaid is the primary payer for nursing facility patients, accounting for about 48.5% of payments. Medicaid is a state-administered program that provides for medical assistance to individuals who meet low-income and other requirements. About half of all nursing home residents pay nursing home costs out of their own savings. After these savings and other resources are exhausted, many long-term nursing home residents become eligible for Medicaid.

Medicare is a social insurance program administered by the federal government that will pay some nursing home costs for people who are aged 65 and older or who meet other special criteria. Medicare payments account for about 27.0% of industry revenue. Patients may be covered up to 100 days. To be covered, a patient must receive the services from a Medicare-certified skilled nursing home after a qualifying hospital stay.

Illness
A common approach used by healthcare providers to measure functional ability in older adults is activities of daily living. This method consists of measuring changes in the person’s ability to perform six ADLs. ADLs include such functions as bathing, dressing and eating. The average number of ADLs that nursing care residents experience difficulty in has been increasing during the past five years. The four ADLs that nursing facility residents receive the most assistance with are bathing (96.0% of residents), dressing (87.0%), toileting (56.0%) and eating (45.0%). The proportion of residents with severe ADL impairments has also been increasing. Nearly half of all nursing home residents require extensive assistance with at least four ADLs. These increases in levels of disability (which have led to higher levels of frailty) and the trend towards entering the facility later, has resulted in operational and clinical challenges that require increased administration and staff.

The most common diagnoses at the time of admission are cardiovascular disease, mental and cognitive disorders, and disorders of the endocrine system (i.e. diabetes mellitus); and, almost without exception, residents have more than one diagnosis when they were admitted. These conditions often contribute to functional decline, which can affect ADLs and instrumental activities of daily living, such as shopping and taking medication. When combined with other risk factors, such as living alone and low income, these conditions make it more difficult for a person to remain independent, increasing the likelihood for admission to an institutional environment such as a nursing facility.

Cognitive and functional impairment are common among residents of nursing homes. The percentage of nursing home residents without reported cognitive impairment has gradually been increasing. Currently, about 32.0% of nursing facility residents are reported to have no cognitive impairment, according to the CMS. The proportion of nursing home residents with severe or very severe cognitive impairment has decreased in about the same proportion. This may reflect a greater proportion of short-stay and subacute residents.
Products & Markets

International Trade

Nursing care facilities primarily provide services to residents of the United States. Many of these facilities receive government-subsidized care when care is provided by registered facilities in the United States. Furthermore, patients who receive Medicare or Medicaid must be US citizens or eligible nonresidents.
Products & Markets

Business Locations 2013

Industry establishments (%)
- Less than 3%
- 3% to less than 10%
- 10% to less than 20%
- 20% or more

Additional States (as marked on map)
1 VT 0.3 2 NH 0.5 3 MA 2.7 4 RI 0.5
5 CT 1.5 6 NJ 2.3 7 DE 0.1 8 MD 1.5 9 DC 0.1

SOURCE: WWW.IBISWORLD.COM
Based on data from the US Census Bureau, the regions that account for the largest share of establishments in the industry are the Southeast, Great Lakes and Mid-Atlantic regions. This trend roughly reflects the age distribution in the United States. Employment in this industry is also concentrated in the Southeast (accounting for an estimated 24.4% of industry employment), the Mid-Atlantic and the Great Lakes regions. The largest states in terms of employment are New York, California, Texas, Ohio and Florida. The average size of establishments in this industry, as measured by average employment per establishment, varies significantly by region. Locations in the Mid-Atlantic region employ an average of 125 people, while Southwestern locations average 75. The Mid-Atlantic has a relatively high number of employees per establishment due to unionization. All states have unionized nursing care facilities; however, the Mid-Atlantic is the most unionized region, according to the Service Employees International Union (SEIU).

Serving an elderly population
A major factor influencing the location of industry facilities is the population of individuals aged over 65 years. According to the US Census, the Mid-Atlantic and Southeast are home to the largest proportion of people aged 65 and over, while these regions have the smallest proportion of people under age 18. The West has the opposite situation.

Nursing care is particularly important in rural areas, given the slightly larger percentage of elderly in rural areas than in urban areas. According to the US Census, about 12.0% of the urban population is over age 65, compared with nearly 13.0% of the rural population. Moreover, rural elderly are older than urban elderly, with the age increasing as one moves along the continuum from urbanized to rural areas. Rural areas are also home to a greater proportion of the oldest population segment.

While many services are lacking in rural areas, nursing homes remain an exception, with 40.0% of all nursing homes in rural areas, according to data from the Texas A&M University System.
Health Science Center. However, nursing homes in rural regions face the challenge of lower reimbursement rates. Currently, some states’ Medicare or Medicaid reimbursement limits vary based in part on a nursing home’s location within the state. For instance, Minnesota is divided into three regions for nursing facility reimbursement. According to the Minnesota House Research and Fiscal Analysis Department, the average per day reimbursement rate is 25.0% higher for nursing homes in metro regions than facilities in deep rural areas and 17.0% higher than rural facilities.

**Nonprofit nursing care facilities**

The proportion of tax-exempt firms varies. According to the US Census, about 26.5% of the industry is operated by nonprofit firms. In the Mid-Atlantic region, these firms account for 36.0% of industry revenue generated, while this percentage is only 25.5% in the Southeast. The role of nonprofit firms tends to be greater in areas where such organizations have existed for a long time.
**Competitive Landscape**

**Market Share Concentration**

Despite recent mergers in the Nursing Care Facilities industry and consolidation over the past five years, the industry is still highly fragmented, characterized by a number of local and regional providers. IBISWorld estimates that the top four firms account for about 12.1% of industry revenue and the largest operator, HCR Manor Care, makes up 3.5% of total revenue. A majority of the businesses in the industry are single facilities and privately owned. Based on data from the Centers of Medicare and Medicaid Services, for-profit operators of nursing home facilities account for about 65.0% of nursing homes, 30.0% are operated as voluntary not-for-profit facilities and the remaining 5.0% are owned by the government and other facilities. The fragmented nature of the industry provides opportunity for aggressive and complementary healthcare companies to acquire smaller facilities to begin establishing a foothold or dominating the industry. Some of the industry’s largest chains have been divesting beds during the past five years. States with high liability costs have led to many national chains selling facilities in those states, as operating these imposes a higher cost and restricts profit potential. The strong competition for patients has caused diversification and specialization of services. This increases the likelihood that facilities will develop subacute and other specialty care units.

**Key Success Factors**

Access to highly skilled workforce
A company’s ability to attract and retain quality nursing and administrative staff is important in maintaining patient satisfaction and reducing risk of liability.

Effective quality control
Quality control helps facilities attract and retain residents and assure compliance with requirements under applicable Medicare and Medicaid regulations.

Proximity to key markets
Residents and family members usually prefer facilities close to their homes.

Understanding government policies and their implications
An understanding of government policies ensures that operators comply with regulations, so that they are not fined and so that they are reimbursed for care given to Medicare and Medicaid patients.

Optimum capacity utilization
Nursing care facilities focus on maintaining an adequate portion of high-acuity and private payment patients in order to remain profitable. Additionally, operators aim to maintain an occupancy rate of at least 80%.

**Cost Structure Benchmarks**

Profit
The average industry’s profit margin, defined as earnings before interest and taxes, is estimated to account for about 6.9% of total revenue in 2013. Industry profitability is affected by a number of factors, including occupancy rates, sources of payment, terms of reimbursement, the acuity level of patients and facilities ownership or lease terms. The types of patient stays and care provided have been affecting profit margins during the past five years, and these trends are expected to continue in the future. Care in nursing care facilities has broadened to include subacute admissions and short-stay residents, who typically provide lower profit due to high expense at the beginning and end of stays. Despite declining government
Competitive Landscape

Cost Structure
Benchmarks continued

payments in conjunction with rising operating costs, a number of operators have been able to implement cost-saving techniques to offset these trends, thus helping lift up profit margins from 4.6% in 2008. However, operating profit will face downward pressure over the next five years due to decreasing reimbursement levels.

Occupancy rates measure the degree to which facilities are fully utilizing the number of beds that are available for patients. Occupancy varies from state to state and region to region. If beds are in demand, which goes hand-in-hand with high occupancy, nursing homes in that region can refuse the fixed-payment, government-reimbursed residents in favor of private-pay insurers. On the other hand, in areas of low occupancy, operators have to accept more low-paying Medicaid and Medicare residents, and private-pay rates will be competitive because buyers will bid one facility against another for their services. As a result, profitability in low-occupancy areas tends to be lower.

Labor costs
Employee-related expenses make up the largest expense category in the industry. Based on data from the US Census Bureau, annual payroll accounts for about 42.0% of industry revenue, and this figure has been rising during the past five years. IBISWorld estimates that wages have increased 1.6% per year on average during the period. Annual personnel turnover can be high, even approaching 100.0% for aides at some facilities. High turnover results in recurring training of new workers, which is costly. An increase in patient acuity has caused care staff and wage expense to rise during the past five years.

When expressed as a percentage of
Competitive Landscape

Cost Structure

Basis of Competition

Competitive Landscape

Nursing care facilities compete with other facilities and with similar healthcare providers on quality of care, reputation, location and physical appearance and the price of services. Because programs for nursing care services are generally uniform, companies compete primarily on customer service and location. There is limited, if any, price competition with respect to Medicare and Medicaid patients, since revenue received for these services provided to such patients are based generally on fixed rates. However, companies compete based on pricing for private payment patients.

Quality and the perception of quality can be affected by the commitment and expertise of staff, the range of services...
Competitive Landscape

Barrier to Entry

The Nursing Care Facilities industry has moderate barriers to entry, particularly in states with no certificate of need (CON) regulation. A CON is a legal document required in many states before proposed acquisitions, expansions, or creations of facilities are allowed. CONs are necessary for the construction of a medical facility in 36 states and are issued by state healthcare agencies. Operators must also adhere to other federal, state and local government laws and regulations (which can be extensive) when establishing and operating facilities. For instance, facilities must be accredited and licensed. Many states have imposed moratoria on new nursing homes beds.

Aside from regulation, barriers to entry are low. Capital costs per bed are lower for nursing facilities than for hospitals, and new operators can enter the market with little personal equity and high debt. Nursing homes do not need highly specialized equipment and the labor force is less skilled than it is in hospitals. Although licensing can be burdensome, the costs to becoming accredited are low. Finally, the market is highly fragmented, so there are few very large operators. Therefore, operators can enter the market with a small number of beds and compete with an existing facility.

However, operators must attract a critical mass of patients to be viable, and

Basis of Competition continued

offered, and the level of innovation in treatment programs. Marketing programs can affect the perception of quality. Marketing to local physicians, hospitals and payers can influence these healthcare providers’ support for facilities.

For-profit operators of nursing care facilities also compete with nonprofit organizations or government agencies, which have access endowments and tax revenue. Facilities and hospitals owned by governmental agencies or not-for-profit corporations are supported by endowments, charitable contributions or tax revenue and can finance capital expenditures and operations on a tax-exempt basis. Nursing care facilities may compete with facilities offering similar services, such as hospitals providing long-term care and subacute care services, and community care facilities for the elderly (such as assisted-living facilities, continuing care facilities, retirement communities and staged living communities).

External competition

Competition from hospitals and other healthcare providers for patients has intensified in recent years. Industry operators face competition from large tertiary care centers, specialty hospitals and surgery centers. The number of freestanding specialty hospitals, surgery centers and diagnostic and imaging centers providing similar services to the industry has increased significantly in recent years. Additionally, increased competition as a result of consolidation of hospitals and healthcare companies is occurring in specific geographic markets. Mounting competition will likely affect the industry’s financial performance in the years ahead in terms of rising pressure on revenue.

Revenue and profitability is also expected to suffer from mounting competition from home- and community-based care. Patients increasingly prefer to remain at home, receiving care from attendants instead of moving to a nursing care facility. The healthcare reform of 2010 also includes various provisions that favor home care over institutional care, mainly due to lower costs.
The Nursing Care Facilities industry has a low level of industry globalization, because services primarily provided by US establishments to US citizens. Because many operators are nonprofit and depend on government and public funding, it is essential for them to comply with regulations and maintain relationships with local governments and public. There is also little, if any, investment by US-based firms in nursing home facilities in other countries, including in neighboring countries. National regulation and government funding of the sector create a barrier to globalization.

### Barriers to Entry checklist

<table>
<thead>
<tr>
<th>Level &amp; Trend</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competition</td>
<td>High</td>
</tr>
<tr>
<td>Concentration</td>
<td>Low</td>
</tr>
<tr>
<td>Life Cycle Stage</td>
<td>Mature</td>
</tr>
<tr>
<td>Capital Intensity</td>
<td>Low</td>
</tr>
<tr>
<td>Technology Change</td>
<td>Low</td>
</tr>
<tr>
<td>Regulation &amp; Policy</td>
<td>Heavy</td>
</tr>
<tr>
<td>Industry Assistance</td>
<td>High</td>
</tr>
</tbody>
</table>

SOURCE: WWW.IBISWORLD.COM
The Nursing Care Facilities industry is highly fragmented, characterized by a number of local and regional providers. IBISWorld estimated that the top four firms account for 9.8% of industry revenue.

**HCR ManorCare**

*Estimated market share: 3.5%*

HCR ManorCare is a privately held company that provides short- and long-term medical and rehabilitation care through a network of nursing and rehabilitation centers, assisted-living facilities and outpatient rehabilitation clinics. The company operates under the Heartland, ManorCare Health Services and Arden Courts brands. With more than 500 locations in 32 states, HCR ManorCare is a leading provider of home care, employing about 60,000 caregivers nationwide. The company is headquartered in Toledo, Ohio. The company's industry relevant nursing care revenue is estimated to account for about 83.0% of its total revenue. About 65.0% of the company's skilled nursing and rehabilitation centers also provide rehabilitation on an outpatient basis and about 62.0% of its facilities are located in Florida, Illinois, Michigan, Ohio and Pennsylvania.

With strong occupancy rates and a diverse mix of patient, HCR ManorCare has experienced solid growth and increased cash flow since its acquisition by private equity group Carlyle Partners in December 2007. In December 2010, HCP Inc., a real estate investment trust paid $6.1 billion to buy the real estate assets of HCR ManorCare. HCP acquired 338 post-acute, skilled nursing and assisted-living properties in 30 states, including Ohio, Pennsylvania and Florida. This acquisition points to the rising interest and activity of private equity funds in the Nursing Care Facilities industry.

During the five years to 2012, the company has focused on maintaining higher standards and quality of care, investing in technology, opening and expanding facilities and reducing debt. Furthermore, in the three years to 2009, the company invested more than $350.0 million in new construction, renovation and expansion of existing facilities, new equipment and information technology. In 2009, many skilled nursing facilities suffered from the recession and from the 1.1% Medicare reimbursement reduction. Nevertheless, HCR ManorCare reported a double-digit increase in its year-to-year operating income. The company was able to offset the Medicare reduction through shifting to more high acuity care. In 2011, HCT ManorCare’s performance continued to benefit from stable occupancy, increased revenue from higher acuity residents. In 2012, IBISWorld estimates that the company’s revenue has reached $3.9 billion.

**GGNSC Holdings LLC**

*Estimated market share: 2.3%*

GGNSC Holdings LLC, with headquarters in Fort Smith, AK, is a holding company doing business as Golden Horizons. The company’s operations include the following: Golden Living, a US nursing home operator with 261 skilled nursing facilities and 16 assisted-living centers; and Beverly Living, which operates 77 skilled nursing facilities and two assisted-living centers.

GGNSC Holdings is the result of the 2006 merger of Beverly Enterprises Inc. and Pearl Senior Care, an affiliate of Fillmore Capital Partners. In 2012, the company is expected to generate about $2.5 billion in revenue. The company’s Golden innovations unit provides hospice and home care services and contract rehabilitation therapy services under the Aegis and Asera banners. Its Ceres unit is a healthcare products distributor, Aedon Staffing provides healthcare staff, and its Vizia Design business builds new and
renovates existing long-term care facilities.

Kindred Healthcare Inc.
Estimated market share: 2.1%
Kindred Healthcare Inc. is a healthcare services company that through its subsidiaries operates hospitals, nursing centers and a contract rehabilitation services business. The company’s hospital division operates 121 long-term acute care centers and five inpatient rehabilitation hospitals; its nursing center division operates 224 nursing and rehabilitation centers and six assisted living facilities. The company is headquartered in Louisville, Kentucky.

The company’s health services division is relevant to the industry, making up about 42.0% of Kindred’s revenue, or an estimated $2.3 billion in 2012. The company derives more than 80.0% of health services and rehabilitation revenue from the Medicare and Medicaid programs and the balance from other third party payers, such as commercial insurance companies, health maintenance organizations, preferred provider organizations and contracted providers. This high exposure to government payers exposes the company to changes in reimbursement rates.

In February 2011, Kindred acquired RehabCare Group, a leading care provider that operates long-term acute care hospitals and inpatient rehabilitation facilities. The price tag for the acquisition was $900.0 million. Kindred will be able to expand its rehabilitation service business and keep patients under its care throughout their recovery, resulting in a one-stop shop on the continuum of care, with patients moving from a hospital to a long-term facility for further care or rehabilitation.

Kindred divested 29 underperforming nursing and rehabilitation centers with about 3,600 licensed beds between 2007 and 2009. During the same period, the company continued to seek additional growth opportunities through strategic acquisitions in selected target markets. Kindred has also made progress over the past five years in the recruitment, retention and development of employees. Investments in employee orientation, education and employee recognition programs have helped Kindred achieve lower turnover percentages, a leading indicator of its business condition. In addition, the company is taking measures to significantly reduce the costs to offset the impact of Medicare reimbursement changes. For example, the company considers further investment in its more profitable cluster geographic markets.

Genesis HealthCare Corporation
Estimated market share: 1.9%
Genesis HealthCare Corporation is made up of inpatient service businesses (accounting for about 90.0% of revenue) and rehabilitation therapy businesses. Genesis operates more than 200 skilled nursing centers and assisted-living residences in 13 eastern states, and provides contract rehabilitation services to more than 1,100 healthcare providers in 35 states and the District of Columbia. Genesis’s largest markets include Massachusetts, Maryland, New Jersey, Pennsylvania and West Virginia. The company’s portfolio has geographic density in metropolitan markets with high barriers to entry, significant hospital system referral source admission efficiencies and high replacement costs. These notable portfolio strengths are a market differentiator for Genesis in the industry.

In April 2011, Health Care REIT Inc. completed the acquisition of substantially all of the real estate assets of Genesis for a purchase price of $2.4 billion. The average occupancy in Genesis’ inpatient facilities is about 90.0% and about 50.0% of net inpatient revenue is derived from Medicaid, 30.0% from Medicare and
20.0% from private pay and other. More than 89.0% of patients come to Genesis’s centers directly from an acute hospital stay. Half of all patients who enter Genesis’ facilities from post-acute care are discharged within 24 days. In 2012, the company’s nursing home operations are expected to generate $2.1 billion in revenue.

**Sun Healthcare Group Inc.**
Estimated market share: 1.7%
Sun Healthcare Group Inc. and its affiliates provide skilled nursing care, long-term residential care and specialized healthcare services primarily to the senior population in the United States. In addition, Sun Healthcare Group provides rehabilitation therapy services and medical staffing and ancillary services. The company operates 205 inpatient facilities spread across 25 states in the United States. Roughly 17 of the 25 states in which the company operates, have certificate of need limitation on the addition of new skilled nursing capacity that affords Sun Healthcare Group some protection from competition in the local marketplace. In November 2010, the company completed a restructuring of its business by separating its real estate assets and its operating assets.

Sun Healthcare has grown its Medicare mix from 24.9% in 2007 to 30.0% in 2012. Sun’s rehabilitation division revenue is affected by reimbursement for outpatient rehabilitation services paid under the Medicare physician fee schedule. The company faced significant challenges in 2011 related to the implementation of CMS’ final rule for Medicare reimbursement to skilled nursing facilities, requiring the company to undertake cost-mitigation efforts and to implement changes to its therapy-delivery processes. In 2012, the company is expected to generate $1.9 billion in revenue.

Managed care has increased as a percent of revenue, but the growth in high acuity patients has come at the expense of private pay revenue, which has dropped since 2007. A key part of Sun’s strategy of driving higher acuity is development of specialized rehabilitation units within its nursing homes called Rehab Recovery Suites. These suites are specifically geared toward younger, short-stay Medicare and managed care patients. Most are single or double occupancy suites and offer dedicated clinical staff, more intense therapy programs, and additional benefits, including concierge services to make the patient’s recovery as comfortable and quick as possible.

In June 2012, Sun Healthcare signed an agreement for the acquisition of Sun Healthcare (Sun) by Genesis Healthcare, one of the nation’s largest skilled nursing care providers with over 200 skilled nursing centers and assisted living facilities. A transaction is valued in about $275 million net of cash and debt acquired and expected to be completed in the fall. The acquisition will strengthen the combined company’s core business and offer better quality services.
Operating Conditions

Capital Intensity  Technology & Systems  Revenue Volatility
Regulation & Policy  Industry Assistance

Capital Intensity

Level

The level of capital intensity is **Low**

The Nursing Care Facilities industry requires relatively high amounts of labor input and moderate levels of capital input. For every $1.00 spent on labor, only $0.05 is spent on capital equipment. Total labor costs represent about 42.0% of industry revenue. Significant levels of personal and nursing care are provided to patients. Additionally, in recent years, there has been a rise in patient acuity, which can increase the number of staff hours required per patient.

Depreciation represents about 2.2% of total revenue in the industry. Capital expenditures can be volatile and are affected by the extent to which facilities are owned (rather than rented) and levels of profitability. While most operators lease facilities, several companies are increasingly owning the properties. For example, Kindred Healthcare increased focus on development and acquiring

Tools of the Trade: Growth Strategies for Success

**New Age Economy**

Recreation, Personal Services, Health and Education. Firms benefit from personal wealth so stable macroeconomic conditions are imperative. Brand awareness and niche labor skills are key to product differentiation.

**Traditional Service Economy**

Wholesale and Retail. Reliant on labor rather than capital to sell goods. Functions cannot be outsourced therefore firms must use new technology or improve staff training to increase revenue growth.

**Old Economy**

Agriculture and Manufacturing. Traded goods can be produced using cheap labor abroad. To expand firms must merge or acquire others to exploit economies of scale, or specialize in niche, high-value products.

**Investment Economy**

Information, Communications, Mining, Finance and Real Estate. To increase revenue firms need superior debt management, a stable macroeconomic environment and a sound investment plan.

**Change in Share of the Economy**
Operating Conditions

Capital Intensity continued

facilities, with a larger portion of its portfolio coming from owned real estate. The company currently owns 52 facilities, up from 16 facilities in 2006. The benefits of owning facilities rather than leasing them include improved integration and coordination of technologies, employees and other resources.

Technology & Systems

There are many different types and levels of technology used in nursing care facilities. Some operators have advanced systems that aid nurses in making treatment decisions, wireless technology to assist in the delivery of care, and systems that support administrative and financial matters and inpatient self-management; however, the majority of nursing care facilities have minimal levels of technology in place.

Technological developments can influence the efficiency of nursing care facilities. This includes computerized systems for patient management and record keeping and medical and other equipment that enable operators to treat specific illnesses. Due to the industry’s low average profit margin, many facilities struggle to afford technological upgrades. Adoption of electronic medical records has been slow, due to the high labor and funding investment that is required to implement these systems. The recent healthcare reform legislation provides healthcare businesses with tax incentives to convert to electronic record keeping, which is expected to increase small operators’ access to this technology.

Computer systems can provide real time access to patient information as well as clinical alerts, and can also enhance financial management. Concerns about errors in healthcare and patient safety have prompted policy makers and government committees to urge the development of technologies to support decision-making and promote data standards.

Revenue Volatility

A higher level of revenue volatility implies greater industry risk. Volatility can negatively affect long-term strategic decisions, such as the time frame for capital investment. When a firm makes poor investment decisions it may face underutilized capacity if demand suddenly falls, or capacity constraints if it rises quickly.
Operating Conditions

Revenue Volatility continued

The Nursing Care Facilities industry has a relatively moderate level of revenue volatility. Medicaid and Medicare account for significant portions of industry revenue. Such a large reliance on government support has made nursing homes vulnerable to vagaries in state and federal reimbursement policies towards nursing homes. Funding volatility may hamper a nursing care provider’s ability to remain focused on improvement. This industry is highly regulated. Due in part to the relatively high cost of nursing care facilities, many state governments have started to shift Medicaid spending on nursing facility care toward spending on non-institutional alternatives. These moves could also cause revenue and profitability to decline. Over the five years to 2013, industry revenue is expected to increase 2.8%.

Volatility is softened by the growth in the population of people aged at least 65 years, which decreases vacancy rates in the industry since this population does not change in size significantly from year to year. The level of industry activity is not highly tied to economic conditions due to the essential nature of health services. Nevertheless, changes in government reimbursement policies can affect revenue and profitability. Companies with diverse locations can benefit from favorable regulations in some areas. For instance, Sun Healthcare Group’s national footprint mitigates risks associated with adverse state regulatory changes related to Medicaid reimbursement in any one state.

Regulation & Policy

The extensive federal, state and local regulations affecting the Nursing Care Facilities industry include, but are not limited to, regulations relating to licensure, conduct of operations, ownership of facilities, addition of facilities, allowable costs, services and prices for services, facility staffing requirements, and the privacy and security of health-related information.

The regulatory environment surrounding the industry is intense. Federal and state governments impose intensive enforcement policies resulting in a significant number of inspections, citations of regulatory deficiencies and other regulatory penalties including demands for refund of overpayments, terminations from the Medicare and Medicaid programs, bars on Medicare and Medicaid payments for new admissions and civil monetary penalties. State and local agencies survey all skilled nursing centers on a regular basis to determine whether such centers comply with the governmental operating and health standards and conditions for participation in government sponsored third-party payer programs. Failure to meet these standards or conditions may result in monetary penalties, decertification of a center or provider from participation in the Medicare and Medicaid programs or licensure revocation.

Healthcare reform

Various healthcare reform provisions became law upon enactment of the Patient Protection and Affordable Care Act (PPACA). Several of the reforms are significant and could change the nature of industry services, the methods of payment and the underlying regulatory environment. The reforms include possible modifications to the conditions of qualification for payment, bundling payments to cover both acute and post-acute care and the imposition of enrollment limitations on new providers. The PPACA creates a series of robust transparency and reporting requirements.
for skilled nursing facilities including requirements to disclose information on organizational structures, financial, clinical and other related data as well as information on officers, directors, trustees or managing employees. In addition, the primary goals of healthcare reform are to increase quality and reduce costs. The PPACA includes reductions in the reimbursement paid to industry operators as well as additional reductions for failure to meet certain quality standards.

Staffing
Various state governments have established minimum staffing requirements. Most states have statutes that require that, before the addition or construction of new beds, the addition of new services, or certain capital expenditures in excess of defined levels, the state must determine that a need exists for such additions. Some state governments have imposed moratoria on new nursing home beds.

Medicare and Medicaid
Medicare is a federal program that provides certain hospital and medical insurance benefits to persons age 65 and over and certain disabled persons. Medicaid is a medical assistance program administered by each state funded with federal and state funds pursuant to which healthcare benefits are available to certain indigent or disabled patients. Within the Medicare and Medicaid statutory framework, there are substantial areas subject to administrative rulings, interpretations and discretion that may affect payments made under Medicare and Medicaid. Operators derive a substantial portion of industry revenue from patients covered by the Medicare and Medicaid programs. Federal self-referral and payment prohibitions generally forbid physicians from referring patients to facilities with which the physician has a direct financial relationship if the services are to be paid for by Medicare or Medicaid.

Privacy protection
The Health Insurance Portability and Accountability Act (HIPAA) privacy regulations seek to limit the use and disclosure of most paper, oral and electronic communications regarding an individual’s physical or mental health or condition, if an individual can be identified by such information. HIPAA provides for the imposition of penalties for improper disclosure.

Liability
During the five years to 2013, there has been an increase in the number and size of lawsuits filed against nursing home operators alleging negligence resulting in injury or death to residents of the homes. Several major insurance companies have ceased to provide liability risk insurance for nursing care facilities. This has caused some nursing facility operators to self-insure.

Certificate of need laws
The primary goals of the National Health Planning and Resources Development Act of 1974 were to contain healthcare costs and increase the accessibility and quality of health services. Certificate of need (CON) regulation is one attempt to constrain healthcare costs by limiting the supply of certain medical care facilities. With respect to the Nursing Care Facilities industry, prospective nursing home operators are required to demonstrate that a “need” exists for more nursing home beds. Some states have also imposed a construction moratorium that prevented any expansion of existing facilities or construction of new facilities regardless of whether or not a “need” existed. These CON and moratorium programs impose a supply constraint that creates a potential barrier to entry and in
The industry receives significant levels of assistance, primarily in the form of funding under the Medicare and Medicaid programs. The federal government makes payments to participating nursing care facilities under its Medicare program based on various formulas for people aged 65 years and older and certain other people aged less than 65 years of age. Medicare covers skilled nursing facility (SNF) services for beneficiaries who have recently been discharged from a stay in an acute care hospital lasting at least three days and who need skilled daily care (with Medicare coverage limited to 100 days). Medicare makes payments for daily care in SNFs under a Prescribed Payment System, which was introduced in 1998 and had an adverse effect on Medicare funding of SNFs.

Medicare covers skilled nursing facility (SNF) services for beneficiaries who have recently been discharged from a stay in an acute care hospital lasting at least three days and who need skilled daily care (with Medicare coverage limited to 100 days). Medicare makes payments for daily care in SNFs under a Prescribed Payment System, which was introduced in 1998 and had an adverse effect on Medicare funding of SNFs.

Federal, state and local governments also make payments under the Medicaid program. Under Medicaid, states have considerable flexibility in establishing payment rates for nursing home care. The Centers for Medicare and Medicaid Services (CMS) made changes in the Medicaid program as a result of the healthcare reform law in early 2010. According to CMS, the healthcare reform establishes a new Medicaid eligibility group. Under the law, for the first time since the Medicaid program was established, states will receive federal Medicaid payments to provide coverage for the lowest income adults in their states, without regard to disability, parental status or most other categorical limitations. This aspect of reform is expected to benefit revenue.

On the other hand, the healthcare reform of 2010 also establishes an Independent Payment Advisory Board (IPAB) to try to reduce national health costs and the federal deficit. Under the reform law, the board will be empowered to make Medicare payment decisions beginning in 2014. Unlike the current Medicare Payment Advisory Commission, the IPAB recommendations will automatically go into effect unless Congress blocks them. The new board will also help shift the healthcare system toward quality and efficiency and away from quantity.

The presence of excess demand may cause a nursing home bed shortage for those residents covered by Medicaid. Even though the Federal CON requirement lapsed in 1986, 42 states and the District of Columbia continue to have a CON, a construction moratorium or both for nursing home facilities.
## Key Statistics

### Industry Data

<table>
<thead>
<tr>
<th>Year</th>
<th>Revenue ($m)</th>
<th>Industry Value Added ($m)</th>
<th>Establishments</th>
<th>Enterprises</th>
<th>Employment</th>
<th>Exports</th>
<th>Imports</th>
<th>Wages ($m)</th>
<th>Domestic Demand</th>
<th>No. of Adults 65 Years and Older (Mils)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>97,981.1</td>
<td>52,405.5</td>
<td>16,732</td>
<td>9,159</td>
<td>1,627,773</td>
<td>--</td>
<td>--</td>
<td>46,134.7</td>
<td>N/A</td>
<td>36.3</td>
</tr>
<tr>
<td>2005</td>
<td>99,204.1</td>
<td>52,432.5</td>
<td>17,268</td>
<td>9,137</td>
<td>1,632,646</td>
<td>--</td>
<td>--</td>
<td>46,182.7</td>
<td>N/A</td>
<td>36.8</td>
</tr>
<tr>
<td>2006</td>
<td>98,958.1</td>
<td>54,179.7</td>
<td>17,267</td>
<td>9,010</td>
<td>1,640,524</td>
<td>--</td>
<td>--</td>
<td>46,658.9</td>
<td>N/A</td>
<td>37.3</td>
</tr>
<tr>
<td>2007</td>
<td>102,250.9</td>
<td>55,381.4</td>
<td>17,132</td>
<td>8,551</td>
<td>1,646,321</td>
<td>--</td>
<td>--</td>
<td>47,917.1</td>
<td>N/A</td>
<td>37.9</td>
</tr>
<tr>
<td>2008</td>
<td>105,228.1</td>
<td>53,798.8</td>
<td>16,462</td>
<td>8,420</td>
<td>1,587,187</td>
<td>--</td>
<td>--</td>
<td>46,748.5</td>
<td>N/A</td>
<td>38.9</td>
</tr>
<tr>
<td>2009</td>
<td>107,887.9</td>
<td>56,046.5</td>
<td>16,480</td>
<td>8,454</td>
<td>1,613,630</td>
<td>--</td>
<td>--</td>
<td>47,738.2</td>
<td>N/A</td>
<td>39.6</td>
</tr>
<tr>
<td>2010</td>
<td>111,342.9</td>
<td>56,164.3</td>
<td>16,568</td>
<td>8,646</td>
<td>1,632,889</td>
<td>--</td>
<td>--</td>
<td>48,036.3</td>
<td>N/A</td>
<td>40.4</td>
</tr>
<tr>
<td>2011</td>
<td>114,184.9</td>
<td>59,229.5</td>
<td>16,591</td>
<td>8,662</td>
<td>1,642,548</td>
<td>--</td>
<td>--</td>
<td>48,610.3</td>
<td>N/A</td>
<td>41.5</td>
</tr>
<tr>
<td>2012</td>
<td>116,696.9</td>
<td>60,227.9</td>
<td>16,628</td>
<td>8,594</td>
<td>1,639,686</td>
<td>--</td>
<td>--</td>
<td>49,141.7</td>
<td>N/A</td>
<td>42.7</td>
</tr>
<tr>
<td>2013</td>
<td>120,586.1</td>
<td>61,555.6</td>
<td>16,543</td>
<td>8,634</td>
<td>1,658,897</td>
<td>--</td>
<td>--</td>
<td>50,582.3</td>
<td>N/A</td>
<td>44.0</td>
</tr>
</tbody>
</table>

### Annual Change

<table>
<thead>
<tr>
<th>Year</th>
<th>Revenue (%)</th>
<th>Industry Value Added (%)</th>
<th>Establishments (%)</th>
<th>Enterprises (%)</th>
<th>Employment (%)</th>
<th>Exports (%)</th>
<th>Imports (%)</th>
<th>Wages (%)</th>
<th>Domestic Demand (%)</th>
<th>No. of Adults 65 Years and Older (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>1.2</td>
<td>0.1</td>
<td>3.3</td>
<td>-0.2</td>
<td>0.5</td>
<td>N/A</td>
<td>N/A</td>
<td>1.0</td>
<td>N/A</td>
<td>0.3</td>
</tr>
<tr>
<td>2006</td>
<td>-0.2</td>
<td>3.3</td>
<td>0.0</td>
<td>-1.4</td>
<td>0.5</td>
<td>N/A</td>
<td>N/A</td>
<td>1.0</td>
<td>N/A</td>
<td>1.4</td>
</tr>
<tr>
<td>2007</td>
<td>3.3</td>
<td>2.2</td>
<td>-0.8</td>
<td>-5.1</td>
<td>0.4</td>
<td>N/A</td>
<td>N/A</td>
<td>2.7</td>
<td>N/A</td>
<td>1.6</td>
</tr>
<tr>
<td>2008</td>
<td>2.9</td>
<td>-2.9</td>
<td>-3.9</td>
<td>-1.5</td>
<td>-3.6</td>
<td>N/A</td>
<td>N/A</td>
<td>-2.4</td>
<td>N/A</td>
<td>2.6</td>
</tr>
<tr>
<td>2009</td>
<td>2.5</td>
<td>4.2</td>
<td>0.1</td>
<td>0.4</td>
<td>1.7</td>
<td>N/A</td>
<td>N/A</td>
<td>2.1</td>
<td>N/A</td>
<td>1.8</td>
</tr>
<tr>
<td>2010</td>
<td>3.2</td>
<td>0.2</td>
<td>0.5</td>
<td>2.3</td>
<td>1.2</td>
<td>N/A</td>
<td>N/A</td>
<td>0.6</td>
<td>N/A</td>
<td>2.0</td>
</tr>
<tr>
<td>2011</td>
<td>2.6</td>
<td>5.5</td>
<td>0.1</td>
<td>0.2</td>
<td>0.6</td>
<td>N/A</td>
<td>N/A</td>
<td>1.2</td>
<td>N/A</td>
<td>2.7</td>
</tr>
<tr>
<td>2012</td>
<td>2.2</td>
<td>1.7</td>
<td>-1.0</td>
<td>-0.8</td>
<td>-0.2</td>
<td>N/A</td>
<td>N/A</td>
<td>1.1</td>
<td>N/A</td>
<td>2.9</td>
</tr>
<tr>
<td>2013</td>
<td>3.3</td>
<td>2.2</td>
<td>0.7</td>
<td>0.5</td>
<td>1.2</td>
<td>N/A</td>
<td>N/A</td>
<td>2.9</td>
<td>N/A</td>
<td>3.0</td>
</tr>
</tbody>
</table>

### Key Ratios

<table>
<thead>
<tr>
<th>Year</th>
<th>IVA/Revenue (%)</th>
<th>Imports/Demand (%)</th>
<th>Exports/Revenue (%)</th>
<th>Revenue per Employee ($1,000)</th>
<th>Wages/Revenue (%)</th>
<th>Employees per Est.</th>
<th>Average Wage ($)</th>
<th>Share of the Economy (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>53.49</td>
<td>N/A</td>
<td>N/A</td>
<td>60.19</td>
<td>47.09</td>
<td>97.29</td>
<td>28,342.22</td>
<td>0.43</td>
</tr>
<tr>
<td>2005</td>
<td>52.85</td>
<td>N/A</td>
<td>N/A</td>
<td>60.76</td>
<td>46.55</td>
<td>94.55</td>
<td>28,287.03</td>
<td>0.42</td>
</tr>
<tr>
<td>2006</td>
<td>54.75</td>
<td>N/A</td>
<td>N/A</td>
<td>60.32</td>
<td>47.15</td>
<td>95.01</td>
<td>28,441.64</td>
<td>0.42</td>
</tr>
<tr>
<td>2007</td>
<td>54.16</td>
<td>N/A</td>
<td>N/A</td>
<td>62.11</td>
<td>46.86</td>
<td>96.10</td>
<td>29,105.56</td>
<td>0.42</td>
</tr>
<tr>
<td>2008</td>
<td>51.13</td>
<td>N/A</td>
<td>N/A</td>
<td>66.30</td>
<td>44.43</td>
<td>96.42</td>
<td>29,453.68</td>
<td>0.41</td>
</tr>
<tr>
<td>2009</td>
<td>51.95</td>
<td>N/A</td>
<td>N/A</td>
<td>66.86</td>
<td>44.25</td>
<td>97.91</td>
<td>29,584.35</td>
<td>0.44</td>
</tr>
<tr>
<td>2010</td>
<td>50.44</td>
<td>N/A</td>
<td>N/A</td>
<td>68.19</td>
<td>43.14</td>
<td>98.56</td>
<td>29,417.98</td>
<td>0.43</td>
</tr>
<tr>
<td>2011</td>
<td>51.87</td>
<td>N/A</td>
<td>N/A</td>
<td>69.52</td>
<td>42.57</td>
<td>99.00</td>
<td>29,594.45</td>
<td>0.45</td>
</tr>
<tr>
<td>2012</td>
<td>51.61</td>
<td>N/A</td>
<td>N/A</td>
<td>71.17</td>
<td>42.11</td>
<td>99.81</td>
<td>29,970.19</td>
<td>0.44</td>
</tr>
<tr>
<td>2013</td>
<td>51.05</td>
<td>N/A</td>
<td>N/A</td>
<td>72.69</td>
<td>41.95</td>
<td>100.28</td>
<td>30,491.53</td>
<td>0.45</td>
</tr>
<tr>
<td>2014</td>
<td>50.89</td>
<td>N/A</td>
<td>N/A</td>
<td>74.35</td>
<td>41.87</td>
<td>101.12</td>
<td>31,313.09</td>
<td>0.45</td>
</tr>
<tr>
<td>2015</td>
<td>50.86</td>
<td>N/A</td>
<td>N/A</td>
<td>76.33</td>
<td>41.89</td>
<td>101.22</td>
<td>31,971.72</td>
<td>0.45</td>
</tr>
<tr>
<td>2016</td>
<td>50.43</td>
<td>N/A</td>
<td>N/A</td>
<td>78.33</td>
<td>41.56</td>
<td>101.59</td>
<td>32,554.00</td>
<td>0.45</td>
</tr>
<tr>
<td>2017</td>
<td>50.29</td>
<td>N/A</td>
<td>N/A</td>
<td>79.98</td>
<td>41.44</td>
<td>102.26</td>
<td>33,145.37</td>
<td>0.45</td>
</tr>
<tr>
<td>2018</td>
<td>50.12</td>
<td>N/A</td>
<td>N/A</td>
<td>81.80</td>
<td>41.29</td>
<td>102.94</td>
<td>33,774.93</td>
<td>0.44</td>
</tr>
</tbody>
</table>

Figures are inflation-adjusted 2013 dollars. Rank refers to 2013 data.
Jargon & Glossary

Industry Jargon

ACTIVITIES OF DAILY LIVING (ADL) Day-to-day tasks, such as preparing meals, shopping, managing money, taking medication and housekeeping.

ACUITY The measurement of the types of disorders, their severity and the intensity of the symptoms.

HOME HEALTHCARE Medical and nursing services that are provided in a person’s home by a licensed provider.

HOSPICE CARE Care and comfort provided to patients with a terminal illness and their families, which may include medical care, counseling and social services.

LONG-TERM CARE Care for a chronic condition, trauma, or illness that limits a person’s ability to carry out basic self-care tasks, called activities of daily living (ADLs).

MEDICARE AND MEDICAID Cost coverage programs. Medicare pays all or part of a stay following hospitalization of at least three days; Medicaid covers a stay of any length for individuals who meet income requirements.

RESPITE CARE Temporary relief for caregivers, ranging from several hours to several days, which may be provided in home or in a residential care setting, such as an assisted-living facility or nursing home.

IBISWorld Glossary

BARRIERS TO ENTRY High barriers to entry mean that new companies struggle to enter an industry, while low barriers mean it is easy for new companies to enter an industry.

CAPITAL INTENSITY Compares the amount of money spent on capital (plant, machinery and equipment) with that spent on labor. IBISWorld uses the ratio of depreciation to wages as a proxy for capital intensity. High capital intensity is more than $0.333 of capital to $1 of labor; medium is $0.125 to $0.333 of capital to $1 of labor; low is less than $0.125 of capital for every $1 of labor.

CONSTANT PRICES The dollar figures in the Key Statistics table, including forecasts, are adjusted for inflation using the current year (i.e. year published) as the base year. This removes the impact of changes in the purchasing power of the dollar, leaving only the “real” growth or decline in industry metrics. The inflation adjustments in IBISWorld’s reports are made using the US Bureau of Economic Analysis’ implicit GDP price deflator.

DOMESTIC DEMAND Spending on industry goods and services within the United States, regardless of their country of origin. It is derived by adding imports to industry revenue, and then subtracting exports.

EMPLOYMENT The number of permanent, part-time, temporary and seasonal employees, working proprietors, partners, managers and executives within the industry.

ENTERPRISE A division that is separately managed and keeps management accounts. Each enterprise consists of one or more establishments that are under common ownership or control.

ESTABLISHMENT The smallest type of accounting unit within an enterprise, an establishment is a single physical location where business is conducted or where services or industrial operations are performed. Multiple establishments under common control make up an enterprise.

EXPORTS Total value of industry goods and services sold by US companies to customers abroad.

IMPORTS Total value of industry goods and services brought in from foreign countries to be sold in the United States.

INDUSTRY CONCENTRATION An indicator of the dominance of the top four players in an industry. Concentration is considered high if the top players account for more than 70% of industry revenue. Medium is 40% to 70% of industry revenue. Low is less than 40%.

INDUSTRY REVENUE The total sales of industry goods and services (exclusive of excise and sales tax); subsidies on production; all other operating income from outside the firm (such as commission income, repair and service income, and rent, leasing and hiring income); and capital work done by rental or lease. Receipts from interest royalties, dividends and the sale of fixed tangible assets are excluded.

INDUSTRY VALUE ADDED (IVA) The market value of goods and services produced by the industry minus the cost of goods and services used in production. IVA is also described as the industry’s contribution to GDP, or profit plus wages and depreciation.

INTERNATIONAL TRADE The level of international trade is determined by ratios of exports to revenue and imports to domestic demand. For exports/revenue: low is less than 5%, medium is 5% to 20%, and high is more than 20%. Imports/domestic demand: low is less than 5%, medium is 5% to 35%, and high is more than 35%.

LIFE CYCLE All industries go through periods of growth, maturity and decline. IBISWorld determines an industry’s life cycle by considering its growth rate (measured by IVA) compared with GDP; the growth rate of the number of establishments; the amount of change the industry’s products are undergoing; the rate of technological change; and the level of customer acceptance of industry products and services.
Jargon & Glossary

IBISWorld Glossary continued

NONEMPLOYING ESTABLISHMENT Businesses with no paid employment or payroll, also known as nonemployers. These are mostly set up by self-employed individuals.

PROFIT IBISWorld uses earnings before interest and tax (EBIT) as an indicator of a company’s profitability. It is calculated as revenue minus expenses, excluding interest and tax.

VOLATILITY The level of volatility is determined by averaging the absolute change in revenue in each of the past five years. Volatility levels: very high is more than ±20%; high volatility is ±10% to ±20%; moderate volatility is ±3% to ±10%; and low volatility is less than ±3%.

WAGES The gross total wages and salaries of all employees in the industry. The cost of benefits is also included in this figure.
At IBISWorld we know that industry intelligence is more than assembling facts. It is combining data with analysis to answer the questions that successful businesses ask.

Identify high growth, emerging & shrinking markets
Arm yourself with the latest industry intelligence
Assess competitive threats from existing & new entrants
Benchmark your performance against the competition
Make speedy market-ready, profit-maximizing decisions

Who is IBISWorld?
We are strategists, analysts, researchers, and marketers. We provide answers to information-hungry, time-poor businesses. Our goal is to provide real world answers that matter to your business in our 700 US industry reports. When tough strategic, budget, sales and marketing decisions need to be made, our suite of Industry and Risk intelligence products give you deeply-researched answers quickly.

IBISWorld Membership
IBISWorld offers tailored membership packages to meet your needs.

Disclaimer
This product has been supplied by IBISWorld Inc. (‘IBISWorld’) solely for use by its authorized licensees strictly in accordance with their license agreements with IBISWorld. IBISWorld makes no representation to any other person with regard to the completeness or accuracy of the data or information contained herein, and it accepts no responsibility and disclaims all liability (save for liability which cannot be lawfully disclaimer) for loss or damage whatsoever suffered or incurred by any other person resulting from the use of, or reliance upon, the data or information contained herein.

Copyright in this publication is owned by IBISWorld Inc. The publication is sold on the basis that the purchaser agrees not to copy the material contained within it for other than the purchasers own purposes. In the event that the purchaser uses or quotes from the material in this publication – in papers, reports, or opinions prepared for any other person – it is agreed that it will be sourced to: IBISWorld Inc.

Copyright 2013 IBISWorld Inc