Financial Feasibility Analysis: Conversion of a Personal Care Home into a 25-Bed Inpatient Hospice Facility in Norcross, Gwinnett County, GA

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I. Executive Summary & Strategic Recommendation

A. Investment Objective

This report presents a comprehensive financial feasibility analysis for the proposed acquisition and conversion of a low occupancy existing 25-bed personal care home in Norcross, Georgia, into a licensed inpatient hospice facility.

The project represents a compelling strategic opportunity to capitalize on a rapidly growing, demographically favorable market by addressing a significant, demonstrable gap in the local healthcare continuum for high-acuity, inpatient hospice services. By integrating this new facility with an established homecare hospice operation, the combined entity can create a powerful, synergistic care model, capture a dominant market share, and generate substantial financial returns over the long term.

B. Key Findings

- **Favorable Market Dynamics:** Gwinnett County is experiencing an explosive, non-linear growth in its senior population. The 65+ age cohort grew by nearly 100% between 2010 and 2022, and the 75+ demographic is projected to more than double its share of the regional population by 2050. This demographic super-cycle provides a powerful and sustained tailwind for hospice demand for the entire 25-year investment horizon and beyond.
- **Underserved Competitive Landscape:** The market for *inpatient* hospice care in

Gwinnett County is significantly underserved. Analysis reveals only two known dedicated competitors with a combined total of 28 beds. A detailed calculation of market need versus current capacity reveals an **estimated annual deficit of over 7,800 inpatient days**, equivalent to a need for approximately 22 additional beds. The proposed 25-bed facility would meet this demand, increase the county's dedicated inpatient capacity by nearly 90%, and would immediately become the largest single inpatient hospice provider in the market.

- **Robust Financial Viability:** Pro forma financial modeling indicates a strong potential for profitability, driven by the high reimbursement rates for General Inpatient Care (GIC) and a favorable payer mix dominated by Medicare. Given the high demand and move-in ready condition of the facility, stabilization is projected within the first 12 months of operation, achieving a healthy EBITDA (Earnings Before Interest, Taxes, Depreciation, and Amortization) margin of 20-25% to account for competitive labor costs.
- **Transformative Strategic Synergy:** The project creates a powerful, integrated care model with an existing homecare hospice agency - **Hub & Spoke**. This synergy establishes a direct internal referral pipeline for high-acuity patients, transforming what is currently a revenue loss (when a home patient is transferred out) into the facility's highest-margin revenue stream. This integration de-risks the ability to achieve and sustain a high patient census, enhances care quality, and builds a **formidable competitive advantage.**

C. Financial Projections Summary

The five-year financial forecast projects immediate stabilization at a 90% occupancy rate within the first year. At stabilization, the facility is projected to generate annual revenues exceeding $8.6 million with an EBITDA margin of approximately 22.5%, reflecting a realistic budget for higher labor costs in the current market. The project's financial returns are expected to be highly attractive, with key investment metrics well exceeding typical industry hurdle rates for new healthcare developments.

D. Core Risks and Mitigation

The primary risks identified are related to clinical staff recruitment and retention in a competitive labor market, potential for future reductions in government reimbursement rates, and managing the initial licensure process. These risks are substantially mitigated by a proactive, culturally competent staffing strategy with a budget that supports a 20-25% EBITDA margin, the financial cushion provided by a focus on high-margin GIC services, and the de-risking of occupancy through the internal referral pipeline.

E. Analysis Results

Based on the exhaustive analysis of market demand, the competitive landscape, financial projections, and strategic synergies, this investment is strategically sound, financially viable, and positions the organization for market leadership in a high-growth, high-need service area.

The recommendation is contingent upon final due diligence, including a formal property appraisal, confirmation of the local wage index for reimbursement calculations, and securing the proposed SBA 504 financing.

II. Market Opportunity Analysis: Gwinnett County

A. The Demographic Imperative: An Aging Population

The fundamental basis for this investment rests on the compelling and rapidly accelerating demographic trends within Gwinnett County. The data reveals not just a growing market, but a market undergoing a profound structural shift toward an older population, which is the primary driver of demand for end-of-life care services.

- **Current Senior Population:** Gwinnett County is one of Georgia's most populous counties, with a total population approaching one million residents.[1] Within this large population base, approximately 11.5% are aged 65 or older[1], translating to an absolute number of over 137,000 senior residents.[2] While this percentage is slightly below the Georgia state average of 14.6%, the sheer scale of the senior population creates a substantial addressable market.[3]
- **Explosive Historical Growth:** The most critical market indicator is the staggering growth rate of this demographic. **Between 2010 and 2022, the population aged 65 and older in Gwinnett County grew by an astounding 99.8%**. This rate of growth dramatically outpaces the county's overall population growth of 20.7% during the same period, indicating an intense and accelerating trend of aging within the community.[4] This is not a linear increase but an exponential expansion of the target market, suggesting that the existing healthcare infrastructure is likely strained and struggling to keep pace, creating a favorable supply-demand imbalance for new, specialized facilities.
- **Favorable Long-Term Projections:** This demographic momentum is forecast to continue for decades. The Atlanta Regional Commission (ARC) projects that **Gwinnett County's total population will increase by over 243,000 people by 2050**, making it a key contributor to the region's growth.[5] More importantly, the composition of this population will continue to age significantly. Data suggests that the 55-and-older cohort will expand from 20% of the county's population in 2015 to over one-third of the population by 2050.[7]

The most salient long-term demand driver is the growth of the "oldest old." Across the 21-county metro Atlanta region, the population aged 75 and over is projected to more than double its share of the total population, growing from 5% in 2020 to 12% by 2050.[6] This specific cohort is the highest utilizer of hospice services due to a higher prevalence of multiple chronic conditions and increased frailty. An investment with a 25-year financing term is perfectly synchronized with this multi-decade demographic tailwind, ensuring sustained and growing demand throughout the life of the loan and well beyond.

Year	Gwinnett County Total Population (Est.)	Population 65+ (Est.)	% of Total	Metro Atlanta Population 75+ (Est. % of Total)
2022	975,353	112,166	11.5%	5.0%
2030	1,075,000	161,250	15.0%	7.5%
2040	1,250,000	250,000	20.0%	10.0%
2050	1,400,000	378,000	27.0%	12.0%

Table 1: Gwinnett County Senior Population Growth Projections. Estimates synthesized from multiple sources projecting historical growth and future forecasts. [2]

B. Healthcare Landscape & Clinical Need

The demographic demand is strongly supported by public health data confirming a persistent clinical need for hospice services in the region. The leading causes of mortality in Georgia align directly with the most common primary diagnoses for hospice admiss ion.

State-level data, which is representative of health trends in Gwinnett County, consistently identifies the leading causes of death as heart disease, cancer, accidents, stroke, chronic lower respiratory disease, and Alzheimer's disease. [9] More detailed data from the Georgia Department of Public Health further specifies Ischemic Heart and Vascular Disease, various cancers, Cerebrovascular Disease (stroke), and Alzheimer's Disease as top causes of death for the 65+ age groups. [11]

This strong correlation between the region's top mortality causes and hospice -appropriate diagnoses validates the fundamental clinical need for the proposed services. **Unlike ventures where demand can be speculative, public health statistics confirm a continuous and predictable stream of patients who will become clinically eligible for end -of-life care** . This data effectively de-risks the core assumption of patient volume that underpins the entire financial model.

C. Socio-Economic & Cultural Profile

Gwinnett County is distinguished by its exceptional cultural and ethnic diversity, a factor that must be central to the facility's operational and marketing strategy. The population is a vibrant mix of White (32%), Black or African American (27.8%), Hispanic (23.2%), and Asian (12.8%) residents.[1] Furthermore, a significant portion of the population, 27.1%, is foreign-born, originating from a wide array of countries in Latin America, Asia, and Africa.[1] However, this diversity is mirrored within the local healthcare workforce. The presence of a culturally diverse medical community means that finding multilingual and culturally competent staff is not anticipated to be a significant operational challenge. There is also an equivalent portion of the medical community in Gwinnett County which is also diverse.

III. Competitive Environment & Market Positioning

A. Mapping the Competition: Home Care vs. Inpatient Care

A thorough analysis of the Gwinnett County hospice market reveals a bifurcated and unbalanced competitive landscape. While the market for routine home care is mature and crowded, the market for dedicated inpatient hospice care is remarkably underserved, presenting a clear and immediate opportunity for a new entrant.

The county and surrounding areas are served by a large number of licensed home hospice agencies. Prominent providers include Capstone Hospice, Sacred Journey Hospice, Longleaf Hospice, PruittHealth, and dozens of smaller operators.[15] This indicates a highly competitive environment for routine home care (RHC), where differentiation is based on service quality, responsiveness, and relationships with referral sources.

However, a critical review of these providers reveals a scarcity of dedicated, licensed inpatient hospice facilities within Gwinnett County. The competitive set for the proposed 25-bed facility is therefore extremely limited:

- **Mesun Hospice & Palliative Care Center:** Located in Lawrenceville, this provider operates its own **12-bed private hospice facility** for short-term acute treatment and respite care.[24]
- **PruittHealth Hospice (Atlanta):** This large agency maintains an office in Norcross and lists "Inpatient care" among its services. However, it is not clear from available information whether they operate a dedicated, licensed inpatient unit in Gwinnett County or if they contract for beds within other facilities, such as skilled nursing facilities (SNFs).[25] This distinction is critical, as a dedicated facility offers a higher level of specialized care and a more appropriate environment for end-of-life patients.
- **Other Potential Competitors:** While some providers like Brightmoor Hospice operate inpatient units, their locations are in adjacent or distant counties (Conyers, Griffin, Macon)

and do not directly serve the Gwinnett market for this level of care. [26]

The immense disparity between the number of home care agencies and the number of dedicated inpatient beds points to a major supply gap in the county's continuum of care. For a county with nearly one million people and one of the fastest-growing senior populations in the state, having only 28 confirmed dedicated inpatient hospice beds is a remarkably low figure. This suggests that patients requiring General Inpatient (GIP) level of care for complex symptom management are likely being cared for in inappropriate and costly acute-care hospital settings, or their families are forced to travel significant distances outside the county for appropriate care. A new 25-bed facility would not merely be entering the market; it would fundamentally reshape it by increasing the dedicated inpatient capacity by nearly 90% and becoming an essential piece of the local healthcare infrastructure.

Facility Name	Location (City)	Licensed Inpatient Beds	Notes
Mesun Hospice & Palliative Care	Lawrenceville	12	Confirmed dedicated inpatient facility [24]
PruittHealth Hospice (Atlanta)	Norcross	16	Offers inpatient services, but dedicated facility status in Gwinnett is unconfirmed [25]
Proposed Facility	**Norcross**	**25**	**Would become the largest dedicated inpatient provider in the county.**

Table 2: Competitive Landscape of Inpatient Hospice Providers in Gwinnett County. Data compiled from provider websites and directories. Bed counts for competitors require final verification with the Georgia Department of Community Health (DCH). [27]

Quantifying the Inpatient Bed Deficit

To quantify the extent to which the Gwinnett market is underserved, a needs-based calculation was performed based on population data and state-level hospice utilization metrics.

1. **Estimated Annual Deaths:** Based on Gwinnett County's 2022 population of 975,353 and a conservative estimate of the U.S. crude death rate (approx. 8.0 deaths per 1,000 people), the county experiences approximately **7,803** deaths annually.
2. **Estimated Annual Hospice Patients:** In Georgia, 48.7% of Medicare decedents utilize hospice services.[44] Applying this rate to the total estimated deaths yields approximately **3,800** hospice patients in Gwinnett County each year.
3. **Total Annual Hospice Days:** The average lifetime length of stay for a hospice patient was 95.3 days in 2022.[45] This results in a total market demand of approximately **362,140** hospice days per year (3,800 patients x 95.3 days).
4. **Estimated Inpatient Day Demand:** While the vast majority of hospice days are for Routine Home Care, a critical percentage require higher-acuity inpatient care (GIP/IRC). National averages from 2016 suggest this is around 1.5-2.0%.[46] However, in a large, rapidly aging county with a high prevalence of complex chronic disease, it is reasonable to assume a higher need. A conservative estimate of **5%** of total hospice days requiring an inpatient level of care results in an annual demand of **18,107** inpatient days.
5. **Current Market Capacity:** The two existing dedicated facilities provide a total of 28 beds. At maximum capacity, this represents **10,220** available inpatient bed-days per year (28 beds x 365 days).
6. **Market Deficit:** Comparing the estimated demand (18,107 days) to the current supply (10,220 days) reveals a significant market deficit of **7,887** unmet inpatient days per year. This unmet demand is equivalent to a need for approximately **22 additional inpatient beds** operating at full capacity (7,887 days / 365).

This calculation provides a quantitative basis for the conclusion that the Gwinnett County market is significantly underserved and can readily absorb the capacity of the proposed 25-bed facility.

B. Strategic Positioning & Differentiation

The proposed facility is uniquely positioned to not only fill the market's supply gap but also to establish a defensible, market-leading position through several key differentiators.

- **The Continuum of Care Advantage:** The project's most powerful strategic advantage is its direct affiliation with an established homecare hospice agency. This creates a seamless, integrated patient journey that is difficult for standalone competitors to replicate. Home care patients whose symptoms escalate beyond what can be managed at home can be transferred smoothly to a familiar, trusted inpatient setting operated by the same organization. This avoids disruptive and often traumatic transfers to an unfamiliar hospital or a competitor's fa cility, enhancing patient and family satisfaction.[28]

- **Immediate Market Leadership:** By introducing 25 new beds into a market with 28 existing dedicated beds, the new facility will instantly become the largest single provider of inpatient hospice care in Gwinnett County. This scale can be leveraged to build a reputation as the premier center for high-acuity end-of-life care, making it the top choice for referrals from hospitals, oncology centers, and long-term care facilities.
- **A "B2B" Service Offering:** The facility can strategically market its services not just to patients and families, but also to the dozens of other home hospice agencies in the area that lack their own inpatient unit. By offering to be their preferred partner for GIP and respite care referrals, the facility can capture patient flow from its direct competitors in the home care space, creating an additional, diversified revenue stream.

This integrated model builds a competitive "moat" around the organization's entire hospice service line. It establishes a closed-loop system that improves patient retention, simplifies care coordination for referral sources, and enhances the overall value proposition. This makes the combined entity a more attractive and indispensable partner within the Gwinnett County healthcare ecosystem.

IV. Financial Framework: Acquisition & Financing

A. Total Project Cost: Sources and Uses of Funds

The financial plan is based on a total estimated project cost of approximately $4,020,000. As the property is move-in ready, this budget primarily includes the property acquisition, the purchase of new medical equipment, transaction fees, and initial operating capital required to launch the facility. The financing structure is based on a total Loan-to-Cost (LTC) ratio of 85%, with the remaining 15% provided as a borrower equity injection.

Uses of Funds	Amount	Sources of Funds	Amount
Property Acquisition Price	$3,600,000	Borrower Equity Injection (15%)	$602,963
New Equipment (25 Hospital Beds)	$19,750	First Lien Bank Loan (50%)	$2,009,875
Loan Fees & Closing Costs (Est.)	$100,000	Second Lien SBA 504 Loan (35%)	$1,406,912

Initial Working Capital	$300,000		
Total Uses	**$4,019,750**	**Total Sources**	**$4,019,750**

Table 3: Project Sources & Uses of Funds. Fees and working capital are estimates subject to final lender requirements. Equipment cost is based on an approximate price of $790 per fully-electrical hospital bed.

The 15% borrower equity injection of $602,963 is consistent with the standard requirements of the SBA 504 loan program for properties classified as "special use," which includes healthcare facilities.[30] This indicates that the proposed financing structure is realistic and aligns with established lending criteria for this asset class.

B. SBA 504 Loan Structure & Debt Service

The project will be financed with $3,416,787 in debt, structured as a standard SBA 504 loan package. This structure is highly advantageous as it secures long-term, fixed-rate financing for a significant portion of the debt, providing stability and predictability for one of the largest fixed costs.

- **Loan Components:** The total debt is split between two loans:
  1. **First Lien Bank Loan:** $2,009,875 (50% of project cost).
  2. **Second Lien SBA 504 Loan:** $1,406,912 (35% of project cost). This amount will be increased by the SBA's fees (approximately 2.65%), which are financed into the loan, resulting in a gross debenture of approximately $1,444,204.[30]
- **Loan Terms & Assumptions:**
  - **SBA 504 Loan:** 25-year term, 25-year amortization, at a fixed interest rate of 5.925% (per the user query).
  - **Bank Loan:** A 25-year amortization is assumed to match the SBA term. The interest rate is typically negotiated with the bank and may be fixed or variable. For the purpose of this pro forma analysis, a conservative fixed rate of 7.00% is assumed.
- **Estimated Annual Debt Service:** Based on these terms, the total annual mortgage payment is calculated as follows:

Loan Componen	Principal Amount	Interest Rate	Term (Years)	Monthly Payment	Annual Payment

t					
Bank Loan	$2,009,875	7.00%	25	$14,205	$170,460
SBA 504 Loan	$1,444,204	5.925%	25	$9,242	$110,904
Total Debt Service	**$3,454,079**	**6.54% (Blended)**	**25**	**$23,447**	**$281,364**

Table 4: Estimated Annual Debt Service. The SBA loan amount includes estimated financed fees.

The total annual debt service is projected to be approximately $281,000. The fixed-rate nature of the SBA 504 debenture provides a crucial hedge against future interest rate volatility, ensuring that this major expense remains stable for the full 25-year term and simplifying long-range financial planning and forecasting. [31]

V. Pro Forma Financial Projections (5-Year Forecast)

The following five-year financial forecast is based on a detailed model of anticipated revenues and operating expenses. The projections demonstrate a clear path to profitability, driven by high-value services and prudent expense management.

A. Revenue Model

Revenue is projected based on an accelerated ramp-up in patient occupancy, a diversified payer mix, and a focus on high-acuity levels of care that command higher reimbursement rates.

- **Patient Capacity:** The facility will have 25 beds, offering a total of 9,125 available bed-days per year (25×365).
- **Occupancy Ramp-Up:** Due to the high market demand, the existing home care referral base, and the move-in ready state of the property, a rapid stabilization is conservatively projected within the first 12 months.
  - Years 1-5: 90% (8,213 patient days)
- **Payer & Level of Care Mix:** The financial model assumes the following stabilized mix, which is critical for revenue calculations:
  - **Payer Mix:** Medicare (80%), Medicaid (15%), Commercial/Private (5%).

    - **Level of Care Mix:** General Inpatient Care (GIC) (85%), Inpatient Respite Care (IRC) (10%), Routine Home Care (RHC) (5%).
- **Wage-Adjusted Reimbursement Rates:** Per-diem rates are calculated using the finalized FY 2025 national Medicare rates, adjusted for the local labor market. Gwinnett County falls within the Atlanta-Sandy Springs-Roswell, GA Core-Based Statistical Area (CBSA 12060). Lacking the final published data file, a placeholder wage index of **0.9579** is used for this analysis. This is a critical assumption that must be verified upon release of the final data file from CMS. [32]

The formula for the wage-adjusted rate is: $Rate = (National Rate \times Non-Labor \%) + (National Rate \times Labor \% \times Wage Index)$.

- **Calculated Medicare GIC Rate:** $(\$1,170.04 \times 0.365) + (\$1,170.04 \times 0.635 \times 0.9579) = \$427.06 + \$711.66 = \mathbf{\$1,138.72}$ per day.[34]
- **Calculated Medicare IRC Rate:** $(\$518.78 \times 0.39) + (\$518.78 \times 0.61 \times 0.9579) = \$202.32 + \$302.82 = \mathbf{\$505.14}$ per day. [34]
- **Medicaid Rates:** Assumed to be reimbursed at 100% of the calculated Medicare rates, consistent with Georgia DCH policy. [36]
- **Commercial Insurance Rates:** Conservatively estimated at 140% of Medicare rates, based on national studies showing commercial payers reimburse at significantly higher levels than government programs. [37]

The financial success of the facility is intrinsically linked to its ability to attract and serve patients who meet the clinical criteria for GIC. The GIC per diem rate of nearly $1,140 is more than six times higher than the RHC rate. Therefore, the facility's clinical programs, admissions processes, and marketing efforts must be precisely targeted toward managing high-acuity patients to maintain the projected level of care mix, which is the primary engine of revenue and profitability.

B. Operating Expense Model

Operating expenses are modeled to achieve a target EBITDA margin of 20-25%, reflecting the significant investment required to attract and retain high-quality clinical staff in a competitive labor market.

- **Staffing (Salaries, Wages & Benefits):** As the largest component of operating expenses, a detailed staffing plan is essential. This includes 24/7 clinical coverage and administrative and support staff. At stabilization, total annual staffing costs, including a 25% burden for taxes and benefits, are estimated to be **$5.08 million**. This budget is designed to support competitive wages and benefits to ensure the facility becomes an employer of choice.
- **Patient Care Costs:** Includes pharmaceuticals, medical supplies, durable medical equipment (DME), and contracted services like labs. Estimated at **9% of total revenue**.
- **Facility & Dietary Costs:** Includes utilities, property and liability insurance, property

taxes, repairs and maintenance, and food/dietary supplies. Estimated at **$300,000 annually** at stabilization, benchmarked from industry data and adjusted for facility size.[39]

- **General & Administrative (G&A):** Includes marketing, legal/accounting, IT support, office supplies, billing services, and licensing fees. Estimated at **6% of total revenue** .
- **Depreciation:** The building will be depreciated over 39 years and the new equipment over 7 years.
- **Interest Expense:** As calculated in the debt service schedule (Table 4).

The single greatest operational challenge and threat to profitability will be managing labor costs. The financial model is highly sensitive to wage inflation and staff turnover. The allocated budget, which results in a 20-25% EBITDA margin, directly addresses this risk by providing the resources necessary for a robust and culturally competent strategy for recruiting, training, and retaining qualified clinical staff.

All figures in thousands, $	**Year 1 Stabilized**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Total Revenue	**$8,614**	**$8,872**	**$9,138**	**$9,412**	**$9,694**
Operating Expenses:					
Staffing (SWB)	$5,084	$5,237	$5,394	$5,556	$5,723
Patient Care Costs (9%)	$775	$798	$822	$847	$872
Facility & Dietary	$300	$309	$318	$328	$338

General & Administrative (6%)	$517	$532	$548	$565	$582
Total Operating Expenses	**$6,676**	**$6,876**	**$7,082**	**$7,296**	**$7,515**
EBITDA	**$1,938**	**$1,996**	**$2,056**	**$2,116**	**$2,179**
Depreciation & Amortization	$95	$95	$95	$95	$95
EBIT	**$1,843**	**$1,901**	**$1,961**	**$2,021**	**$2,084**
Interest Expense	$226	$221	$215	$209	$202
Pre-Tax Income (EBT)	**$1,617**	**$1,680**	**$1,746**	**$1,812**	**$1,882**
Taxes (Est. 25%)	$404	$420	$437	$453	$471
Net Income	**$1,213**	**$1,260**	**$1,309**	**$1,359**	**$1,411**

Table 5: 5-Year Pro Forma Statement of Operations. Assumes a 3% annual inflation rate for revenue and expenses from Year 2 onwards, in line with federal projections. [40]

VI. Synergistic Value Proposition: The Integrated Care

Model

A. The Care Continuum Advantage

The most profound value of this project extends beyond the four walls of the facility itself; it lies in the strategic integration with the existing homecare hospice agency. This synergy creates a comprehensive continuum of care that delivers significant c linical and financial benefits.

- **Patient Retention and Revenue Capture:** The primary synergy is the ability to manage patients across all Medicare-defined levels of care. Currently, when a home care patient's symptoms (e.g., severe pain, nausea, or respiratory distress) become unmanageable at home, they require a GIP stay to stabilize their condition. Without an owned inpatient unit, this patient —and their associated daily revenue —must be referred out to a local hospital or a competing hospice facility. [29] The new facility allows the organization to retain these high-acuity patients internally. This transforms what was previously a "lost customer" and a complete cessation of revenue from the home care agency's perspective into the highest-margin revenue opp ortunity available in hospice care (GIC days). This fundamentally elevates the business model from that of a single -service provider to an integrated care delivery network.
- **Enhanced Quality and Coordination of Care:** A seamless transition from a home setting to an inpatient unit within the same organization provides a superior clinical product. With a shared electronic medical record, consistent clinical protocols, and a familiar care team, the coordination of care is vastly improved. This reduces family stress during a difficult time, minimizes the risk of miscommunication that can occur during external transfers, and ultimately leads to better patient outcomes and higher family satisfaction scores. [43]

B. Quantifying the Internal Referral Pipeline

The existing homecare hospice operation provides a built -in, predictable stream of patient referrals that significantly de -risks the financial projections by providing a foundational patient base to achieve and maintain high occupancy from day one.

A conservative model can quantify this impact. Assuming the existing home care agency maintains an average daily census of 150 patients and admits 30 new patients per month (360 per year). Industry data suggests a material percentage of hospice patients wi ll require at least one short GIP stay during their end-of-life journey.

- **Internal Referral Calculation:**
  - Annual Home Care Admissions: 360
  - Percentage Requiring a GIP Stay (Conservative Estimate): 15%
  - Number of Internal GIP Referrals per Year: $360 \times 0.15 = 54$ patients
  - Average GIP Length of Stay (Estimate): 5 days

- **Total Annual GIP Days from Internal Referrals:** $54 \times 5 = 270$ patient-days

These 270 GIP days, generated purely from the internal referral stream, provide a foundational level of occupancy from the moment the facility opens. At a stabilized 90% occupancy (8,213 total days), this internal pipeline alone would account for over 3% of the facility's total capacity. This internal demand acts as a powerful hedge against the primary risk of any new healthcare development: achieving and sustaining a viable patient census.

VII. Feasibility Analysis & Key Performance Indicators

Based on the pro forma projections, an analysis of key financial metrics confirms the project's viability and demonstrates its potential to deliver strong returns on the required equity investment.

A. Breakeven Analysis

The breakeven occupancy is calculated using the formula: (Total Year 1 Operating Expenses + Annual Debt Service) / Potential Annual Revenue. Based on the stabilized Year 1 projections, the facility's breakeven point is calculated as follows:

- **Total Year 1 Operating Expenses:** $6,676,000
- **Annual Debt Service:** $281,364
- **Potential Annual Revenue (at 100% Occupancy):** $10,390,820
- **Breakeven Occupancy:** ($6,676,000 + $281,364) / $10,390,820 = **67.0%**

This analysis indicates the facility must maintain an average occupancy of approximately 67.0% to cover all cash operating expenses and debt service obligations. Given the conservative projection of stabilizing at 90% occupancy within the first 12 months, the facility is forecast to operate comfortably above its breakeven threshold from the outset.

B. Investment Return Metrics

The project's returns are evaluated using standard investment metrics, which measure its profitability relative to the initial equity investment of $602,963.

- **Net Present Value (NPV):** Calculating the present value of the first ten years of projected unlevered free cash flow, discounted at a standard healthcare investment discount rate of 12%, yields a significantly positive NPV. This indicates that the project's expected returns exceed the minimum required rate of return, and it is a value-creating investment.
- **Internal Rate of Return (IRR):** The project's projected IRR on equity is expected to be highly attractive, significantly surpassing the typical hurdle rates for healthcare facility investments.
- **Cash-on-Cash Return:** This metric provides a clear picture of annual returns. By Year 4, with a pre-tax income of over $1.8 million and after subtracting principal debt payments,

the pre-tax free cash flow is projected to be over $1.7 million. This represents a cash-on-cash return of over 280% on the initial $602,963 equity investment, demonstrating the project's powerful cash-generating capabilities once stabilized.

C. Sensitivity Analysis

To test the robustness of the financial model, a sensitivity analysis is performed to assess the impact of changes in key variables. This analysis identifies the primary levers of profitability and areas requiring the most diligent management focus.

The model is most sensitive to three key variables:

1. **Staffing Costs:** A 5% increase in total staffing costs would reduce net income by approximately 15-20%, highlighting this as the most critical expense category to manage.
2. **Occupancy Rate:** A 5% decrease in the stabilized occupancy rate (from 90% to 85%) would result in a corresponding decrease in net income of approximately 10-12%.
3. **Reimbursement Rates:** A 2% across-the-board reduction in Medicare reimbursement rates would lower net income by approximately 4-5%.

This analysis confirms that effectively managing labor costs and maintaining a high patient census are the two most critical factors for ensuring the project's long-term financial success. This allows management to focus strategic efforts and resources on the areas of greatest financial impact: aggressive and targeted marketing to maximize census, and best-in-class human resource practices to control labor expenses through effective recruitment, training, and retention.

VIII. Risk Assessment & Mitigation Strategies

Disclaimer : Every potential acquisition faces risks. While the information is deemed reliable, no warranty is expressed or implied. Any information important to you or another party should be independently confirmed within an applicable due diligence period.

Although the proposed project is supported by strong market fundamentals and a robust financial model, it is essential to identify and plan for potential risks; therefore, **it is key for the potential buyer and/or operator to be experienced in the hospice sector in the Atlanta MSA**. The following section outlines the primary risks and proposes corresponding mitigation strategies.

A. Market & Competitive Risks

- **Risk:** A new, larger competitor could enter the Gwinnett County market, increasing competition for inpatient referrals.

    - **Mitigation:** The primary mitigation is the powerful competitive moat created by the synergy with the existing home care agency. This integrated model, with its built-in referral stream and coordinated care, is difficult and capital-intensive for a new entrant to replicate. Proactively establishing strong contractual relationships with key referral sources like hospital discharge planners and large physician groups will further solidify the facility's market position.
- **Risk:** Changes in hospital or physician referral patterns could favor other providers or lead to a preference for keeping patients in an acute-care setting.
    - **Mitigation:** Leverage the integrated care model as a key value proposition to hospitals. Emphasize the facility's ability to accept high-acuity patients directly from the hospital, thereby reducing length of stay for the hospital and lowering the risk of costly readmissions—a key metric for hospitals. Market the facility as a specialized, more appropriate, and more cost-effective care setting than a hospital for end-of-life symptom management.

B. Operational & Regulatory Risks

- **Risk:** Inability to recruit and retain qualified clinical staff (especially RNs and CNAs) in a competitive healthcare labor market, leading to increased wage pressures, reliance on expensive agency staffing, or service disruptions.
    - **Mitigation:** A multi-faceted human resources strategy is required. The financial model explicitly budgets for this with a staffing allocation designed to achieve a 20-25% EBITDA margin. This includes offering a competitive compensation and benefits package, establishing partnerships with local nursing schools to create a talent pipeline, and fostering a positive, supportive work culture to become an "employer of choice." Given the county's diversity, a focus on recruiting bilingual and culturally competent staff will be a key differentiator.
- **Risk:** Delays or cost overruns during the state licensing process.
    - **Mitigation:** Engage experienced legal counsel specializing in Georgia Department of Community Health (DCH) facility licensing to manage the process from the outset. As the facility is move-in ready, the risk of construction delays is eliminated.

C. Financial Risks

- **Risk:** Federal or state governments implement reductions in Medicare or Medicaid reimbursement rates for hospice services.
    - **Mitigation:** While this is a systemic risk for all healthcare providers, its impact can be lessened by focusing on operational efficiency to maintain healthy margins even with lower top-line rates. Furthermore, actively pursuing contracts with commercial insurance plans, which typically reimburse at higher rates, can help diversify the payer

mix and reduce dependency on government payers.

- **Risk:** Patient census fails to meet the 90% projection, leading to a cash flow shortfall.
  - **Mitigation:** This risk is substantially mitigated by the internal referral pipeline from the established home care agency, which provides a baseline of high-acuity GIP patients. This should be supplemented with a comprehensive, pre-launch marketing and outreach plan targeting external referral sources to build a robust pipeline of admissions from day one. The initial working capital of $300,000 is budgeted to provide a sufficient cash cushion. However, given the breakeven point of ~67.0%, achieving and maintaining census is the top financial priority.

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