REPORT OF THE

OFFICE OF THE AUDITOR GENERAL

TO THE

JOINT LEGISLATIVE AUDIT COMMITTEE

275.1

LONG-TERM CARE FOR THE AGED
(Part One)

AN OVERVIEW
AND
MEDI-CAL REIMBURSEMENTS FOR
SKILLED NURSING CARE

Department of Health

JANUARY 1977

Joint Legislative Audit Committee

OFFICE OF THE AUDITOR GENERAL

California Legislature

MIKE CULLEN
CHAIRMAN

January 17, 1977

The Honorable Speaker of the Assembly
The Honorable President pro Tempore of the Senate
The Honorable Members of the Senate and the
Assembly of the Legislature of California

Members of the Legislature:

Your Joint Legislative Audit Committee respectfully submits the Auditor General's report on Medi-Cal Reimbursements for Skilled Nursing Care.

The cautious approach of the Auditor General reflects the elusive relationship between efficiency (quality) and economy. Manifestly, low-quality patient care will yield desirable savings while high-quality care will not. The statistics gathered by the Auditor General demonstrate the extremes. Thus, the crux of the matter becomes a determination of the standard of care, in terms of quality, that our society will agree to provide. The Auditor General charges the Director of Health with the responsibility of making this determination.

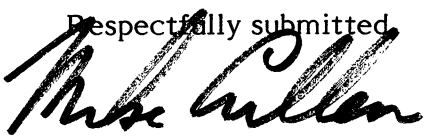
Noteworthy is the present inclusion in the cost-reimbursement formulae of debt-service (mortgage) and plant operating costs (heating, air-conditioning, etc.). All else being equal, and with identical reimbursement, a nursing home in Northern California could find itself in a deficit position solely because of high fuel bills. Wage rates and real property values which vary from region to region could contribute to the same result.

Both the Auditor General's findings and the response by Dr. Jerome Lackner, Director of the Department of Health, will require elaboration before standing committees of the Legislature.

By copy of this letter, the Department is requested to advise the Joint Legislative Audit Committee within sixty days of the status of implementation of the recommendations of the Auditor General that are within the statutory authority of the Department.

The auditors are Harold L. Turner; Gerald A. Hawes; Robert E. Christophel; Mildred M. Kiesel, CPA; Charles A. Dobson, CPA; Dore C. Tanner, CPA; Thomas P. Callanan; and Nancy Dobbs-Dixon.

Respectfully submitted,



MIKE CULLEN
Chairman

SUITE 750 • 925 L STREET • SACRAMENTO 95814 • (916) 445-0255

TABLE OF CONTENTS

AN OVERVIEW OF LONG-TERM CARE FOR THE AGED

In recent months, increased attention has been focused on the Department of Health's administration of health programs. The increased awareness of problems in publicly assisted health programs has been the result of situations disclosed in legislative hearings, Grand Jury investigations, and investigative news reports. As a result of this public interest and concern and in specific response to a resolution of the Joint Legislative Audit Committee of the California Legislature, we have undertaken a study and analysis of long-term health and supportive care provided to the aged citizens in California.*

Our study includes those publicly supported long-term care programs that are basically designed to serve citizens 65 years of age and over who have a disability that limits their self-sufficiency and who lack the financial resources to independently obtain this needed care.

The number of elderly citizens needing some form of long-term care will undoubtedly increase as medical and environmental technology increases our expected life span. In 1970 Californians 65 and over constituted nine percent (1.8 million persons) of the total state population; by 1990 eleven percent, or nearly three million persons will be 65 and over.

---

*The authority to conduct this review is vested in the Auditor General by Section 10527 of the Government Code.

The elderly Californian, in general, has limited financial resources available since he or she often lives on a fixed income such as a pension or Social Security. Because of their advanced age, older citizens typically have more health problems than their younger counterparts. Many live alone and away from the aid of their children and other relatives. As the elderly experience increasingly costly health problems, depleted financial resources, and constricted support from family and friends, they must, of necessity, turn to the State for assistance.

The State of California is authorized through a number of federal and state funded programs to provide a broad spectrum of long-term health and supportive care for the aged. These services range from minimal in-home supportive services for the less severely ill, who need such services to maintain their self-sufficiency, to intensive acute hospital care. As an individual's need for health care changes, the long-term health care system must be responsive by providing more or less intensive care as the circumstances dictate. Table 1, on the following page, identifies the levels of care and funding resources available for long-term care programs.

TABLE 1
SPECTRUM OF CARE AUTHORIZED FOR ADULT RECIPIENTS OF PUBLIC ASSISTANCE

Patient Location	Recipient Physical Condition	Type of Service or Facility	Funding Sources	Responsible Agency
Recipient at Home	Recipients' conditions range from fully mobile to bedfast; mentally alert to mentally disabled	Home-Delivered Meals Protective Social Services Chore Services Homemaker Services Health-Related Social Services Personal Care Aide* Home Health Aide	Older Americans Act Title XX (Social Services) Title XX Title XX Title XX Title XIX (Medi-Cal) Title XIX	Department of Aging State Department of Health: In-Home Supportive Services General Social Services Medi-Cal Benefits State Dept. of Benefit Payments County Welfare Departments Commission on Aging Home Health Agencies
Recipient in Out-of-Home Placement: Part-Time Care	Recipients are mobile and mentally capable of using these resources	Small Family Day Home (capacity of 6) Large Family Day Home (capacity of 7-15) Day Care Center (capacity of 16 and up) Social Rehabilitation Center Regional Centers Mental Health Service Centers Clinics	Vocational Rehab. Funds Mental Health Funds Title XX (Medi-Cal) Title XVIII (Medicare) Title XIX (Medi-Cal) Private Pay	State Department of Health: Licensing and Certification Continuing Care Services Regional Centers State Dept. of Vocational Rehab. County Welfare Departments Local Mental Health Services Private Agencies
Full-Time Residential Care	Recipients are mobile (ambulatory or non-ambulatory but not bedfast); mentally alert to mentally disabled	Small Family Homes (capacity of 6) Large Family Homes (capacity of 7-15) Group Homes (capacity of 16 and up)	SSI/SSP Mental Health Funds Private Pay	State Department of Health: Licensing and Certification Continuing Care Services Regional Centers State Hospitals State Dept. of Benefit Payments County Welfare Departments Local Mental Health Services Private Agencies
Full-Time Health Care	Recipients' conditions range from mobile to bedfast; mentally alert to disabled to unconscious	Intermediate Care Facilities Skilled Nursing Facilities Acute Care Facilities	Mental Health Funds Title XVIII (Medicare) Title XIX (Medi-Cal) Private Pay	State Department of Health: Licensing and Certification Medical Review Teams Continuing Care Services Regional Centers State Hospitals Medical Consultants State Dept. of Benefit Payments Local Mental Health Services County Welfare Departments Private Agencies

*This type of service is not currently available in California.

Skilled nursing care is available when illness or disability makes it impossible for a person to function without such skilled care or when a convalescent from an acute care facility requires continuous skilled nursing and rehabilitative services. These facilities are intended to provide comprehensive medical care and other supportive services necessary for rehabilitation.

Elderly citizens who do not require the care provided by skilled nursing facilities but who, nevertheless, still require a comprehensive health care environment to assist them in their daily lives, may look to the intermediate care facility. Here, intermittent nursing care and recurring supportive services are provided in response to the needs of the patient.

For the elderly patient whose medical condition is such that professional nursing care is not generally necessary but whose capacity to function independently may be impaired, residential care facilities provide an individual with the necessary supportive services. Residing in a residential care facility provides the opportunity for the patient to live with others in a community-like environment while receiving room and board, assistance with personal hygiene, and guidance in social activities.

For those who have a part-time need for the social, nutritional, therapeutic and personal care services provided by the residential care facility, but who are capable of living somewhat independently, adult day care facilities provide an alternative. The aged

patient has the opportunity to live in his or her own home, outside the institutional environment, and yet still participate in the widely varying mix of services that will assist in the process of daily living.

For many elderly, the need for institutional care is not necessary if they can receive certain needed services in their own home. Services such as home delivered meals, or domestic services including cleaning, laundry, shopping or cooking may be all that is needed to allow an elderly person to function self-sufficiently. Certain health-related services can also be provided in the home through the use of home-health aides.

All of the long-term health and social services (from acute care to in-home services) discussed above are essential components of a long-term care system if the elderly in California are to be assured of an opportunity to receive a level and quality of care responsive to their needs.

To be responsive to these health and social needs of the elderly, the State is authorized by federal legislation* to provide a comprehensive long-term care system. In 1965 Congress passed Public Law 89-97 and established Medicare and Medicaid to help meet the health needs of the poor and persons aged 65 and over. The following summarizes the relevant sections of the federal legislation:

---

*The Social Security Act, as amended, and the Older Americans Act of 1965, as amended.

- The California Medical Assistance (Medi-Cal) Program (Title XIX of the Social Security Act) was established in 1966 to implement the Federal Medicaid Program. Medi-Cal services range from in-home health to acute hospital care. Eligibility for Medi-Cal is based on the patient's income and resources. The Medi-Cal Program is funded by federal, state, and county governments; the counties' share is increased each year by the percentage change in assessed valuation. Federal matching funds are available for all portions of the progam, except for medically indigent adults. This cost is shared by the counties and the State.

- The Federal Medicare Program (Title XVIII of the Social Security Act), administered by the Social Security Administration, is somewhat different from the State's Medi-Cal Program. The Medicare Program is funded by the federal government. Medicare limits its complete coverage of skilled nursing care to 20 days. The 21st to 100th day in such facilities requires a $13* per diem coinsurance from the patient. To be eligible for Medicare, an individual must have been an employee or spouse of an employee who paid into the Social Security System. Medicare coverage, in comparison with Medi-Cal, is oriented more toward acute care and convalescence after hospitalization.

---

*On January 1, 1977, the Medicare coinsurance requirement was increased to $15.50 per day.

- The Supplemental Security Income--State Supplemental Payment (SSI-SSP) Program (Title XVI of the Social Security Act) provides supplemental income to persons who are blind, disabled, or have reached the age of 65. The SSI-SSP payment is intended to cover the recipient's basic needs and living expenses, whether the recipient is living in his or her own home or in a residential care facility. The SSI portion is 100 percent federally funded while the SSP portion is shared by the federal and state governments under various sharing arrangements outlined in Public Law 92-603 (HR-1).

- Social Services Programs (Title XX of the Social Security Act) provide services to enable recipients to achieve or maintain self-sufficiency and to prevent unnecessary institutional care by providing community and home-based services. Social services including protective services for children and adults, homemaker and chore services, and employment services for recipients of Aid to Families with Dependent Children (AFDC) are authorized. Total program costs are shared 25 percent by state and local governments and 75 percent by the federal government, subject to a maximum federal allocation.

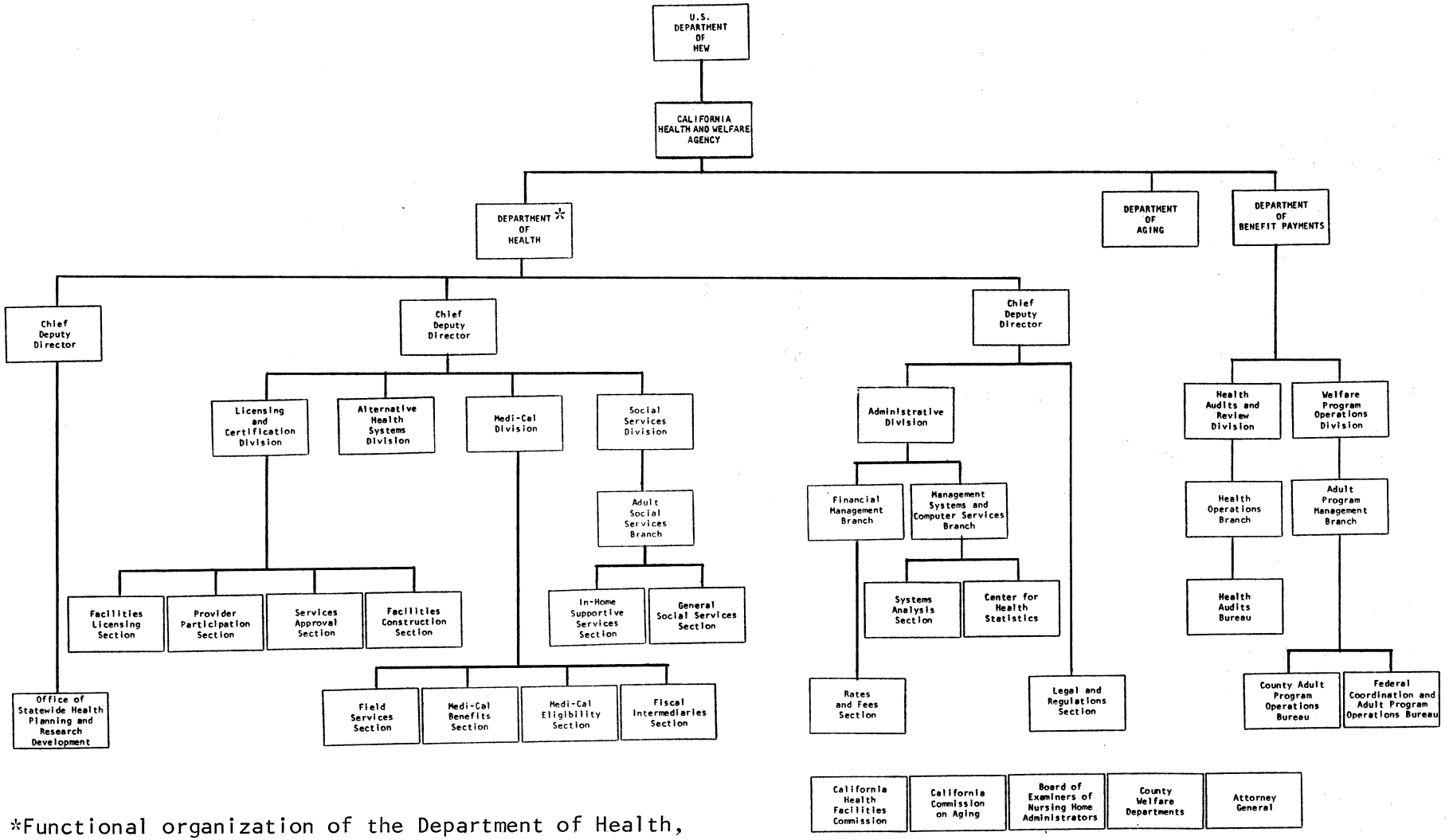
Three departments under the Secretary of Health and Welfare are responsible for the delivery of a broad spectrum of long-term care for the aged in California. The Department of Health has primary

responsibility for administration of Medi-Cal. The Department of Benefit Payments audits and recovers Medi-Cal funds expended improperly. The Department of Aging administers federal funds to develop and implement community service planning and nutrition programs for the aged.

The U. S. Department of Health, Education and Welfare, through the Office of Long-Term Care, is responsible for assuring state compliance with federal regulations.

The agencies responsible for long-term care are illustrated by the organization chart (Table 2) on page 9. While the Department of Health is in the process of reorganizing, the organization chart serves to illustrate the complexity and magnitude of the long-term care for the aged program in California.

TABLE 2
AGENCIES RESPONSIBLE FOR
LONG-TERM CARE FOR THE AGED



*Functional organization of the Department of Health, as of November 9, 1976.

In order to address this large and complex program of long-term care, we will issue four separate reports--each addressing different aspects of the overall issue. We are excluding from our review that care provided to the mentally and developmentally disabled patient and that care provided in acute care facilities. This care and the related compensation for this care are not comparable to that provided by other long-term care programs.

This first report discusses the method used by the Department of Health for determining reimbursements paid to skilled nursing facilities under the Medi-Cal Program, and contains recommendations for alleviating identified deficiencies.

Subsequent reports to be issued during calendar year 1977 will address:

- The quality of health care provided to Medi-Cal recipients in skilled nursing facilities. We will evaluate the State's performance in ensuring that the appropriate and adequate levels and quality of care are provided to aged Californians receiving public assistance.

- Various alternatives to nursing home care such as residential care, day health care, and in-home supportive services. We will discuss whether the State has met its responsibility of providing a comprehensive system of long-term care for the aged.

- The progress that has been made by the responsible departments in resolving the conditions outlined in our first three reports. We will also address the performance of the State in the overall administration of the long-term health and supportive care program and make recommendations which we feel may assist in the attainment of a comprehensive program of appropriate long-term care for the aged at a reasonable cost.

SUMMARY

We were requested by the Joint Legislative Audit Committee to review the cost of patient care, profitability of operations, and the State's role in the funding of publicly supported care in skilled nursing facilities.

On pages 24 and 25, we recommend that the Department of Health identify the individual components of care that a Medi-Cal patient can reasonably be expected to receive and develop the cost of providing that standard of care as a basis for reimbursement of costs to skilled nursing facilities. We also make several suggestions as to how the Department might proceed to accomplish this objective.

During our review, it became apparent that serious deficiencies exist in Department procedures for establishing reimbursement rates for skilled nursing services.

There were wide fluctuations in the per patient day costs reported to us which raised questions of what differences may exist in the services provided, and whether nursing homes are overpaid or underpaid.

The Department has not developed adequate procedures to determine whether there is a correlation between a skilled nursing facility's cost of patient care and the quality of care provided to Medi-Cal patients at public expense.

AUDIT RESULTS

MEDI-CAL REIMBURSEMENTS ARE UNRELATED TO THE CARE PROVIDED IN SKILLED NURSING FACILITIES.

Skilled nursing facilities in California provide services to an estimated 230,000 patients each year. In order to ensure that skilled nursing home patients receive an appropriate level of quality care, the Department of Health is responsible for regulating and monitoring the performance of these facilities. In addition, the Department is responsible for evaluating and certifying all skilled nursing facilities that provide services to patients receiving financial assistance through the Medi-Cal Program.

Those facilities providing services to Medi-Cal patients are reimbursed at a predetermined rate per patient day which should be representative of the costs of providing necessary services. However, the rates are established from cost and profit information which is periodically obtained from a sample of the nursing homes. The established rate per patient day is only a midpoint or average and is only indirectly related, if at all, to the actual services provided.

The Rates and Fees Section of the Department of Health is responsible for developing the rate-setting methodology and establishing an appropriate Medi-Cal reimbursement rate. The Department has the authority and the responsibility to require the use, maintenance, and submission of forms, reports, and records by skilled nursing facilities under its jurisdiction. In fiscal year 1975-76 payments to skilled nursing facilities based upon the highly questionable reimbursement rates established by the Department amounted to over $348 million, representing 15.7 percent of the total Medi-Cal budget of approximately $2.2 billion.

In 1970 the Department's rate-setting methodology was challenged in a legal action initiated by a representative of the nursing home industry. The court directed that the Department develop a data base of costs in skilled nursing facilities and that these data be used as a basis for establishing the Medi-Cal reimbursement rate.

In order to comply with the court mandate, the Department contracted in 1970 with a private audit firm to develop this data base. Cost data from a sample of nursing facilities were then to be used in determining a reasonable reimbursement rate. Upon analyzing the sample facilities, many did not meet the criteria for an acceptable facility established by the Department. The Department's criteria were:

- The facility must have been certified to provide services to Medi-Cal patients and must have been in operation for the entire 1969 calendar year

- The facility must have an overall occupancy rate of at least 65 percent

- The facility must have at least a 20 percent Medi-Cal occupancy rate

- The facility must have adequate financial records available in California.

A total of 157 facilities had to be selected in order to find 76 that met the criteria defined above.

The audit firm solicited reports on revenues and costs of operation from the 76 acceptable facilities and observed that "select cost components of the 76 records show considerable variation." Yet, these data were used to establish a "reasonable" reimbursement rate in spite of the fact that none of the reports were audited to attest to the accuracy or appropriateness of the costs reported.

The reimbursement rate in 1970 was determined by simply selecting the median (mid-point) cost (excluding profit) of the 76 facilities selected. In subsequent periods, a similar median rate was developed and then factored by an amount to account for inflation and a reasonable profit.

In order to determine the profitability of "well run nursing facilities which provide exemplary care," the Department initiated an audit in 1974 of six of the facilities included in the data base used for rate-setting that year. The audit disclosed that three of the facilities earned a profit while three incurred losses. The audit also showed that wide variations in cost and profit still existed among the facilities.

Until September 1976, the facilities used by the Department of Health in the rate-setting analysis for Medi-Cal reimbursements were generally selected by the nursing home industry through the California Association of Health Facilities. In September 1976 the Department made its own selection of skilled nursing facilities that were offering "average or above average care." The cost data from these facilities exhibited the same variations that existed in the 1970 and 1974 studies. The September 1976 variances in reported costs were as follows:

Range of Costs Per Patient Day
Reported to the Department of Health
For September 1976 Rate Setting

Number of Facilities	Bed Size	Lowest Cost	Median Cost	Highest Cost	Range
33	1-59	$17.28	$22.24	$ 38.64	$21.36
23	60-99	17.27	20.56	27.63	10.36
20	100+	17.33	19.69	24.98	7.65

In order to independently evaluate the cost of skilled nursing facility services, we reviewed the revenue and costs of 224 skilled nursing facilities throughout the State. The results of our survey also reflect wide variations in cost. The total cost of providing one patient day of care among our 224 facilities ranged between $12.98 and $40.17--a 209 percent variance, or a difference of $27.19 per patient day. Examples of variations among specific cost elements are presented in the following table:

Ranges of Selected Cost Elements
Per Patient Day
From the Auditor General's
Sample of 224 Facilities

	Lowest Cost	Average Cost	Highest Cost	Range
Patient Care Salaries	$ 4.28	$ 6.70	$14.84	$10.56
Raw Food Costs	.88	1.50	3.43	2.55
Kitchen, Laundry and Housekeeping Expense	.16	3.18	12.56	12.40
Facility Expense	.15	2.12	5.18	5.03
Administrative Expense	.74	2.72	11.17	10.43

The wide variations in cost are also reflected in the profits and losses reported. The net result of operations reported by the 224 facilities in our study ranged from a profit of $5.71 per patient day to a loss of $9.53--a 267 percent variance, or a difference of $15.24.

Variations among major cost categories occur for at least several reasons, one of which is a lack of consistency among facilities in classifying and reporting types of expenses. However, the total cost of care and the resulting profits or losses cannot be distorted by these inconsistencies in classification since the total cost represents the sum of all costs regardless of classification. Notwithstanding accounting inconsistencies, wide fluctuations in the cost of providing care may also be reflective of wide ranges of quality and levels of care and the degree by which nursing home management is able to control cost. (The second in this series of reports, will discuss levels and quality of care related to cost.) Appendix M illustrates major cost differences between two essentially comparable nursing homes.

The Department of Health has not required skilled nursing facilities in California to account for and report their costs consistently. Furthermore, the Medi-Cal reimbursement rate for skilled nursing services has, for the last seven years, been developed using arbitrary methods and generally unaudited data.

New federal and state legislation* requiring uniform reporting and audits of all facilities will alleviate some of the deficiencies in the present Department of Health procedures for rate setting. The new legislation will assure a more accurate report of the costs of providing care; however, it will not assure that reimbursements will produce the desired level of care at the lowest cost to taxpayers. The uniform cost

---

*Discussed in detail in "Other Pertinent Information," page 32.

and reporting system is required to be implemented by all nursing home facilities in California with fiscal years commencing on or after January 1, 1977. However, the reports from the first facilities going on the system will not be received until after April 1978, and the complete cycle for reporting will not occur until April 1979. Therefore, two and one-quarter years will elapse before the data base is complete.

In establishing the reimbursement rate, the Department takes into account only the median cost of providing care, but gives little consideration to whether the level of care provided by facilities is substandard, adequate, or excessive in relation to cost.

The Department has promulgated numerous guidelines and regulations directed at ensuring an appropriate level of quality care in skilled nursing facilities. These regulations are enforced by the Licensing and Certification Division and the Field Services Section which periodically review skilled nursing facilities to ensure compliance. Generally, the results of these reviews are not considered by the Rates and Fees Section in the process of establishing the reimbursement rate for services provided.

Basic management principles in both the public and the private sector require an effective method of relating results accomplished to their cost. In order for the Department of Health to meet its obligations to taxpayers and the aged, they must identify what constitutes an

acceptable level of care for Medi-Cal patients. The Department should identify specific categories of patient conditions which can reasonably be anticipated, and determine what costs are reasonably incurred in providing the necessary care for each category.

The effective allocation of Medi-Cal resources by associating realistic costs with appropriate care is extremely important because of (1) the fiscal magnitude of the program, and (2) the recipients served by the program are, for the most part, dependent upon the policies of the Department for their health and well being.

The problem of potential over- or underreimbursements for skilled nursing services is not unique to California. In addressing this issue at the federal level, the U. S. Senate Committee on Finance, in its Report 92-1230 dated July 1976, notes:

> . . . with concern that, without any statutory requirements that payment for medical care and services in long term care facilities be on a reasonable cost-related basis, some facilities are being overpaid by Medicaid, while others are being paid too little to support the quality of care that Medicaid patients are expected to need and receive.
>
> . . . the Committee was concerned about the effect of both underpayment and overpayment on the quality of medical care of recipients.

The presence of this problem in other states does not, of course, justify the existence nor negate the importance of resolving these problems in California.

Underreimbursement of skilled nursing service costs may pressure skilled nursing facilities to take such actions as:

- Reducing the level and quality of care provided
- Increasing the rates charged to private patients to recoup losses under Medi-Cal
- Closing the facility
- Refusing to admit Medi-Cal patients.

Overreimbursement to a skilled nursing facility, on the other hand, would result in forfeiture of the opportunity to utilize those public funds to provide additional services or provide tax savings to the citizens of California.

The magnitude of public funds expended for skilled nursing services is such that even an apparently insignificant variation in the per patient day reimbursement rate can result in a substantial cost to the State. For example, a one-cent increase in the Medi-Cal reimbursement rate will result in a corresponding annual increase in Medi-Cal expenditures of approximately $250,000. This fact alone demonstrates the critical need for an accurate and timely base of cost information and for extreme care in determining an appropriate reimbursement rate.

Recently, the Medi-Cal reimbursement rate was increased $0.90 per patient day to compensate for the impact of the new federal minimum wage law. This increase was developed through the analysis of

the median payroll cost from data submitted to the Department by the California Association of Health Facilities and will result in an increased Medi-Cal expenditure of approximately $20 million annually.

Clearly, the substantial fiscal impact of relatively small increases (or decreases) in the reimbursement rate indicates the necessity for the development of an accurate cost-related reimbursement schedule. Moreover, the need is also evident for the Department of Health to identify the appropriate care to be provided to Medi-Cal patients and for a means to ensure that reimbursements to skilled nursing facilities are commensurate with that care.

CONCLUSION

The Department of Health has not exercised its authority to administer the skilled nursing industry in a manner to assure appropriate care for the Medi-Cal patient at a commensurate cost.

The wide fluctuations in reported cost and profitability per patient day and the arbitrary methodology used by the Department of Health in establishing the Medi-Cal reimbursement rate create substantial doubt that the State is properly utilizing $348 million of Medi-Cal funds annually for skilled nursing care.

RECOMMENDATIONS

The Department of Health should identify the individual components of skilled nursing care that a Medi-Cal patient can reasonably be expected to require and use this to establish reimbursement rates based upon independently determined costs to provide these services.

This could be accomplished in the following manner:

- Initiate a staff study to determine what constitutes acceptable standards of care. This could include relating to each identifiable patient condition category the daily number of hours of required nursing care, the proper diet, and all other supportive services provided by the facility necessary to adequately treat the patient's condition.

- Independently develop a cost model consisting of a matrix of specific cost to perform each care standard.

- Establish a standard reimbursement rate for direct patient care.

- Establish a separate "facility" rate to compensate skilled nursing facilities for the cost of land and buildings. The present rate structure does not consider that some facilities are located where land cost is high, while others are not. Nor does it consider the adequacy of the facility to provide an appropriate level of care.

  The facility rate would not necessarily need to be related to number of patient days but could be related to such factors as square footage or number of beds. The facility rate could also include a factor for administrative overhead related to bed capacity.

- On the basis of the above, reimburse skilled nursing facilities (1) at a standard rate for care services and (2) at a variable "facility" rate tailored to the cost of land and buildings for each facility.

- At least annually, perform an in-depth study of the reasonableness of the standard reimbursement rate, comparing the standard rate with actual cost incurrence by facilities from data generated by the new uniform accounting and reporting system. Variances from standard should be carefully evaluated before the standard rate is adjusted.

BENEFITS

Proper implementation of these recommendations will:

- Assure more effective utilization of public funds by relating an acceptable level of care to the cost of providing that care

- Better satisfy federal regulations which require that Medi-Cal reimbursements be related to the cost of providing care.

OTHER PERTINENT INFORMATION

Cost Data on Nursing Homes Requested by the Legislature

The sample used in our cost study of nursing homes represents 224 facilities, selected from the State Department of Health's "Health Facilities Directory," March 1975. Facilities included in our analysis of cost data were selected from 1,095 facilities licensed for Medi-Cal patients. (We excluded facilities that exclusively care for the mentally retarded and the developmentally disabled patients.)

Questionnaires were mailed to 408 skilled nursing facilities randomly selected from four ownership categories--individuals and partnerships, profit corporations, nonprofit corporations, and governmental entities. The number of facilities responding to our questionnaire was 299, or 73.3 percent of the facilities solicited. A desk review of the 299 questionnaires eliminated 113 for various deficiencies, and 43 facilities responded that they could not comply. This reduced the number of responses we could use to 143, or 35 percent of the 408 facilities solicited.

To obtain additional cost data, we visited organizations that operated 93 skilled nursing facilities in the State. Twelve facilities were eliminated from our sample for various deficiencies. The remaining 81 usable field reviews were combined with the 143 usable questionnaires to provide data from 224 facilities for our analysis.

Appendix A compares the 224 facilities used in our cost analysis with the total nursing home industry by type of ownership, number of beds per facility, and regional location. Our sample of 224 facilities represents 20 percent of the 1,095 facilities licensed for Medi-Cal patients.

Average Cost of Care and Profitability

The average revenue, expenses and profit per patient day for the 224 facilities included in our review are as follows:

Average Revenue, Expenses and Profit
Per Patient Day
From the Auditor General's
Sample of 224 Facilities

	Average Per Patient Day	Percent of Revenue
Revenue*		
Routine Revenue	$ 20.49	95.5
Other Revenue	.96	4.5
Total Revenue	21.45	100.0
Expenses		
Patient Care Salaries	6.70	31.2
Employee Benefits	1.69	7.9
Raw Food Costs	1.50	7.0
Kitchen, Laundry and Housekeeping Expense	3.18	14.8
Facility Expense	2.12	9.9
Administrative Expense	2.72	12.7
Interest Expense	.48	2.2
Other Expense	2.36	11.0
Total Expenses	20.75	96.7
Profit	$ .70	3.3

*Appendix B provides an explanation of accounting classifications.

Appendix C displays the major cost and profit categories, in "Pie Chart" form as a percentage of the revenue dollar. Appendixes D through F present the average revenue, expenses and profit per patient day by such major categories as number of beds per facility, type of ownership, and regional location within the State.

The average revenue, expenses and profit per patient day shown in Appendixes D through F may not be comparable since the data represent five separate annual accounting periods ended March 31, 1975; June 30, 1975; September 30, 1975; December 31, 1975; and March 31, 1976. Therefore, the financial data represent costs incurred over a two-year interval from April 1974 through March 1976. To eliminate any timing differences, the financial data is also arrayed by these five accounting periods in Appendix G.

There are significant variations among the major expense categories. These occur in part due to the lack of uniform accounting systems which would provide the basis for a consistent classification of expenses. However, the total cost of care cannot be distorted by inconsistencies in expense classifications.

To illustrate the significant expense variations among major categories and eliminate possible timing differences, the ten highest and the ten lowest cost facilities with an accounting period ended December 31, 1975 are shown in Appendixes H and I.

Home Office Management Fees

Several corporations which operate more than one skilled nursing facility are included in our review. In many cases the corporation has a home office which directs the overall operations and provides certain centralized services. The home office management costs for these services are then allocated to the individual skilled nursing facilities owned by the corporation. The majority of these costs are administrative in nature, such as accounting, financial, purchasing, legal, etc. However, some of the larger corporations do provide nursing and dietary consultants as well as centralized training programs at the home office level. Management fee expense for these services averaged $0.73 per patient day.

Owner's Compensation

Salaries paid to owners of skilled nursing facilities were generally for administrative functions--primarily administrator and assistant administrator of the facility. The average owner's compensation was $0.76 per patient day of the skilled nursing facilities reporting such salaries. The largest annual amount reportedly paid to a single owner was $48,000.

Return on Owner's Equity

Due to the generally poor quality of the financial statement information received from the facilities, it is not possible to accurately report on the average return on owner's equity. However, the average profit was 3.3 percent of the revenue dollar.

Percentage of Occupancy

The average occupancy of the sample is 92.5 percent. For the facilities reviewed, 170 of the 224 facilities, or 76 percent, had between a 90 and 100 percent occupancy rate for the period. The average patient mix is composed of 31 percent private patients, 5 percent Medicare patients, and 64 percent Medi-Cal patients. The patient mix fluctuated from all private patients to all Medi-Cal patients.

Private Patient Rates

The cost to the private patients in skilled nursing facilities averaged $23.28 per day. The highest private patient rate in our review was $75 per day. Another facility offers private accommodations from $50 to $60 a day in a "luxurious resort-like" atmosphere with a "delightful" view of the "beautiful" half-acre garden court. This facility features custom designed bedrooms, fingertip electrically controlled beds, pillow speakers, private telephones, piped-in music, remote control TV, and meals kept either hot or cold in the kitchen where electronic carts stand ready to deliver at the patient's request. Also for the patients' convenience the facility has a fully stocked library, colorful ice cream parlor, beauty and barber salon, and recreation lounge for movies, lectures, games, and conversation.

Governmentally Operated Facilities

There are very few skilled nursing facilities operated by governmental units. Financial questionnaires were sent to government-operated facilities and one facility was field reviewed. The data obtained were not included in this report because of its lack of comparability. Many of these facilities maintain several levels of care varying from acute care to home health care. The reported costs of the governmentally operated facilities ranged from $27.56 to $124.54 per patient day.

Effect of New Legislation on Fiscal Data

Effective July 1, 1975, the California Health Facilities Disclosure Act was amended to rename the California Hospital Commission to the California Health Facilities Commission. The duties of the Commission were also expanded to require the development of a uniform system of accounting and cost reporting for skilled nursing facilities. The data accumulated by the California Health Facilities Commission shall be made available to other state agencies for programs they administer.

Effective July 1, 1976, new federal regulations require that the State develop a plan to reimburse skilled nursing facilities for Medi-Cal patient care on a reasonable cost-related basis. The state plan must provide for on-site audits to verify the accuracy and reasonableness of cost reports submitted by the skilled nursing facility. The financial and statistical records of each participating provider shall be audited within three years after the end of the first fiscal year under the new accounting system.

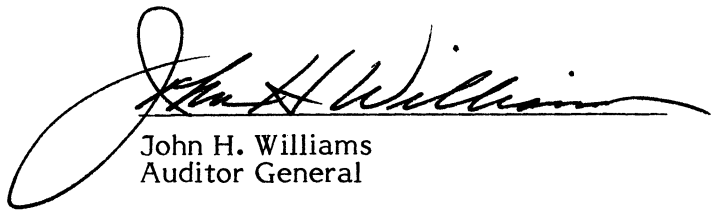
Although the new federal regulations do not require a uniform cost-reporting year end, the uniform accounting system will generate a consistent basis for comparisons of facilities' major cost categories. Large numbers of facilities in the industry have a calendar year end, but a complete cost data base will not be available for analysis until April 1979.

Trends in the Number of Nursing Home Facilities and Beds

Appendix L shows that since 1970, the number of skilled nursing facilities has decreased. However, one of the most noticeable trends in skilled nursing facilities is that the average number of beds per facility is increasing.

A 1972 amendment to the Social Security Act authorized intermediate care as a Medi-Cal benefit. Appendix L also shows the number of licensed facilities and beds for intermediate care facilities.

Respectfully submitted,



John H. Williams
Auditor General

January 14, 1976

Staff: Harold L. Turner
Gerald A. Hawes
Robert E. Christophel
Mildred M. Kiesel, CPA
Charles A. Dobson, CPA
Dore C. Tanner, CPA
Thomas P. Callanan
Nancy Dobbs-Dixon

DEPARTMENT OF HEALTH
714 P STREET
SACRAMENTO, CALIFORNIA 95814
(916) 445-1248

January 13, 1977

Mr. John H. Williams
Auditor General
925 L Street, Suite 750
Sacramento, CA 95814

Dear Mr. Williams:

We have reviewed the draft audit report regarding skilled nursing facilities transmitted by you under the date of January 10, 1977. This is an extensive report dealing with complex issues, therefore, our comments should be considered preliminary.

While we agree that there are valid alternatives to our current rate setting method, we do not agree with your conclusion that the Department has not exercised its authority to administer the skilled nursing industry in a manner to assure appropriate care for the Medi-Cal patient at a commensurate cost. Nor do we agree that this methodology is arbitrary and creates substantial doubt that the State is properly utilizing $348 million of Medi-Cal funds annually for skilled nursing care.

Your report is highly critical of the stratified, flat rate payment system. You characterize it as having serious deficiencies both in relation to quality of care and to actual services and stresses the variation in facilities' expenses and profits as a major weakness of the stratified, flat rate system, whereas current skilled nursing facility rates are based upon the average cost of providing average or above average care. Facilities used in our most recent sample to determine costs were selected by the Licensing and Certification Division of the Department. This Division periodically inspects facilities to determine whether they are in compliance with all licensing and certification standards and are providing levels of care appropriate to the needs of the patients.

While no payment system will guarantee the provision of quality care, reimbursements must be at a level which will permit quality. Recent state legislation mandated minimum nursing hours and training programs for personnel in skilled nursing facilities. Those Acts will have a positive effect on the overall quality of care and the costs associated therewith have been quantified and the reimbursement rates adjusted accordingly.

Quality can only be assured through a system which ensures that the needs of each patient are identified and that appropriate action is taken to meet those needs. The inspection and enforcement program of the Licensing and Certification Division monitors this aspect of care and action is taken to eliminate substandard providers from the Medi-Cal program. The possibility of decertification is a very real and significant threat to licensees which helps to ensure quality care for all.

The Department recognizes that costs do vary between facilities providing similar services. However, this cost variation does not necessarily reflect a wide difference in the range of quality and level of care. There are many factors which contribute to this variation in costs. For example, in Appendix M of the report, Facility A had substantially less capital and employee benefit costs than Facility B, yet their direct patient care costs were virtually identical. Facility B reported total expenses 14.7% higher than Facility A. However, it should be noted that when total liabilities are considered along with expenses, the total is virtually identical for both facilities. As an aside, it is curious that of the two facilities chosen for the example, Facility B shows $151,915 as "All Other Expenses", representing 23% of its total expenses.

While it is well known there are variations in costs among facilities, we believe the data reported on page 16 may provide a distorted picture of the degree of variation. All that is reported in measuring the dispersion of expenses is the lowest and highest cost facilities. It is a well accepted fact that the total range is not the most reliable measure of variability because only two measurements are used to determine it. A far better measure of the amount of variation in expenses between facilities would be the standard deviation, or in the case of non-normal distributions, with a few very high or low values which would distort the mean average, the semi-interquartile range should be used. In fact, 70% of the facilities in each of the bed size categories were within $3.49 of the median for bed size 1-59; $2.95 for bed size 60-99; and $3.89 for bed size 100 plus. The semi-interquartile range which measures the amount of variation around the median shows that 50% of the facilities in each size categories were within $2.34 of the median for size 1-59; $2.09 for size 60-99; and $1.68 for 100 beds and over. In summary, while there is a variation in expenses, the variation for the vast majority of the facilities is not nearly as extreme as would be assumed from the information shown in the report. These same general comments would apply to the data and discussion of the Auditor General's sample of facilities' expenses and profits.

As you noted, the uniform accounting and reporting system now being implemented for skilled nursing facilities by the California Health Facilities Commission will provide a more adequate data base for cost determination. In addition, new federal requirements for review and audit of cost reports from these facilities will help to provide more accurate information on costs and expenditures. The Department of Benefit Payments is requesting additional audit staff for this function.

We believe that your recommendation that the Department "identify components of skilled nursing care that a Medi-Cal patient can reasonably be expected to require and use this to establish reimbursement rates based upon independently determined costs to provide these services" is a potential approach which certainly merits further study. The Department has done some preliminary work in this area in compliance with ACR 87 authored by Mr. Cullen. This resolution requests the Director to evaluate an alternative rate structure based on a random sampling of individual patient care

profiles. The Department will undertake a study to determine identifiable patient need categories, the individual service need components of each category, and independently determine the expenses associated with these service need components for consideration as an alternative rate setting mechanism.

Sincerely,

Jerome A. Lackner, M.D.
Director of Health

COMPARISON OF ALL SKILLED NURSING FACILITIES
WITH THE REVIEWED FACILITIES BY
OWNERSHIP, BED SIZE AND GEOGRAPHIC LOCATION

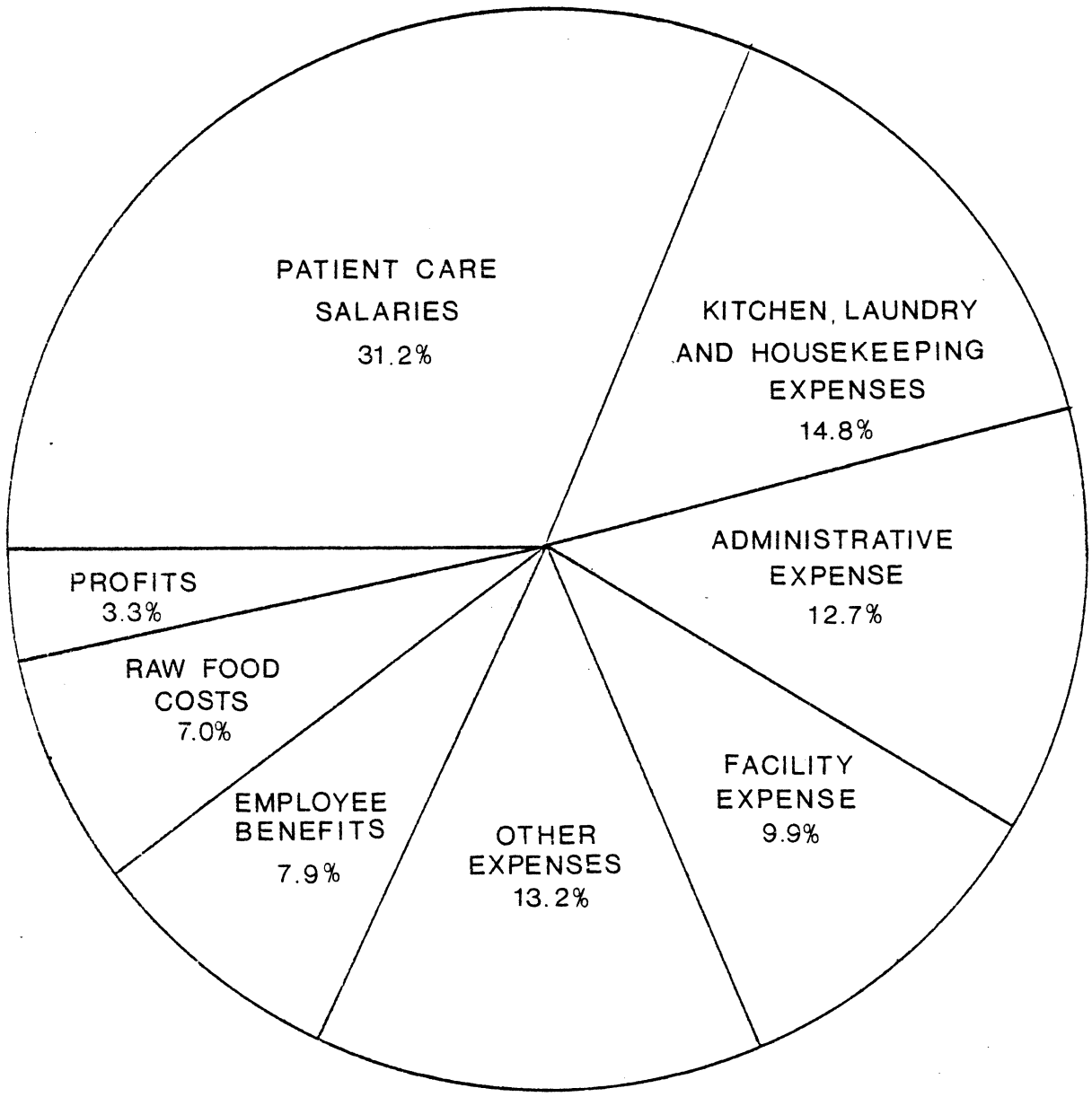
	Industry		Facilities Reviewed	
	Number	Percent	Number	Percent
Ownership				
Individual and Partnerships	288	26.3	60	26.8
Corporations	655	59.8	134	59.8
Nonprofit	135	12.3	30	13.4
Public	17	1.6	--	--
Total	1,095	100.0	224	100.0
Bed Size				
1-25	62	5.7	4	1.8
26-59	328	29.9	53	23.7
60-99	451	41.2	99	44.2
100 Plus	254	23.2	68	30.3
Total	1,095	100.0	224	100.0
Geographic Location*				
Region 1	212	19.4	49	21.9
Region 2	96	8.8	27	12.0
Region 3	374	34.1	56	25.0
Region 4	130	11.9	41	18.3
Region 5	193	17.6	40	17.9
Region 6	90	8.2	11	4.9
Total	1,095	100.0	224	100.0

*See Appendix J.

ACCOUNTING CLASSIFICATIONS FOR FIELD REVIEWED FACILITIES

Routine Revenue	--	Private, Medicare, and Medi-Cal revenue related to the basic elements of patient care: room, board and nursing care.
Other Revenue	--	Ancillary services, drugs, therapy, grant revenue, and miscellaneous revenue.
Patient Care Salaries	--	Director of Nurses, Registered Nurses, Licensed Vocational Nurses, Aides, and Orderlies.
Employee Benefits	--	Includes employee benefits and employers' payroll taxes for all employees.
Raw Food Costs	--	The cost of food exclusive of any preparation expense and dietary supplies.
Kitchen, Laundry, and Housekeeping Expenses	--	Includes supplies and related salary expense.
Facility Expense	--	Lease expense for building and equipment and/or depreciation of building and equipment.
Administrative Expense	--	Administrator's salary, office expenses and related salaries, management fees, insurances, utilities, bad debts and advertising.
Interest Expense	--	Cost of borrowed money.
Other Expense	--	Ancillary expenses, utilization review, property taxes, nursing supplies, and all other miscellaneous expenses.

AVERAGE EXPENSES AND PROFIT AS A
PERCENTAGE OF THE REVENUE DOLLAR



January 13, 1977

To the Legislature of California:

The accompanying Appendixes D through I represent consolidated statements of income per patient day derived from a sample of 224 skilled nursing facilities in California. Appendix M is a comparative balance sheet and comparative revenues and expense statement for two of these facilities. These statements were not audited by us and accordingly we do not express an opinion on them.

This disclaimer of opinion is required by Rule 58.2 of the California Accountancy Act when the name of certified public accountants is associated with unaudited financial statements.

John H. Williams, CPA
Auditor General

SUITE 750 • 925 L STREET • SACRAMENTO 95814 • (916 445-0255

AVERAGE REVENUE AND EXPENSES PER PATIENT DAY BY BED SIZE (Unaudited)

	1-25 Beds	Percent	26-59 Beds	Percent	60-99 Beds	Percent	100 Plus Beds	Percent
Revenue								
Routine Revenue	$22.21	97.5	$20.73	96.1	$20.43	95.2	$20.47	95.6
Other Revenue	.58	2.5	.84	3.9	1.02	4.8	.94	4.4
Total Revenue	22.79	100.0	21.57	100.0	21.45	100.0	21.41	100.0
Expenses								
Patient Care Salaries	7.98	35.0	7.46	34.6	6.56	30.6	6.63	31.0
Employee Benefits	1.45	6.4	1.48	6.9	1.68	7.8	1.76	8.2
Raw Food Costs	1.90	8.3	1.65	7.7	1.50	7.0	1.47	6.9
Kitchen, Laundry and Housekeeping Expense	2.97	13.0	3.60	16.7	3.14	14.6	3.11	14.5
Facility Expense	1.88	8.3	1.84	8.5	2.16	10.1	2.15	10.0
Administrative Expense	3.54	15.5	2.66	12.3	2.74	12.8	2.69	12.6
Interest Expense	.61	2.7	.50	2.3	.41	1.9	.54	2.5
Other Expense	1.51	6.6	2.20	10.2	2.48	11.6	2.30	10.8
Total Expense	21.84	95.8	21.39	99.2	20.67	96.4	20.65	96.5
Profit	$ .95	4.2	$ .18	.8	$ .78	3.6	$ .76	3.5
Number of Facilities	4		53		99		68	

(Unaudited)

AVERAGE REVENUE AND EXPENSES
PER PATIENT DAY
BY TYPE OF OWNERSHIP
(Unaudited)

	Individual and Partners	Percent	Corporations	Percent	Nonprofits	Percent
Revenue						
Routine Revenue	$19.60	96.4	$20.90	95.4	$20.03	94.5
Other Revenue	.73	3.6	1.01	4.6	1.16	5.5
Total Revenue	20.33	100.0	21.91	100.0	21.19	100.0
Expenses						
Patient Care Salaries	6.33	31.1	6.64	30.3	7.75	36.6
Employee Benefits	1.37	6.8	1.86	8.5	1.39	6.5
Raw Food Costs	1.63	8.0	1.41	6.4	1.76	8.3
Kitchen, Laundry and Housekeeping Expenses	3.13	15.4	2.99	13.7	4.32	20.4
Facility Expense	1.93	9.5	2.36	10.8	1.19	5.6
Administrative Expense	2.08	10.2	3.00	13.7	2.45	11.6
Interest Expense	.45	2.2	.37	1.7	1.15	5.4
Other Expense	2.35	11.6	2.46	11.2	1.86	8.8
Total Expense	19.27	94.8	21.09	96.3	21.87	103.2
Profit (Loss)	$ 1.06	5.2	$ .82	3.7	$ (.68)	(3.2)
Number of Facilities	60		134		30	

(Unaudited)

AVERAGE REVENUE AND EXPENSES PER PATIENT DAY BY GEOGRAPHIC REGIONS* (Unaudited)

	Bay Area	Percent	Los Angeles	Percent	San Diego Area	Percent	All Other North Counties	Percent	All Other South Counties	Percent
Revenue										
Routine Revenue	$21.56	95.1	$20.12	95.2	$21.62	94.6	$19.49	96.6	$19.98	96.1
Other Revenue	1.10	4.9	1.02	4.8	1.23	5.4	.68	3.4	.82	3.9
Total Revenue	22.66	100.0	21.14	100.0	22.85	100.0	20.17	100.0	20.80	100.0
Expenses										
Patient Care Salaries	7.49	33.0	6.47	30.6	6.47	28.3	6.59	32.7	6.48	31.2
Employee Benefits	1.93	8.5	1.50	7.1	1.70	7.4	1.65	8.2	1.75	8.4
Raw Food Costs	1.51	6.7	1.56	7.4	1.50	6.6	1.41	7.0	1.51	7.3
Kitchen, Laundry and Housekeeping Expenses	3.26	14.4	3.27	15.5	3.31	14.5	2.80	13.9	3.30	15.9
Facility Expense	2.23	9.8	2.07	9.8	2.25	9.8	2.24	11.1	1.77	8.5
Administrative Expense	2.96	13.1	2.82	13.3	2.90	12.7	2.28	11.3	2.63	12.6
Interest Expense	.40	1.8	.66	3.1	.39	1.7	.33	1.6	.57	2.7
Other Expense	2.29	10.1	2.66	12.6	2.85	12.5	1.69	8.3	2.38	11.4
Total Expense	22.07	97.4	21.01	99.4	21.37	93.5	18.99	94.1	20.39	98.0
Profit	$ .59	2.6	$ .13	.6	$ 1.48	6.5	$ 1.18	5.9	$ .41	2.0
Number of Facilities	48		33		48		40		55	

*See Appendix K.

(Unaudited)

AVERAGE REVENUE AND EXPENSES
PER PATIENT DAY
BY ACCOUNTING PERIODS
(Unaudited)

	Year End 3/31/75	Percent	Year End 6/30/75	Percent	Year End 9/30/75	Percent	Year End 12/31/75	Percent	Year End 3/31/76	Percent
Revenue										
Routine Revenue	$18.36	96.8	$18.80	95.2	$20.83	94.6	$20.53	96.5	$22.45	92.0
Other Revenue	.61	3.2	.94	4.8	1.20	5.4	.75	3.5	1.95	8.0
Total Revenue	18.97	100.0	19.74	100.0	22.03	100.0	21.28	100.0	24.40	100.0
Expenses										
Patient Care Salaries	6.28	33.1	6.45	32.7	8.04	36.5	6.58	30.9	7.21	29.5
Employee Benefits	1.15	6.1	1.47	7.4	1.50	6.8	1.59	7.5	2.56	10.5
Raw Food Costs	1.47	7.7	1.41	7.1	1.71	7.8	1.51	7.1	1.51	6.2
Kitchen, Laundry and Housekeeping Expenses	3.32	17.5	3.07	15.6	3.46	15.7	3.15	14.8	3.26	13.4
Facility Expense	1.56	8.2	1.96	9.9	1.79	8.1	2.16	10.1	2.36	9.7
Administrative Expense	2.65	14.0	2.23	11.3	2.73	12.4	2.61	12.3	3.63	14.9
Interest Expense	.44	2.3	.35	1.8	.61	2.8	.54	2.5	.35	1.4
Other Expense	1.45	7.7	1.86	9.4	2.36	10.7	2.38	11.2	3.00	12.3
Total Expense	18.32	96.6	18.80	95.2	22.20	100.8	20.52	96.4	23.88	97.9
Profit (Loss)	$ .65	3.4	$ .94	4.8	$ (.17)	(.8)	$ .76	3.6	$ .52	2.1
Number of Facilities	11		24		14		138		37	

(Unaudited)

REVENUE AND EXPENSES PER PATIENT DAY
FOR THE TEN HIGHEST COST FACILITIES
WITH 12/31/75 YEAR END
(Unaudited)

Revenue										
Routine Revenue	$23.98	$21.99	$34.40	$29.26	$31.61	$25.78	$22.11	$20.44	$25.24	$27.04
Other Revenue	4.69	11.63	1.27	1.32	.71	4.84	5.22	1.41	2.41	2.37
Total Revenue	28.67	33.62	35.67	30.58	32.32	30.62	27.33	21.85	27.65	29.41
Expenses										
Patient Care Salaries	9.79	7.39	9.60	8.03	7.96	7.37	13.03	12.91	8.82	8.49
Employee Benefits	1.35	2.33	1.41	2.24	2.09	1.98	1.96	2.94	.87	1.46
Raw Food Costs	3.10	2.73	2.39	1.49	1.59	2.19	1.62	*	2.64	1.47
Kitchen, Laundry and Housekeeping Expenses	12.50	6.42	5.88	3.79	4.10	4.40	3.90	6.27	7.13	4.05
Facility Expense	2.53	1.65	5.17	3.88	1.49	4.85	1.32	.94	2.37	3.05
Administrative Expense	6.85	6.43	1.08	3.65	3.85	3.44	1.78	3.89	1.53	.96
Interest Expense	.02	1.66	.04	.05	3.20	.13	1.38	-	.40	-
Other Expense	1.44	6.45	5.58	5.89	4.63	4.34	3.36	1.19	3.83	7.87
Total Expense	37.58	35.06	31.15	29.02	28.91	28.70	28.35	28.14	27.59	27.35
Income (Loss)	$(8.91)	$(1.44)	$ 4.52	$ 1.56	$ 3.41	$ 1.92	$(1.02)	$(6.29)	$ .06	$ 2.06

*Raw Food Cost included in Kitchen, Laundry and Housekeeping Expenses.

(Unaudited)

REVENUE AND EXPENSES PER PATIENT DAY
FOR THE TEN LOWEST COST FACILITIES
WITH 12/31/75 YEAR END
(Unaudited)

Revenue										
Routine Revenue	$18.73	$19.47	$17.86	$19.25	$19.25	$19.76	$19.37	$19.02	$18.22	$19.06
Other Revenue	.25	.93	-	.48	.03	.42	.46	.43	.71	.49
Total Revenue	18.98	20.40	17.86	19.73	19.28	20.18	19.83	19.45	18.93	19.55
Expenses										
Patient Care Salaries	6.11	5.35	6.12	5.71	6.25	6.24	6.44	4.28	6.21	7.02
Employee Benefits	1.33	1.51	.93	1.16	1.20	1.27	.77	1.71	1.43	1.57
Raw Food Costs	1.37	1.11	1.85	1.90	1.64	1.43	1.39	1.41	1.58	1.50
Kitchen, Laundry and Housekeeping Expenses	2.56	1.17	2.07	2.57	1.93	2.80	2.13	3.17	3.12	2.30
Facility Expense	.52	1.03	1.04	.63	.88	2.36	1.00	.93	.82	2.25
Administrative Expense	1.72	2.90	2.56	1.67	1.98	1.22	1.37	3.00	1.69	1.15
Interest Expense	.20	.90	.47	.53	1.43	-	1.30	.84	.79	.20
Other Expense	1.20	1.13	.64	2.47	1.55	1.77	2.94	2.04	1.79	1.47
Total Expense	15.01	15.10	15.68	16.64	16.86	17.09	17.34	17.38	17.43	17.46
Income	$ 3.97	$ 5.30	$ 2.18	$ 3.09	$ 2.42	$ 3.09	$ 2.49	$ 2.07	$ 1.50	$ 2.09

(Unaudited)

COUNTIES INCLUDED IN THE DEPARTMENT OF HEALTH'S SIX GEOGRAPHIC REGIONS

Region 1	Region 2	Region 3
Alameda	Fresno	Los Angeles
Monterey	Kern	
San Benito	Kings	
San Francisco	Madera	
San Mateo	Mariposa	
Santa Clara	San Luis Obispo	
Santa Cruz	Santa Barbara	
	Tulare	
	Ventura	

Region 4	Region 5	Region 6
Alpine	Imperial	Contra Costa
Amador	Inyo	Del Norte
Butte	Mono	Humboldt
Calaveras	Orange	Lake
Colusa	Riverside	Marin
El Dorado	San Bernardino	Mendocino
Glenn	San Diego	Napa
Lassen		Solano
Merced		Sonoma
Modoc		
Nevada		
Placer		
Plumas		
Sacramento		
San Joaquin		
Shasta		
Sierra		
Siskiyou		
Stanislaus		
Sutter		
Tehama		
Trinity		
Tuolumne		
Yolo		
Yuba		

Source: Department of Health Directory of Health Facilities, March 1975.

COUNTIES INCLUDED IN THE URBAN vs. RURAL GEOGRAPHIC REGIONS

Bay Area	Los Angeles	San Diego Area
Alameda	Los Angeles	Orange
Contra Costa		Riverside
Marin		San Diego
San Francisco		
San Mateo		
Santa Clara		

Northern Counties	Southern Counties
Alpine	Fresno
Amador	Imperial
Butte	Inyo
Calaveras	Kern
Colusa	Kings
Del Norte	Madera
El Dorado	Mariposa
Glenn	Merced
Humboldt	Mono
Lake	Monterey
Lassen	San Benito
Mendocino	San Bernardino
Modoc	San Luis Obispo
Napa	Santa Barbara
Nevada	Santa Cruz
Placer	Tulare
Plumas	Ventura
Sacramento	
San Joaquin	
Shasta	
Sierra	
Siskiyou	
Solano	
Sonoma	
Stanislaus	
Sutter	
Tehama	
Trinity	
Tuolumne	
Yolo	
Yuba	

SKILLED NURSING FACILITIES
NUMBER OF LICENSED FACILITIES AND BEDS
AND AVERAGE NUMBER OF BEDS PER FACILITY
1966 THROUGH 1976

Year	Facilities	Beds	Average Beds/Facility
1966	1,132	56,734	50
1968	1,168	73,303	63
1970	1,234	94,359	76
1972	1,190	95,793	80
1974	1,156	96,381	83
1976	1,115	95,963	86

Source: 1966-74 California Statistical Abstracts, 1976 Statewide Health Planning and Development Office.

INTERMEDIATE CARE FACILITIES
NUMBER OF LICENSED FACILITIES AND BEDS
1972 THROUGH 1976

Year	Facilities	Beds
1972	17	647
1974	36	1,396
1976	35	1,833*

Source: 1972-74 California Statistical Abstract, 1976 Statewide Health Planning and Development Office.

*An Additional 319 beds are located within skilled nursing facilities.

FINANCIAL COMPARISON OF TWO SIMILAR NURSING HOMES

The following 1975 financial data of two skilled nursing facilities were drawn from our sample of 224 facilities statewide. Both facilities have (1) nearly equal numbers of licensed beds, (2) nearly the same percentage of occupancy, and (3) almost exactly the same ratio of Medi-Cal patients to all other categories. In these cases, 85 percent of the patient days are attributable to Medi-Cal.

Nursing home "B" incurred a 1975 overall profit of $11,139 on gross revenues of $665,500, while nursing home "A" incurred a profit of $67,086 on gross revenues of $637,700. The following comparison demonstrates the categorical cost differences between these homes:

BALANCE SHEET

	Facility A	Facility B	Difference A Over (Under) B
Assets			
Investment in Buildings	$ 328,458	$ -0-	$ 328,458
Accumulated Depreciation--Buildings	(50,455)	-0-	(50,455)
Investment in Equipment	89,075	104,345	(15,270)
Accumulated Depreciation--Equipment	(43,794)	(25,672)	(18,122)
All Other Assets	41,266	134,623	(93,357)
Total Assets	$ 364,550	$ 213,296	$ 151,254
Liabilities			
Long-Term Liabilities	$ 268,493	$ 123,548	$ 144,945
All Other Liabilities	-0-	69,638	(69,638)
Total Liabilities	$ 268,493	$ 193,186	$ 75,307
Equity			
Retained Earnings	$ -0-	$ 19,110	$(19,110)
Paid-In Capital	96,057	1,000	95,057
Total Equity	$ 96,057	$ 20,110	$ 75,947

REVENUE AND EXPENSE STATEMENT
for 12 months

	Facility A	Facility B	Fiscal Advantage (Disadvantage) A Over B
Revenues			
Private Patients	$ 105,806	$ 106,843	$(1,037)
Medicare Patients	6,520	4,191	2,329
Medi-Cal Patients	514,940	545,309	(30,369)
Ancillary Revenue	2,015	-0-	2,015
Other Revenue	8,438	9,191	(753)
Total Revenue	$ 637,719	$ 665,534	$(27,815)
Expenses			
Director of Nurses Salary	$ 10,840	$ 11,940	$ 1,100
Registered Nurses Salaries	16,841	2,814	(14,027)
Licensed Vocational Nurses Salaries	47,392	55,551	8,159
Aides and Orderlies Wages	132,679	137,400	4,721
Administrator Salary	14,640	9,500	(5,140)
Employees Benefits	24,635	54,308	29,673
Raw Food Cost	47,770	40,087	(7,683)
Kitchen Wages and Supplies	36,684	31,701	(4,983)
Laundry Costs (Including Wages)	12,211	14,777	2,566
Housekeeping and Grounds Expense (Including Wages)	34,816	20,928	(13,888)
Depreciation Expense--Building	13,435	-0-	(13,435)
Depreciation Expense--Equipment	11,716	15,599	3,883
Rent/Lease Expense--Building	-0-	67,329	67,329
Rent/Lease Expense--Equipment	-0-	425	425
Administrative Expense (Other than Administrator Salary)	40,746	14,313	(26,433)
Bad Debts Expense	2,377	372	(2,005)
Advertising and Promotion Expense	-0-	2,854	2,854
Interest Expense	38,447	19,891	(18,556)
Drugs Expense	-0-	1,912	1,912
Therapy Expense	-0-	354	354
Utilization Review Expense	856	425	(431)
Ancillary Expense	1,672	-0-	(1,672)
Management Fees to Home Office	33,999	-0-	(33,999)
All Other Expenses	48,877	151,915	103,038
Total Expenses	$ 570,633	$ 654,395	$ 83,762
Total Profit	$ 67,086	$ 11,139	$ 55,947

cc: Members of the Legislature
Office of the Governor
Office of the Lieutenant Governor
Secretary of State
State Controller
State Treasurer
Legislative Analyst
Director of Finance
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
California State Department Heads
Capitol Press Corps