

WOLD | JJCA | SENIOR LIVING PRACTICE

The Rural Hospital + Senior Living Partnership

*A New Model for Community Care, Financial Sustainability, and the
Post-Acute Continuum*

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ABOUT THIS PAPER

This white paper explores a structured partnership model between rural and community hospitals and senior living providers, examining the financial, operational, and community care rationale.

Intended Audiences:

Hospital CEOs & CFOs
Community Health System
Leadership
Senior Living Operators
Healthcare Capital Partners
Rural Community
Stakeholders

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Executive Summary

Rural and community hospitals across the United States are navigating converging financial pressures: declining reimbursement, CMS readmission penalties, fixed overhead costs spread across small patient populations, and growing demand for post-acute and senior care services that their communities lack. At the same time, senior living operators face the challenge of establishing viable facilities in rural and secondary markets where credibility, referral pipelines, and operational infrastructure are difficult to build independently.

This white paper explores a structured partnership model that addresses both sets of challenges simultaneously. By co-developing or formally linking a senior living community with a Critical Access Hospital or community health system, the partnership creates a care continuum that reduces hospital readmissions, lowers per-unit operational overhead, unlocks supply procurement savings, and provides the community with a local senior care option, allowing families to stay together and improving quality of life .

The hospital solves its discharge placement and readmission problem. The senior living provider gains a credible referral pipeline and community anchor. The community gains a local care solution. Capital is attracted by the de-risked occupancy model.

The financial case is grounded in three distinct but complementary arguments: the shared services overhead reduction, the aggregated supply procurement advantage, and the capital stack benefits of a hospital land contribution. Together, these create a partnership structure with compelling economics for all parties — hospital, operator, capital partner, and community.

Wold | JJCA brings a uniquely informed perspective to this model, combining over two decades of senior living development and operations experience — including a leadership role at Brookdale Senior Living, the nation's largest senior living provider — with full architectural project delivery capability. This positions Wold | JJCA not merely as a design firm, but as a strategic advisor capable of guiding hospital and health system clients through the full arc of partnership development, from initial concept to project delivery.



Section 1 - The Problem This Partnership Solves

The Hospital's Challenge

Critical Access Hospitals and small community health systems operate in a structurally difficult environment. CMS certification as a Critical Access Hospital — requiring no more than 25 acute care inpatient beds — was designed to protect rural hospital access, but it also codifies a fundamental economic challenge: fixed overhead costs that cannot be distributed across a large patient census.

The result is a cost structure that defies ordinary economics. A hospital laundry operation designed to serve 25 patients runs at a fraction of its capacity on a typical census day. A dietary department staffed and equipped to provide therapeutic meals around the clock serves, in practice, a handful of patients at a time. Environmental services staff, facilities management, and administrative overhead all follow the same pattern — fixed costs thinly spread, driving cost-per-unit figures that bear no relationship to the actual service delivered.

Compounding this structural challenge is the growing financial penalty for post-acute discharge failures. Under the Hospital Readmissions Reduction Program (HRRP), CMS imposes financial penalties on hospitals that exceed expected 30-day readmission rates for a defined set of conditions: heart failure, chronic obstructive pulmonary disease, pneumonia, acute myocardial infarction, coronary artery bypass graft surgery, and elective total hip and knee arthroplasty. For a rural hospital with limited discharge options, placing patients in distant or suboptimal post-acute settings is not just a quality concern — it is a financial liability that compounds over time.

For a rural CFO already operating at thin margins, the question is not whether a partnership makes sense — it is whether the hospital can afford to continue without one.

Finally, many rural hospitals carry an explicit community benefit obligation as part of their nonprofit tax status. Providing senior care access to a community that has none — keeping families together and elderly residents near their support networks, resulting in an improved quality of life for all — is a mission-aligned investment, not merely a financial transaction.

The Senior Living Provider's Challenge

Senior living operators face a different but equally real set of pressures in rural and secondary markets. Establishing a new community without an established referral base requires significant investment in marketing and community outreach, and the lease-up period — the time from

opening to stabilized occupancy — can extend well beyond projections when the operator lacks a credible local anchor.

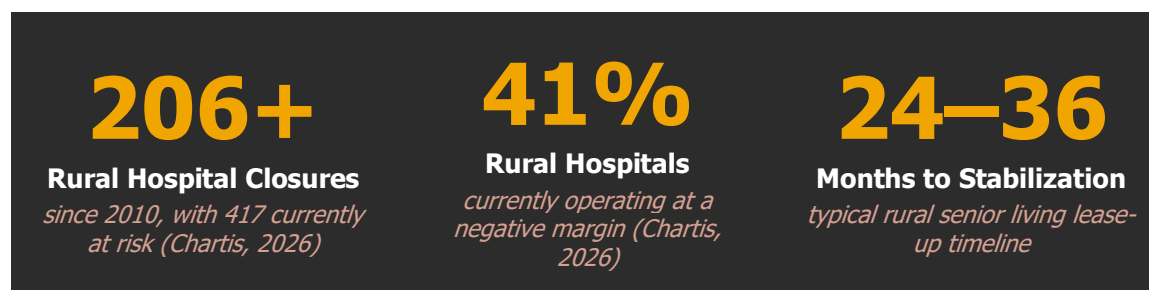
A hospital partnership fundamentally changes this dynamic. The hospital's discharge planning team becomes, in effect, the most credible referral source in the community. Families making difficult decisions about post-acute and long-term care for elderly loved ones are far more likely to trust a senior living community that carries an explicit hospital endorsement than one that arrived without a local institutional relationship.

Beyond the referral pipeline, a hospital partnership provides access to clinical staff, established supply chains, and operational infrastructure that a standalone rural operator would need to build from scratch. For operators experienced in suburban or urban markets, the rural cost structure — and the difficulty of recruiting skilled clinical and culinary staff in remote locations — represents a genuine barrier. A hospital partnership lowers that barrier substantially.

The Community's Need

Behind both institutional perspectives is a human reality: rural seniors who need care are routinely displaced from their communities. Without local options, families face the agonizing choice between placing a loved one in a distant community — severing the relationships and routines that matter most in late life — or attempting to provide care at home without adequate support.

The community impact of a well-structured hospital-senior living partnership extends beyond the residents it directly serves. It reduces unnecessary emergency department utilization by seniors who have no other care option. It provides employment for community members in meaningful, stable roles. It creates economic activity that anchors the community's healthcare infrastructure at a time when rural hospital closures are accelerating nationally — the Chartis Center for Rural Health documented 206 rural hospital closures or inpatient care eliminations since 2010, with 417 facilities currently identified as vulnerable to closure.



Section 2 - The Human Dimension: Transformation at the Community Level

The partnership described in this paper is, at its core, a financial and operational proposition. However, behind every pro forma and every shared services agreement is a more fundamental question: what does it mean for a family when their loved one can age and receive care in the community where they have lived their entire lives?

The answer is consequential. When a senior living option exists locally — co-located with the hospital that community members already trust, staffed by neighbors, and woven into the social fabric of the town — the act of transitioning from independent living to supported care becomes something different. It becomes a continuation rather than a displacement. For the resident, for the family, and for the community itself, that distinction is transformative.

The greatest gift this partnership offers is not efficiency. It is the ability of a family to remain a family — visiting easily, participating in care decisions, sharing meals — because distance has not separated them from someone they love.

Keeping Families Together

When a family must place a loved one in a community two hours away — because no local option exists — the relationship changes in ways that no amount of phone calls or video visits can fully replace. The spontaneous visit after work, the Sunday afternoon drop-in, the ability to be present for a difficult medical conversation: these are lost. The senior becomes more isolated precisely at the moment their need for connection is greatest.

A hospital-adjacent senior living community changes this entirely. The resident remains embedded in a familiar geography — near the church, the neighbors, the grandchildren's school. Family members can visit without sacrifice. The care team knows the family. The hospital that the resident has trusted for decades is steps away if a health need arises.

This is not a marginal benefit. Research consistently links social connectedness in older adults to slower cognitive decline, lower rates of depression, reduced ED utilization, and better overall health outcomes. A model that enables families to stay close is not just humane — it is clinically sound and economically rational for the hospital whose readmission outcomes depend in part on the quality of post-discharge support.

Transforming the Quality of Later Life

For the senior living resident, the proximity of a hospital partnership also signals something important: that their care is serious, supported, and connected to a broader healthcare system. The presence of hospital clinical staff — whether for routine oversight, therapy services, or emergency response — provides a layer of assurance that standalone rural senior living communities cannot replicate.

Beyond clinical security, the community benefit of a shared dining operation, community events, and a community designed for engagement — rather than simply warehousing — creates conditions for genuine quality of life. A senior living community that serves as a community dining destination, that hosts family gatherings, that opens its doors to the broader neighborhood, becomes an asset to the town rather than an institution apart from it.

This is the distinction between care that sustains life and care that enriches it. The physical design of the campus, the programming model of the senior living operator, and the integration with the hospital's clinical resources all contribute to an environment where later life is not merely managed but meaningfully supported.

Transforming the Community Itself

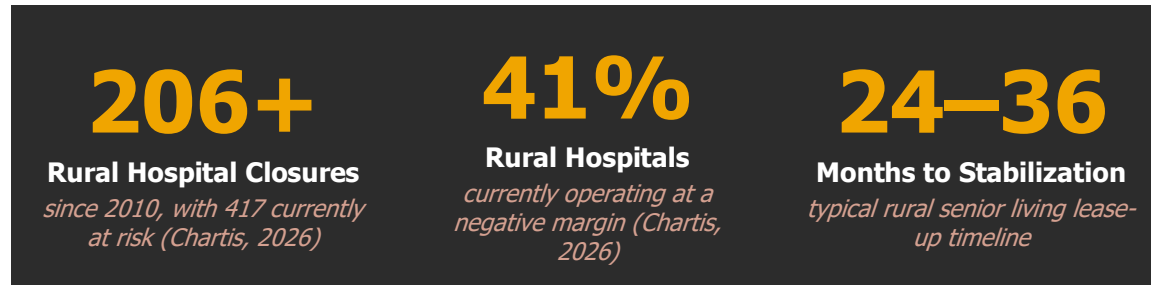
The ripple effects extend beyond the individuals directly served. A rural community with a hospital that is financially healthier, a senior living community that employs local workers, and families who no longer face the agonizing choice of displacement is a more cohesive and resilient community. Healthcare infrastructure anchors local economies: it keeps spending local, supports auxiliary businesses, and signals to younger residents and employers that the town has a future.

Critical Access Hospitals that survive and stabilize — partly through the shared overhead efficiencies this partnership enables — continue to provide emergency services, obstetric care, surgical capacity, and primary care that would otherwise disappear. The senior living community does not just help one hospital department; it contributes to the viability of the entire institution and, by extension, to the health of every person in that community who might need emergency care at any hour of any day.

What This Partnership Makes Possible

- A senior who transitions from hospital to a nearby care community without leaving the town they have called home for 60 years.
- A family that visits their father on a Tuesday evening because it takes 10 minutes, not a planned three-hour trip.
- A hospital that can afford to keep its emergency department open because shared overhead and referral revenue have improved its margin.
- A rural community where the hospital campus has become a center of healthcare, employment, dining, and civic life — not a fragile institution awaiting closure.
- A senior living resident who is seen by a familiar face from the hospital the morning after a difficult night, because the clinical relationship already exists.

These outcomes are not guaranteed by the partnership structure alone. They require intentional design, thoughtful programming, and operators and hospital administrators who hold this larger vision as they make the hundreds of small decisions that shape a project. But the structure creates the conditions. The human outcomes flow from it.



Section 3 - The Shared Services Advantage

One of the most compelling — and most frequently overlooked — financial arguments for this partnership is the opportunity to share operational overhead between the hospital and the senior living community. The math is straightforward: fixed costs distributed across a larger combined population produce dramatically lower per-unit costs. For a Critical Access Hospital whose overhead cannot be diluted across a large census, co-locating with a senior living community of 30, 60 or 120 residents can be transformative.

What follows is a department-by-department analysis of the shared services opportunity. In each case, the argument runs in both directions: the hospital reduces its disproportionate per-unit overhead, and the senior living operator gains access to established infrastructure it would otherwise need to build independently.

Housekeeping and Environmental Services

A small hospital cannot justify a fully staffed Environmental Services department for 15 to 25 occupied beds. The result is typically one of two unsatisfactory outcomes: overstaffed relative to census, producing high cost-per-patient-day, or understaffed, creating quality and compliance risk. Neither is sustainable.

A senior living community requires daily housekeeping for every occupied unit — a predictable, high-volume demand that runs on a schedule fundamentally compatible with hospital EVS operations. The same staff, supervision structure, and chemical inventory that serves the hospital can extend into the senior living community on a scheduled rotation, spreading labor and overhead across a combined footprint two to four times the hospital's standalone size.

Key Operational Point

- EVS schedules in assisted living and memory care are highly predictable — daily unit cleaning, weekly deep cleans, and common area maintenance run on fixed timetables.
- Hospital EVS demand, by contrast, is tied to census and discharge/admit cycles — creating natural scheduling flexibility.
- A combined EVS operation leverages both patterns, improving staff utilization rates and reducing overtime costs for both facilities.

Laundry and Linen Services

Hospital laundry equipment is sized for peak capacity — but a 20-bed Critical Access Hospital rarely operates at peak. The cost per pound of laundry processed in a small standalone hospital is consequently one of the highest in the healthcare spectrum. Equipment runs below rated capacity, energy and water costs per pound are elevated, and the amortized cost of the capital equipment is spread over a fraction of the volume it was designed to handle.

Senior living generates significant, consistent linen volume: bed linens changed on scheduled cycles, resident clothing laundered regularly, dining room linens, and towels. This volume is not just large — it is predictable in a way that hospital linen demand is not, providing a stable baseline load that improves equipment utilization across the combined operation.

The capital efficiency argument is equally important. A shared laundry expansion or equipment upgrade can be justified on combined-volume grounds that neither institution could support independently, enabling investment in higher-efficiency equipment that further reduces energy and water costs per pound.

Food Service and Dietary

Food service may represent the most financially compelling shared service of all. CMS requires hospitals to provide therapeutic patient meals around the clock — a full dietary operation with appropriate staffing, equipment, and clinical oversight — for as few as five to fifteen patients at any given time in a small rural hospital. The cost per meal in this context is extraordinarily high, and it is largely invisible in cost reports because it is allocated across a denominator that is chronically too small.

A 20-bed Critical Access Hospital spending \$400,000 annually on food service is effectively paying \$20,000 per licensed bed. Add 80 senior living residents to the same kitchen operation and that figure drops to roughly \$4,000 per unit — an 80% reduction in the cost metric that matters most.

Dining in Senior Living is not a supplemental service — it is a core resident amenity and a primary factor in move-in decisions. Three meals per day, seven days per week, for the full resident population creates a high-volume, consistent demand that transforms the economics of a shared kitchen operation. The dietary staff, equipment, and management structure required to serve the hospital well can, with relatively modest additional investment, provide restaurant-quality dining for the senior living community.

The revenue opportunity deserves equal attention. A senior living dining operation can serve as a community dining amenity — open to family members during visits, available for community events, and positioned as a destination for the broader community. This generates additional revenue that partially offsets shared overhead and reinforces the partnership's community benefit narrative.

Regulatory Consideration

- Hospital food service operates under CMS Conditions of Participation, which include specific requirements for therapeutic diet protocols, food safety, and dietitian oversight.

- Senior living dining is regulated at the state level under assisted living licensing, with requirements that vary considerably by state.
- A shared kitchen operation must be designed and managed to satisfy both regulatory frameworks. This is achievable with proper operational protocol design and appropriate credentialing of dietary staff — but it requires advance planning and regulatory counsel familiar with both settings.
- The architectural design of the shared kitchen should be addressed early in the project to ensure it accommodates the operational requirements of both facilities.

Facilities Maintenance and Engineering

Maintaining hospital-grade mechanical, electrical, and plumbing systems — including medical gas, emergency power, fire suppression, and life safety systems — requires skilled facilities staff. In a small rural hospital, the scope of work may not justify full-time employment of adequately skilled maintenance professionals at competitive wages, creating a cycle of either underqualified staff or chronic vacancy.

A combined facilities management operation covering both the hospital and the senior living campus provides sufficient scope to justify full-time skilled personnel, supports competitive compensation, and enables a more systematic approach to preventive maintenance. Vendor relationships for specialized services — elevator maintenance, HVAC service contracts, generator testing — can be consolidated across both facilities, reducing both unit costs and administrative burden.

Life safety system requirements — regular testing of fire suppression, emergency egress, and emergency power systems — are present in both settings and create natural operational overlap. A single, qualified facilities team managing a unified life safety program is more reliable and more cost-effective than two separate programs operating in institutional isolation.

Section 4 - The Supply Procurement Advantage

Supply procurement represents one of the most immediate and quantifiable financial benefits of the partnership — and one that can begin generating savings before the first resident moves in, as the combined purchasing entity establishes its vendor relationships during the development and pre-opening phase.

The fundamental economics are straightforward: hospitals and senior living facilities share extensive overlap in the categories of supplies they consume daily, and purchasing power scales directly with volume. A Critical Access Hospital purchasing for 20 beds is, from the perspective of a national distributor, a small, low-priority account with limited negotiating leverage. A combined purchasing entity covering both a hospital and a 60- to 100-unit senior living community is a meaningfully different conversation — one that commands attention and competitive pricing.

Group Purchasing Organization Tier Access

Most hospitals access supply pricing through Group Purchasing Organizations — national entities like Vizient, Premier, and HealthTrust that negotiate volume contracts with distributors and manufacturers on behalf of their member institutions. GPO pricing is structured in tiers: the more volume a member purchases within a category, the lower the unit price. Small rural hospitals, purchasing alone, typically qualify only for the lowest pricing tiers — a structural disadvantage that compounds across every supply category. The Healthcare Supply Chain Association reports that providers using GPOs see supply chain spending decline by 10 to 18 percent compared to independent purchasing.

A combined purchasing arrangement with a senior living partner can move the partnership into a meaningfully higher tier in several key categories. The tier improvement translates directly to unit price reductions across medical-surgical supplies, personal protective equipment, cleaning chemicals, paper goods, and food commodities. For a hospital already operating at thin margins, even a modest percentage improvement in supply costs across high-volume categories produces material financial benefit.

GPO Tier Impact — Illustrative Framework

- A 20-bed CAH purchasing \$800,000 annually in medical-surgical supplies may qualify for entry-level GPO pricing tiers.
- Adding a 80-unit senior living community with estimated supply spend of \$300,000 in overlapping categories increases the combined purchasing footprint meaningfully.
- The Healthcare Supply Chain Association reports that GPO participation reduces supply chain costs by 10 to 18 percent. For a hospital spending \$800,000 annually on medical-surgical supplies, even the lower end of that range represents \$80,000 or more in annual savings.
- The senior living operator, previously purchasing outside the GPO structure entirely, gains access to contract pricing it could not achieve as a standalone rural community — the Chartis Center reports over 95% of U.S. hospitals use GPOs, while most senior living operators in rural markets do not.

Clinical and Medical Supplies

Gloves, wound care products, incontinence supplies, personal hygiene items, and other clinical consumables are purchased in significant volume by both settings. Assisted living and memory care communities consume the same categories of items that a hospital orders through its standard distribution channel — but typically purchase through less favorable retail or regional distribution arrangements. Consolidating these purchases under a single, GPO-backed contract with a preferred distributor improves pricing, simplifies ordering and receiving operations, and reduces the administrative burden of managing multiple vendor relationships.

Food and Dietary Commodities

Both settings require large, recurring purchases of proteins, produce, dairy, dry goods, and food service consumables. A combined food service operation purchasing for hospital dietary and senior living dining simultaneously presents a volume profile that broadline distributors — Sysco, US Foods, and their regional equivalents — compete aggressively to capture. This competition is notably muted for small, standalone rural accounts, where delivery logistics reduce distributor margins and limit their willingness to offer favorable pricing.

Combined volume changes the calculus. Rural markets that previously saw minimal competitive distributor activity become attractive when the account size warrants a dedicated sales relationship and competitive pricing. The partnership should explicitly leverage this dynamic in initial distributor negotiations, establishing the combined account as a priority relationship from the outset.

Linen, Housekeeping, and Janitorial Supplies

Laundry chemicals, cleaning products, paper goods, and janitorial supplies represent recurring operating expense for both facilities. Consolidated purchasing under a single distributor relationship or GPO contract reduces per-unit cost and simplifies vendor management. The combined linen program — covering hospital patient linens, senior living residential linens, and

shared dining linens — supports favorable pricing from linen suppliers and laundry equipment vendors alike.

Capital Equipment and Durable Goods

When the partnership progresses into renovation or new construction, joint procurement of furniture, fixtures, and equipment offers additional savings. Items common to both settings — adjustable-height beds, patient lifts, mobility aids, wheeled dining chairs, commercial kitchen equipment — can be specified and purchased as a combined package, supporting volume pricing and simplified warranty and service relationships. The architectural programming process should explicitly identify these overlapping equipment categories to maximize joint procurement savings during the project phase.

For the senior living operator, hospital GPO access alone can represent a meaningful competitive advantage over independent rural operators purchasing outside a group purchasing structure. For the hospital, the combined volume is often the single fastest path to a better pricing tier.

Pharmacy and Medication Management

For partnerships that incorporate assisted living with medication management services — or memory care with higher clinical acuity — coordinated pharmacy relationships through the hospital's existing pharmacy contracts offer potential savings on medication costs and simplified clinical oversight. The hospital's pharmacist or pharmacy service relationship can extend, under appropriate licensure and protocol arrangements, to support medication management for senior living residents, reducing the operator's need for a separate pharmacy service infrastructure.

Section 5 - Partnership Structures and the Capital Case

The financial and operational case described above must ultimately be housed in a formal partnership structure. There is a spectrum of arrangements — from low-commitment preferred provider agreements to full co-development joint ventures — and the appropriate entry point depends on the hospital's appetite for risk, its capital position, and the pace at which the community relationship can develop.

The Spectrum of Partnership Models

Model	Description and Considerations
Preferred Provider Agreement	The hospital designates the senior living community as its preferred discharge destination. No capital required from either party. The lowest barrier to entry and the natural starting point for most hospital conversations. Creates the referral relationship without requiring institutional commitment.
Services Agreement	The hospital provides on-site clinical services — rehabilitation, primary care, telemedicine, dietary oversight — within the senior living community under a formal services contract. Deepens the integration and creates recurring revenue for the hospital without requiring real estate ownership.
Land Contribution	The hospital contributes underutilized campus land as equity into the development partnership. For land-rich, cash-constrained Critical Access Hospitals, this is often the most achievable and most compelling structural move — it reduces the capital stack requirements for the development, lowers the loan-to-value ratio for lenders, and signals genuine community commitment to capital partners.
Joint Venture / Co-Development	Full co-ownership and co-development of a senior living community on or adjacent to the hospital campus. The most capital-intensive structure, but the most compelling to equity investors and the most durable from a community benefit perspective. Proven by health systems including Intermountain Healthcare, Banner Health, and regional Catholic health systems nationally.

What Capital Partners Need to See

Capital follows conviction. Before a capital partner — equity fund, healthcare REIT, mission-driven health system capital arm, or USDA rural development program — will engage seriously

with a rural hospital senior living proposal, they need to see evidence that the concept has been stress-tested by the principals. The presence of the following elements substantially increases the probability of a productive capital conversation:

Capital Partner Prerequisites

- A named, willing hospital — even a letter of intent or executed MOU signals deal seriousness in a way that a theoretical partnership does not.
- A committed or seriously interested senior living operator with a verifiable track record in comparable markets.
- A market feasibility read — at minimum a 10-mile radius analysis of 65+ population, income, private-pay penetration, and competitive supply.
- A site — hospital land contribution, optioned adjacent parcel, or identified development site.
- A credible development team — the presence of a co-developer with senior living and healthcare expertise reduces perceived execution risk significantly.

The correct sequencing of conversations matters: hospital interest first, then operator alignment, then feasibility confirmation, then capital. Arriving at a capital partner conversation without the first three elements established wastes the relationship and signals that the concept is still speculative rather than fundable.

Rural Capital Stack Considerations

Rural senior living development often requires a layered financing approach that draws on programs specifically designed to support rural healthcare infrastructure. The USDA Community Facilities loan guarantee program, HUD Section 232 financing, New Markets Tax Credits in eligible census tracts, and state rural development programs can all contribute to a capital stack that reduces the equity requirement and extends the debt repayment horizon — accommodating the longer stabilization timeline that rural markets typically require.

Mission-aligned capital sources — healthcare foundations, faith-based system capital arms, and Community Development Financial Institutions — are often better fits for rural hospital-senior living partnerships than conventional real estate equity funds, whose IRR requirements may not be compatible with a patient, community-oriented investment thesis. The hospital's own financial institution relationships are frequently an underutilized starting point for these conversations.

Section 6 - Initiating the Conversation

The practical question for hospital and health system leadership is how to begin. The partnership concept described in this paper is not a theoretical exercise — it is a structured, actionable model that can be initiated through conversations that hospital leaders are already having about community benefit, readmission rates, and financial sustainability.

Questions to Raise with Hospital Leadership

The most productive initial conversations are diagnostic rather than prescriptive. Before proposing a partnership structure, it is worth understanding the hospital's specific pain points and existing awareness of the opportunity. The following questions are designed to surface the hospital's readiness and identify the strongest points of alignment:

Initial Diagnostic Questions for Hospital CEO / CFO

- "What does your current discharge pathway look like for senior patients who are no longer acute but not yet ready to return home?"
- "Are you experiencing CMS readmission penalties under the Hospital Readmissions Reduction Program, and for which diagnoses?"
- "What is your current cost-per-meal in dietary, and your cost-per-pound processed in laundry? How does that compare to a benchmark facility of similar size?"
- "Do you have underutilized land on or adjacent to your campus that has been difficult to monetize or develop?"
- "Has your board or strategic planning process discussed senior living as a community benefit or care continuum investment?"
- "What is your current relationship with your post-acute referral network, and how confident are you in the quality of placements your discharge team is able to make?"

The CFO's answer to the cost-per-meal and cost-per-pound questions is frequently the most powerful moment in the initial conversation. These numbers are almost universally shocking in small hospitals — and they immediately make the shared services argument concrete and personal rather than theoretical.

Questions to Raise with Senior Living Operators

The senior living operator conversation is fundamentally different from the hospital or capital partner dialogue. Operators are evaluating whether the rural market is viable, whether the hospital relationship is genuine and durable, and whether Wold|JJCA can deliver the kind of project that meets their operational requirements. The goal of the initial conversation is not to persuade — it is to qualify and align.

The most productive operators for this model are regional or mid-size organizations with experience in secondary or rural markets, faith-based systems with community-anchored

mission orientations, and operators who have navigated the specific challenges of rural staffing and rural lease-up before. The questions below are designed to surface fit quickly and honestly — and to signal that Wold|JJCA understands the operator's world, not just the real estate side of the transaction.

Initial Diagnostic Questions for Senior Living Operators


- "Are you actively looking at rural or secondary market expansion, and what has your experience been with lease-up dynamics outside of primary markets?"
- "If a hospital were willing to serve as a formal referral partner and potentially contribute land or clinical services, how would that change your underwriting assumptions for a rural project?"
- "What care types are you most comfortable operating in a rural context — independent living, assisted living, memory care, or a combination — and how does that affect your minimum market size requirements?"
- "How do you typically approach shared services arrangements, and have you operated in a co-located or hospital-adjacent model before?"
- "What does your typical management agreement structure look like, and what level of owner involvement do you expect during development and lease-up?"
- "What are the biggest operational risks you see in a rural hospital-anchored model, and what would you need to see to get comfortable with them?"

The last question is particularly important. An operator who engages seriously with the risk question — staffing pipelines, Medicaid payor mix exposure, the pace of family decision-making in rural communities — is an operator who has thought through the model. An operator who deflects or gives a purely promotional answer is likely not the right fit for a project that will require genuine problem-solving in a non-standard market.

The right operator for this model sees the hospital relationship not as a marketing story but as a structural advantage — one that changes the risk profile of the project in ways that a conventional rural development cannot replicate.

Questions to Raise with Capital Partners

For capital partners unfamiliar with the hospital-senior living partnership model, the most effective opening is a question that positions the partnership's distinguishing feature — the hospital anchor — as the primary differentiator from a conventional rural senior living development:



"Given where you are deploying capital in senior living right now, what would a rural hospital-anchored deal need to look like — in terms of structure, operator profile, and market characteristics — to be worth serious consideration?"

This question does several things simultaneously. It acknowledges the capital partner's expertise and invites their framework rather than presenting a pre-formed proposal. It surfaces their familiarity with rural markets, their operator relationship depth, and their mission orientation — all of which are critical filters for identifying the right capital partner for this deal type. And it frames the hospital anchor as a structural differentiator rather than a contextual detail.

Section – 7 Building Internal Alignment: Health Systems and Senior Living Operators

Pursuing a hospital-senior living partnership is not a decision that a single administrator can make unilaterally on either side of the table. It requires alignment across several internal stakeholders who each bring a different lens to the proposal — and who each need to be engaged on the terms that matter most to them. Understanding who those stakeholders are, and how to frame the conversation for each, is often the difference between a concept that gains traction and one that stalls in committee.

Within the Hospital or Health System

The most receptive entry point in most health system organizations is the CFO or Chief Financial Officer. The financial case — shared overhead reduction, supply procurement savings, and readmission penalty exposure — is concrete, quantifiable, and directly relevant to the pressures a rural hospital CFO faces daily. This is the conversation that opens the door.

The VP of Strategy or Business Development, where that role exists, is the natural internal champion once the CFO is engaged. This person is typically responsible for care continuum thinking, competitive positioning, and community benefit strategy — all of which this partnership directly addresses. They are often the stakeholder most capable of building the internal coalition needed to advance the concept from idea to formal feasibility.

The VP of Facilities or Real Estate is a critical voice if campus land is part of the equation. Their participation ensures that any land contribution is evaluated accurately and that the physical development concept aligns with the hospital's long-term campus plan. Bringing them in early avoids the common failure mode of a partnership concept that advances through strategy conversations only to be derailed by facilities objections later.

The Chief Medical Officer or VP of Medical Affairs should be engaged on the clinical continuum argument — specifically the readmission reduction data, the discharge planning improvement opportunity, and the clinical oversight model for the senior living community. Their endorsement is often required before a hospital board will take a partnership proposal seriously.

Finally, senior leadership and the board itself will ultimately need to approve any formal partnership structure. Framing the concept as a community benefit initiative — one that keeps seniors in the community, reduces hospital financial pressure, and creates local employment — tends to resonate strongly at the board level, where mission and margin are both on the agenda.

Within the Senior Living Organization

The internal alignment challenge for a senior living operator is a direct mirror image of the hospital's. The stakeholders are different in title but identical in function, and the sequence in which they need to be engaged follows the same logic.

The development team or VP of Real Estate is typically the first internal audience — they need to believe that the market can support the project and that the capital structure makes sense before any other conversation can advance. The hospital anchor changes both of those assessments in ways that are worth quantifying early: a committed referral relationship improves lease-up projections, and a potential land contribution materially changes the required equity investment.

The VP of Operations or Chief Operating Officer needs to get comfortable with the co-located or hospital-adjacent model — specifically how shared services will be managed, what the clinical interface looks like, and how the staffing model holds up in a rural labor market. These are legitimate operational questions, and an operator whose VP of Operations is engaged early is far more likely to follow through to execution than one where operations is brought in after the development team has already committed.

The CFO or financial analyst responsible for underwriting has to get comfortable with rural market assumptions — occupancy ramp, payor mix, and the longer stabilization timeline that rural lease-up typically requires. The hospital's referral commitment, and any land contribution that reduces the capital requirement, are the two most powerful tools for improving the underwrite. Presenting those elements clearly and early shortens the internal approval process considerably.

Senior leadership and ownership — whether a regional operator's CEO, a faith-based system's board, or a private equity firm's investment committee — will ultimately approve or deny the market entry decision. The framing that tends to resonate at this level is not purely financial: it is the combination of a de-risked occupancy model, a mission-aligned community benefit story, and a development partner who understands both the operator's world and the hospital's.

Connecting the Two Organizations

What makes this partnership work in practice is not just that both institutions reach internal alignment independently — it is that their internal champions find each other and begin building the relationship at the right level. A hospital CFO who has internal support for the concept needs to be talking to a senior living operator's development lead, not their sales team. A senior living VP of Operations who is evaluating the shared services model needs a direct line to the hospital's facilities director, not a general inquiry channel.

Mapping your internal stakeholders to their counterparts on the other side of the partnership is one of the most practical steps either organization can take in the early stages of this conversation. The hospital's readmission problem is the operator's occupancy solution. The operator's dining and housekeeping infrastructure is the hospital's overhead relief. The more clearly each organization understands who on the other side owns which problem, the faster the partnership moves from concept to structure.

If you are reading this paper and see the opportunity — whether from the hospital side or the senior living side — the first step is identifying who your internal champion is. The second step is finding their counterpart across the table. Everything else follows from that.

Section 8 - Implementation Considerations

Moving from concept to executed partnership requires attention to a set of structural, regulatory, and operational considerations that vary by market and by the specific configuration of the partnership. The following is not an exhaustive framework but a summary of the considerations that most frequently determine whether a partnership succeeds or stalls.

Market Feasibility

Not every rural market will support a senior living development, and no partnership structure can substitute for adequate demand. Before committing significant development resources, a basic market feasibility analysis should confirm the following:

Factor	Key Consideration
Population Base	A minimum of 2,500 to 3,000 seniors aged 75 and older within a 10-to-15-mile primary market area is generally considered a floor for a viable assisted living community. Memory care may be viable at lower population thresholds given higher acuity and fewer alternatives.
Income Profile	Private-pay penetration is the critical variable. Median household income, home ownership rates, and asset levels in the trade area determine what percentage of the senior population can afford market-rate monthly fees without Medicaid support.
Competitive Supply	Existing occupancy rates at competing facilities — if any exist — are the clearest signal of unmet demand. A market with no existing senior living options and a growing senior population is the strongest feasibility indicator.
Payor Mix Assumption	The financial model must make explicit assumptions about the proportion of private-pay versus Medicaid-eligible residents. The more private-pay dominant the payor mix, the more straightforward the capital conversation.

Regulatory Planning

Senior living development intersects with healthcare regulation at multiple points — state assisted living licensure, CMS conditions of participation for the hospital, certificate of need requirements in applicable states, and food service licensing for shared dining operations. Regulatory planning should begin early in the project, with counsel experienced in both healthcare facility regulation and senior living licensing in the relevant state.

The shared services arrangements described in this paper — particularly shared food service and shared clinical oversight — require careful protocol design to ensure that each regulatory framework is satisfied without creating operational conflict. In most states, this is achievable

with proper planning, but it is not automatic. Architectural programming for shared spaces should be coordinated with regulatory planning from the earliest design phase.

Governance and Management

Clarity on governance — who manages shared departments, how disputes are resolved, how costs are allocated over time, and how the partnership adapts as senior living census grows — is essential to long-term success. Shared services arrangements that appear financially compelling on paper can become sources of operational friction if the management structure is ambiguous or the cost allocation methodology is perceived as unfair by either party.

The most durable partnerships establish a formal governance structure early: a shared services agreement that specifies management authority, cost allocation methodology, performance standards, and adjustment mechanisms as census changes. This agreement is distinct from the real estate or development partnership documents and should be negotiated with equal care.

Architectural Design Implications

The physical design of a hospital-senior living partnership campus significantly affects the degree to which shared services can be operationalized. Co-located facilities that share a building connection — a covered corridor, a shared service wing, or a central utility plant — realize substantially greater shared services benefit than campus-proximate but operationally separate buildings.

Early-stage programming should explicitly address the following design considerations: the location and design of the shared kitchen and dining facility; the routing of laundry services between buildings; the configuration of shared mechanical, electrical, and plumbing systems; and the integration of life safety and security systems across both facilities. These decisions, made correctly at the programming stage, can dramatically reduce the long-term operating cost of the shared services arrangement.

One of the most consequential design decisions in a hospital-senior living partnership is the deliberate differentiation between the two environments. Hospital and clinical facilities are inherently institutional — defined by infection control requirements, clinical workflow, equipment clearances, and regulatory standards that produce spaces which communicate care and competency but not comfort. The senior living community must communicate something entirely different: that this is a place to live, not a place to be treated.

This distinction does not require opulence or highly sophisticated finishes. In rural and small community contexts, the most effective senior living environments are those that feel residentially familiar — warm in material and scale, comfortable in proportion, and reflective of the community's own character rather than importing an aesthetic that feels foreign to the people it is meant to serve. The goal is an environment where a prospective resident and their family can see themselves living rather than being admitted there.

The architectural programming process should address this differentiation explicitly. Even where facilities share a physical connection — a covered walkway, a shared service corridor, a common utility plant — the experiential language of the two buildings should be unmistakably distinct. The hospital's entrance communicates clinical readiness. The senior living entrance

communicates welcome and belonging. Both are honest expressions of their purpose. And the clarity of that distinction is one of the strongest signals a family receives that the people who designed and operate this community understood the difference between a place to heal and a place to live.

Section 8 - Conclusion

The partnership model described in this paper is not speculative — it is a structured response to converging pressures that rural and community hospitals, senior living operators, and the communities they serve are already experiencing. The financial case is grounded in demonstrable cost arithmetic: fixed overhead spread across a larger combined census, supply procurement volume that unlocks better pricing tiers, and a capital structure de-risked by an institutional anchor that no conventional senior living development can replicate.

The community case is equally clear. Rural seniors deserve access to high-quality care near their families and communities. Rural hospitals deserve a path to financial sustainability that does not require compromising their mission. And the communities that depend on both deserve solutions that leverage existing institutional relationships rather than waiting for market forces that may never arrive.

The hospital-senior living partnership is not a real estate transaction with a community benefit veneer. It is a structural response to a structural problem — and it creates value for every party at the table.

Wold|JJCA proposes to develop this model with community health system and rural hospital clients. We welcome the opportunity to explore how this framework might apply to your community, your institution, and your specific circumstances. The conversation begins with a simple question — and the answers almost always confirm that the partnership makes sense.

About Wold | JJCA | Senior Living Practice

Wold|JJCA's Senior Living Practice brings over two decades of combined experience in senior living development, operations, and architectural design. Wold|JJCA through the Jay Keopf, whose background includes the development, repositioning and renovation of senior living communities with American Retirement Corporation and Brookdale Senior Living — the practice offers an unusual combination of operator-side financial fluency and full-service architectural capability.

We work with hospitals, health systems, senior living operators, and capital partners at every stage of project development: from initial partnership concept and feasibility analysis through architectural programming, design, regulatory approvals, construction administration, and project closeout. Our experience on the operator side of the desk means we understand what a senior living community needs to perform — financially, operationally, and for the residents it serves.

To discuss this framework in the context of your institution or community, contact Jay Keopf at Wold@JJCA.

Disclaimer

This white paper is intended for general informational and educational purposes only. It does not constitute legal, financial, regulatory, or investment advice. Statistical data is drawn from publicly available sources cited herein; illustrative financial figures are noted as such and do not represent audited data or guarantees of specific outcomes. Readers should consult qualified legal, financial, and healthcare regulatory counsel before entering into any partnership arrangement.

Sources and Notes

All statistical claims in this white paper are drawn from the sources listed below, or are identified as illustrative estimates based on the author's professional experience. Readers are encouraged to consult primary sources directly for the most current data.

Section 1 — The Problem This Partnership Solves

Critical Access Hospital Count

"As of July 2024, there were 1,367 CAHs across 45 states." Applied Policy, Critical Access Hospitals overview, citing CMS data. Available at: appliedpolicy.com/critical-access-hospitals. See also: Centers for Medicare & Medicaid Services, Critical Access Hospitals program page, cms.gov/medicare/health-safety-standards/certification-compliance/critical-access-hospitals.

CAH Bed Limit

The 25-bed maximum for Critical Access Hospital certification is established by statute at 42 CFR Part 485 Subpart F. Centers for Medicare & Medicaid Services, Code of Federal Regulations, ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-485/subpart-F.

Hospital Readmissions Reduction Program (HRRP)

The HRRP was established under Section 1886(q) of the Social Security Act, effective October 1, 2012. The six conditions subject to readmission measurement are: acute myocardial infarction (AMI), heart failure (HF), pneumonia, chronic obstructive pulmonary disease (COPD), coronary artery bypass graft (CABG) surgery, and elective total hip and/or total knee arthroplasty. Payment reductions are capped at 3% of Medicare fee-for-service base operating DRG payments. Sources: CMS HRRP program page, cms.gov/medicare/quality/value-based-programs/hospital-readmissions; QualityNet HRRP FAQ, qualitynet.cms.gov/inpatient/hrrp; NEJM Catalyst, "Hospital Readmissions Reduction Program," catalyst.nejm.org.

Rural Hospital Closures and Financial Vulnerability

"Since 2010, there have been 206 rural hospitals that have either closed or have converted to models that exclude inpatient care." The Chartis Center for Rural Health, 2026 Rural Health State of the State (February 2026), citing data from the Cecil G. Sheps Center for Health Services Research at the University of North Carolina. Available at: chartis.com/insights/2026-rural-health-state-state.

"41.2% of all rural hospitals are operating in the red, and 417 are vulnerable to closure." Ibid. Prior year figure (46%) from the same series: Chartis Center for Rural Health, 2025 State of Rural Health (February 2025), chartis.com/insights/2025-rural-health-state-state.

Rural Population

"As of July 2024, the rural population of the United States increased to 46.2 million people, representing 13.6 percent of the total U.S. population." USDA Economic Research Service, "Rural population reaches 46.2 million in 2024," ers.usda.gov. See also: USDA ERS, Rural America at a Glance: 2024 Edition (EIB-282), ers.usda.gov/publications/pub-details?pubid=110350.

Section 4 — The Supply Procurement Advantage

GPO Utilization Rate

"Over 95% of hospitals in the United States use Group Purchasing Organizations." PMC / National Institutes of Health, "Role of supply chain intermediaries in steering hospital product choice," pmc.ncbi.nlm.nih.gov/articles/PMC11152204. The Healthcare Supply Chain Association (HSCA) reports that 72% of nonlabor hospital supply purchases are made through GPOs.

GPO Supply Savings Range

"Providers who used GPOs saw supply chain spending decline by 10 to 15 percent." Healthcare Supply Chain Association, cited in TechTarget / RevCycle Intelligence, "Leveraging Group Purchasing for Hospital Supply Chain Management," revcyclemanagement.com.

"The GPO approach is estimated to save hospitals 10% to 18% annually." Vizient, "Hospitals and patients nationwide benefit from Group Purchasing Organization collaboration" (May 2022), vizientinc.com.

"Studies referenced by the Healthcare Supply Chain Association report typical savings of 10–18% compared to independent purchasing." Ramp, "How Group Purchasing Organizations Operate," ramp.com/blog/how-group-purchasing-organizations-operate.

Note: The savings range of 10–18% cited in this paper reflects the range reported across multiple HSCA-cited studies. Actual savings for any specific institution will vary based on current contract participation, purchasing volume, product mix, and GPO tier. The illustrative dollar figures in Section 3 are constructed examples for conceptual purposes and should not be treated as projections.

Major GPO Identification

Vizient, Premier, and HealthTrust are identified as the three largest GPOs by hospital purchasing volume. Together they represent more than 75% of the hospital GPO market. Source: PMC / NIH, "Role of supply chain intermediaries," *ibid*. Vizient membership represents nearly \$110 billion in annual purchasing volume. Source: U.S. House Ways and Means Committee, "Health Care and the Climate Crisis" RFI response data, citing Definitive Healthcare, democrats-waysandmeans.house.gov.

Section 5 — Partnership Structures and the Capital Case

Named Health System Partnership Precedents

Intermountain Healthcare, Banner Health, and regional Catholic health systems are referenced as examples of health systems that have pursued hospital-affiliated senior living or post-acute co-development models. These are named as general market precedents based on the author's professional knowledge of the senior living development landscape. Specific project details are not cited; readers interested in specific precedent transactions should conduct independent research or contact those organizations directly.

USDA and Rural Financing Programs

References to USDA Community Facilities loan guarantees, HUD Section 232 financing, New Markets Tax Credits, and state rural development programs reflect general knowledge of programs available for rural healthcare and senior living development. Program eligibility, terms, and availability vary and are subject to change. Readers should consult current program documentation at [usda.gov](https://www.usda.gov), [hud.gov](https://www.hud.gov), and [cdfifund.gov](https://www.cdfifund.gov), and seek qualified counsel before pursuing these financing structures.

Notes on Illustrative Figures

Food Service Cost Illustration

The illustration of a 20-bed CAH spending \$400,000 annually on food service, producing a \$20,000 cost per licensed bed, is a constructed example for conceptual purposes. Actual hospital dietary costs vary considerably by geography, staffing model, vendor contracts, and census levels. The cost-per-unit comparison is intended to demonstrate the directional arithmetic of shared services economics, not to represent a specific benchmark or guarantee a specific outcome. Hospital CFOs seeking actual benchmarks for their institution should reference the Healthcare Cost Report Information System (HCRIS) data available through CMS, or engage a healthcare financial advisory firm with access to peer comparison data.

Senior Living Lease-Up and Stabilization Timeline

The "24–36 months to stabilization" figure cited in this paper reflects general practitioner experience with rural and secondary-market senior living lease-up timelines, informed by the author's background in senior living development. NIC MAP Vision ([nicmap.com](https://www.nicmap.com)) publishes occupancy and absorption data for primary and secondary markets that can be used to benchmark stabilization timelines for specific geographies; that data does not specifically isolate rural hospital-anchored communities. Readers undertaking project-specific feasibility work should commission a market feasibility study by a firm with access to NIC MAP data and experience in comparable rural markets.

Market Feasibility Thresholds

The suggested minimum trade area thresholds (2,500 to 3,000 seniors aged 75 and older within a 10–15-mile primary market area) are practitioner-informed rules of thumb drawn from the author's senior living development experience, not published regulatory standards. They reflect general industry practice for assisted living feasibility analysis. Any specific project should be evaluated through a formal market feasibility study that accounts for local demographics, competitive supply, income levels, and the specific care type proposed.

Primary Sources Referenced

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- Centers for Medicare & Medicaid Services. "Code of Federal Regulations, 42 CFR Part 485 Subpart F — Critical Access Hospitals." ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-485/subpart-F.
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- QualityNet. "Hospital Readmissions Reduction Program." qualitynet.cms.gov/inpatient/hrrp.
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