IRTS vs Assisted Living (ALF) vs Recuperative Care
Reimbursement, Staffing, Qualifications & Operational Comparison

5–6 Bed Residential Model Comparison

Facility Structure Assumptions

Assisted Living (ALF)

- 5 bedrooms
- Single occupancy only
- Approximately 5 resident's total
- Lower-to-moderate acuity residents
- Home-like residential environment
- Minnesota Department of Health (MDH) licensed

IRTS (Intensive Residential Treatment Services)

- 5 bedrooms
- Double occupancy possible
- Approximately 6 residents total
- High behavioral health acuity
- Structured psychiatric residential setting
- DHS behavioral health licensed

Recuperative Care

- 5–6 bed transitional recovery model
- Primarily post-hospital discharge patients
- Residents require medical monitoring but not hospitalization
- Medical respite / recovery-focused environment
- Often partnered with hospitals, Medicaid programs, counties, or community health organizations

Reimbursement Comparison

Category	Assisted Living (ALF)	IRTS	Recuperative Care
Reimbursement Model	Monthly waiver/private pay	Daily per diem	Daily rate / contract-based
Typical Payer	EW/CADI/Private Pay	Medicaid Behavioral Health	Medicaid / Hospitals / County Contracts
Estimated Revenue Per Resident	$4,500–$12,000/month	$250–$1,000+/day	$150–$500+/day
Estimated Monthly Revenue (5–6 Residents)	$30K–$70K/month	$70K–$180K+/month	$40K–$120K+/month
Revenue Predictability	Moderate–High	Moderate	Moderate
Audit Risk	Moderate	Very High	Moderate–High
Documentation Burden	Moderate	Extremely High	High

Estimated Revenue Breakdown

Assisted Living – 5 Private Bedrooms

Occupancy Model	Estimated Monthly Revenue
Conservative	$25K–$35K
Moderate Acuity	$35K–$50K
High Acuity Customized Living	$50K–$70K+

IRTS – 6 Resident Model

Acuity Level	Estimated Monthly Revenue
Conservative	$70K–$90K
Moderate	$90K–$140K
High Acuity	$140K–$180K+

Recuperative Care – 5–6 Bed Model

Acuity Level	Estimated Monthly Revenue
Conservative	$40K–$60K
Moderate	$60K–$90K
High Medical Acuity	$90K–$120K+

Staffing Comparison

Category	Assisted Living	IRTS	Recuperative Care
Staffing Intensity	Moderate	Extremely High	Moderate–High
24/7 Staffing	Usually Yes	Mandatory	Mandatory
Awake Overnight	Usually, 1 staff	Mandatory	Usually Required
RN Requirement	RN oversight	RN required	RN oversight/required
Psychiatrist Requirement	No	Yes/Contracted	Usually No
Clinical Director	Usually No	Required	Sometimes Required
Mental Health Professional	Not usually required	Required	Case management/social work
Group Therapy Staff	No	Yes	No
DSP/Caregiver Ratio	1:4–1:6	1:3–1:4	1:4–1:5
Compliance Burden	Moderate	Very High	High

Qualifications Required to Open

Assisted Living (ALF)

Required Leadership

Role	Requirement
Assisted Living Director	Licensed/Qualified Administrator
RN	Required oversight
Housing Manager	Operational management
Caregivers	Assisted living trained
Medication Staff	Medication administration training

Assisted Living Clinical Requirements

- RN oversight
- Medication administration policies
- Resident assessments
- Emergency preparedness
- Staff training compliance
- MDH survey readiness

Important

An RN is typically sufficient for clinical oversight in smaller assisted living operations.

IRTS Qualifications Required

Required Leadership

Role	Requirement
Program Director	Behavioral health experience
Mental Health Professional	LICSW / LPCC / LMFT / LP
RN	Required
Psychiatrist	Contracted/medical oversight
Clinical Supervisor	Required
Mental Health Practitioners	Required
Overnight Staff	Mandatory

Does IRTS Require a DNP (Doctor of Nursing Practice)?

Not specifically.

However, IRTS requires:

- Psychiatric oversight
- Mental health professionals
- Clinical supervision
- RN involvement

A DNP is NOT specifically mandatory by statute, but:

- Some organizations use psychiatric APRNs/DNPs
- Psychiatric provider oversight is generally expected
- Strong clinical leadership is critical

Most Likely Requirements

- Psychiatrist or psychiatric APRN relationship
- Licensed Mental Health Professional
- RN oversight
- Behavioral health treatment infrastructure

Recuperative Care Qualifications Required

Required Leadership

Role	Requirement
Program Administrator	Healthcare/housing operations experience
RN	Usually required or contracted
Case Manager	Required
Care Coordinators	Required
CNA/HHA Staff	Often required
Medical Director	Sometimes contracted
Overnight Staff	Usually required

Recuperative Care Clinical Requirements

- Medication monitoring
- Discharge coordination
- Care transition management
- Hospital communication workflows
- Transportation coordination
- Community resource linkage
- Infection control protocols
- Medical documentation systems

Important

Recuperative care typically focuses on short-term medical stabilization and recovery after hospital discharge rather than long-term residential care.

Staffing Cost Comparison (Estimated Monthly)

Assisted Living – 5 Bed Model

Position	Estimated Monthly Cost
RN Oversight	$4K–$8K
Caregivers/DSPs	$12K–$22K
Administrator	$4K–$8K
Overnight Staff	$4K–$8K
Total Estimated Staffing	$25K–$45K/month

IRTS – 6 Resident Model

Position	Estimated Monthly Cost
RN	$7K–$12K
Mental Health Professionals	$10K–$25K
Psychiatric Oversight	$5K–$15K
Mental Health Practitioners	$15K–$35K
Overnight Staff	$8K–$15K
Clinical Supervisor	$6K–$12K
Total Estimated Staffing	$60K–$120K+/month

Recuperative Care – 5–6 Bed Model

Position	Estimated Monthly Cost
RN Oversight	$6K–$12K
CNAs/HHAs	$10K–$22K
Case Managers	$5K–$10K
Overnight Staff	$5K–$10K
Medical Coordination	$3K–$8K
Total Estimated Staffing	$35K–$70K+/month

Timeline Comparison

Phase	Assisted Living	IRTS	Recuperative Care
Property Acquisition	1–3 months	1–3 months	1–3 months
Renovations	1–4 months	2–6 months	1–4 months
Licensing Prep	1–2 months	2–4 months	1–3 months
State Approval	2–4 months	3–6+ months	2–5 months
Staffing	Moderate	Difficult	Moderate
Total Estimated Timeline	4–9 months	6–12+ months	4–10 months

Room Structure Comparison

Feature	Assisted Living	IRTS	Recuperative Care
Bedrooms	5	5	5–6
Occupancy	1 per room	1–2 per room	Usually 1–2 per room
Total Residents	5	Approx. 6	Approx. 5–6
Environment	Residential/home-like	Structured clinical	Medical recovery
Safety Modifications	Moderate	Extensive	Moderate–High

Operational Difficulty Comparison

Category	Assisted Living	IRTS	Recuperative Care
Licensing Complexity	Moderate	Very High	High
Clinical Complexity	Moderate	Extremely High	High
Audit Exposure	Moderate	High	Moderate–High
Staffing Difficulty	Moderate	Very High	High
Startup Risk	Moderate	High	Moderate–High
Scalability	High	Moderate	Moderate–High

Final Strategic Recommendation
Best Immediate Opportunity

Assisted Living (ALF)

Reason

- Faster startup
- Lower staffing burden
- Easier operational structure
- Lower compliance exposure
- Easier scalability
- Lower startup risk

Recommended Model

- 5 private bedrooms
- Single occupancy
- Moderate acuity residents
- RN oversight
- Expand later to 8–16 beds

Highest Revenue Potential

IRTS

Reason

- Very strong reimbursement potential
- Significant behavioral health demand
- High Medicaid reimbursement capability

However

- Extremely staffing intensive
- Major compliance burden
- Difficult operational model
- Higher liability exposure
- Requires advanced behavioral health infrastructure

Recommendation

Recommended ONLY after establishing strong operational and clinical infrastructure through simpler residential models first.

Strong Mid-Level Opportunity
Recuperative Care

Reason

- Growing hospital discharge demand
- Increasing Medicaid/community support
- Lower complexity than IRTS
- Strong community partnership opportunities
- Good expansion potential

However

- Requires strong hospital/community relationships
- Moderate medical oversight required
- Funding structures vary significantly
- Operational workflows must be medically coordinated

Recommendation

Can be an excellent bridge model between Assisted Living and higher-acuity behavioral health programs like IRTS.