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STATE OF MAINE
118TH LEGISLATURE
SECOND REGULAR AND SECOND SPECIAL SESSIONS

Final Report of the

COMMISSION TO EXAMINE RATE SETTING AND THE FINANCING OF MAINE'S LONG-TERM CARE FACILITIES

November 20, 1998

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Executive Summary

I. Legislative history and commission process

The 118th Maine Legislature established the Commission to Examine Rate Setting and the Financing of Maine's Long-term Care Facilities in 1997 with the passage of Resolve of 1997, Chapter 81 and the amendment to it passed in Resolve of 1997, Chapter 129.

The duties of the commission include examination of the following issues concerning long-term care facilities:

1. The setting of rates for the different payers within the long-term care system for nursing facility services, including monthly charges and charges for resident services and supplies, and ensuring affordability;

2. The levels of profit guaranteed by the rate of reimbursement, a comparison of rates among the different states and financial stability within the system;

3. The advisability of rate equalization between private and public payers, implementation of rate equalization and what the possible benefits and detriments might be for nursing facility residents;

4. The case mix payment system for private paying patients;

5. The possibility of regulating the long-term care nursing facility industry in the manner of regulating public utilities;

6. The relationship between staffing levels and quality of care and maintaining high-quality care;

7. Mechanisms for providing consumer participation in decisions on the reimbursement for nursing facility care under the Medicaid program; and

8. Salaries, dividends and management fees in nursing facilities.

The commission met 15 times during its work over two interim sessions. Experts in the field of nursing facility quality of care and reimbursement met with the commission and participated in telephone conferences with commission members. Interested parties representing nursing facilities, regulators and consumer advocates attended meetings and provided information to the commission. The commission considered the following issues: nursing facility reimbursement by Medicare, Medicaid, insurance and private pay sources, the Medicaid Principles of Reimbursement, rate setting, rate equalization, the financial health of the nursing facility industry, employment issues, financial assistance from the Maine Health and Higher

Educational Facilities Authority, quality of nursing facility care, minimum staffing requirements, paperwork reduction initiatives and interaction with consumers and families.

II. Commission recommendations

The Commission believes that Maine residents should have access to high quality long-term care services in their homes and communities and in long-term care facilities close to their homes. To ensure that these services are available, long-term care facilities and agencies must be financially healthy and consumers must be able to plan for their care and to understand the services that are provided in the long-term care system. To these ends the commission makes the following recommendations:

1. Outcome-based incentives. The commission recommends that the Legislature direct the Department of Human Services to undertake pilot projects to reward high quality care in nursing facilities based on successful performance by the facilities. The commission suggests that successful performance be measured using quality indicators from the Minimum Data Set already in use and from consumer and family satisfaction surveys. The commission suggests that successful performance may be rewarded by means of financial rewards, favorable public information, decreased regulation by the State or in other ways. The commission cautions the department to preserve consumer choice in urban and rural settings to the extent practical, to avoid preserving with financial or other assistance facilities that perform poorly because of incompetence and to avoid inadvertently restricting access to care.

2. Reimbursement for nursing facility care through the Medicaid system. The commission is persuaded that reimbursement to nursing facilities through the Medicaid program may be inadequate to ensure high quality care to residents. The commission recognizes, however, that the need for more reimbursement for facilities needs to be balanced against the need to fund home and community based care. Therefore, the commission recommends that the Department of Human Services review the Principles of Reimbursement as well as information from facilities in order to identify the specific areas in which reimbursement is inadequate.

The commission recommends that the Legislature direct the Department of Human Services to develop new approaches to reimbursement targeted to specific problems, including the following, and report to the Legislature's Joint Standing Committee on Health and Human Services by February 1, 1999:

A) Examining operating costs to determine specific areas in which reimbursement may be inadequate. In doing so the department should consider the following options for reimbursement:
- reimbursing facilities' costs for medical directors at a level reflecting the increased acuity of nursing facility residents;
- merging the indirect and routine cost components;

- reimbursing for all aspects of direct care for residents, including medical supplies, in one cost category so that they may be adjusted by case mix;
- reviewing the most recent information from time studies being used for the Medicare prospective payment system and making a determination whether the time study presently in use reflects nursing costs in Maine's facilities and is appropriate for use; and
- studying employment markets, labor costs and turnover rates at facilities around the State and, for those facilities that are at or above direct care limits, developing methods for providing increased reimbursement. This study should be done in conjunction with the Department of Labor and should build upon the work already done by that department and by the Maine Health Care Association;

B) Re-basing reimbursement rates from 1993 to 1996 or the most recent complete audited year and adopting new medians and cost caps in order to keep up with the higher costs faced by facilities due to inflation, increased paperwork requirements, and higher resident acuity. In doing so the department should consider the following options for re-basing:
- re-basing costs with an emphasis on those most directly impacting high quality resident care; and
- re-basing cost components on a rolling schedule whether periodically or when a stated event occurs, such as when 50% of the facilities are over the cap;

C) Tying caps applicable to the different cost components to the size of the facility, placing higher caps on the smaller facilities, which are often in rural areas, in recognition of the higher costs faced by those facilities and the importance of maintaining access to nursing facility care in rural areas; and

D) Removing any reimbursement incentives that have unintended adverse impacts on resident care.

3. Minimum staffing requirements. The commission recommends that the Legislature direct the Department of Human Services to replace its current minimum staffing ratios with minimum staffing requirements that:

A) are tied to the acuity level of residents and to the other needs of residents that effect the quality of their lives; and
B) ensure that adequate numbers of direct care staff are available at all times to meet residents' needs.

The commission recommends that the Commissioner of Human Services present a proposal to implement and fund these new requirements to the Legislature's Joint Standing Committee on Health and Human Services by March 1, 1999.

4. Rate Setting. While some members of the commission support the concept of rate equalization, they recognize that legislation requiring nursing facilities to charge equal

rates to Medicaid residents and private payers could require additional legislative appropriations which would jeopardize needed funding for home and community based care. Accordingly, the commission does not recommend that equal rates be mandated at this time.

5. Paperwork reduction. The commission recommends that the Legislature direct the Commissioner of Human Services to report to the Joint Standing Committee on Health and Human Services by June 1, 1999 with a plan to reduce paperwork in nursing facilities which must include consideration of the opportunities presented by advancing technology and the feasibility of linking data between the Minimum Data Set (MDS 2.0) and Medical Eligibility Determination (MED'96) forms.

6. Interaction with consumers and families. The commission recommends that the Legislature take the following actions:

A) direct the Department of Human Services to improve the provision of information on long-term care services, costs and performance; and

B) strengthen and make more independent the Long-term Care Steering Committee by allocating more resources to it and changing its duties so that it advises the Commissioner and the Legislature.

7. Flex beds. The commission encourages the Department of Human Services and the Maine Health Care Association to continue their work on a proposal to allow the use of "flex beds," by which the commission means that beds licensed for long-term or residential care may be used to meet the changing needs of residents and may be reimbursed according to the level of care provided. The commission cautions that any proposal must not compromise the quality of life of a facility's residents.

8. Regulatory barriers to high quality care. The commission recommends that the Legislature direct the Commissioner of Human Services to study and identify regulatory barriers to high quality care and make recommendations for relief or modification of rules and report to the Joint Standing Committee on Health and Human Services by January 1, 2000.

9. Long-term care insurance information. The commission recommends that the Legislature direct the Bureau of Insurance to:

A) collect information on long-term care insurance and provide a report by March 1 each year to the Commissioner of Human Services, the Joint Standing Committee on Health and Human Services and the public. The information collected should include the number and types of policies purchased by consumers, the cost of premiums, daily benefit levels and the duration of benefits. Information should also be collected on policies paying benefits to or for consumers, including the types of policies, daily benefit levels and remaining duration of benefits; and

B) conduct a study of the use of individual income tax credits as incentives to encourage the purchase of long-term care insurance. The study should analyze the effectiveness of tax credits in encouraging the purchase of long-term care insurance in other states and the anticipated cost to the State from establishing a tax credit for all or part of the premium cost of qualifying long-term care policies. The Bureau should provide a report to the Joint Standing Committee on Health and Human Services by January 1, 2000.

10. Report on changes in long-term care. The commission recommends that the Legislature direct the Commissioner of Human Services to consult with the Long-term Care Steering Committee, study changes in the delivery and financing of long-term care and report to the Joint Standing Committee on Health and Human Services by March 1, 2000. The report should cover changes in the delivery of long-term care in facilities and by home and community-based providers, changes in reimbursement systems including, but not limited to the changes in the Medicare reimbursement system, the use of "flex beds," the quality of care provided to residents of Maine, the growth in home and community-based care and the availability of services and providers in all parts of the State.

11. Medicare reimbursement system. The commission recommends that the Legislature pass a legislative resolution opposing the change to the proposed prospective payment reimbursement system that has been instituted in the federal Medicare program for the reasons that it is flawed in its structure and that its application will cause financial hardship for Maine's long-term care facilities and will reduce the quality of care provided to Maine's residents. The commission is concerned that the new reimbursement system will lower reimbursement for care, cause the loss of skilled nursing facility beds available under the Medicare program and restrict access to care for residents who are eligible for Medicare. Maine was one of six states participating in a demonstration project under the Medicare program. Nursing facilities in all states that participated in the demonstration project are in jeopardy because the system omitted reimbursement for Part B pharmaceuticals for providers in states that participated in the demonstration project. Commission members fear that the new reimbursement system will lower reimbursement for staffing to a national average, which is below the staffing level provided in Maine facilities, and thus will lower the quality of care provided in Maine.

I. INTRODUCTION

The 118th Maine Legislature established the Commission to Examine Rate Setting and the Financing of Maine's Long-term Care Facilities in 1997 with the passage of Resolves of 1997, Chapter 81. The resolve established the commission, charged the commission with duties and required a report to the 118th Legislature by December 15, 1997. See Appendix A.

The commission held meetings on November 3, 12 and 19 and December 3 and 17, 1997. Despite the intensive work and voluminous information considered in only two months, the commission was unable to complete its work by the December 15th deadline. The commission submitted a letter to the Legislative Council requesting an extension of its authority and a new reporting date. The Legislative Council approved the extension request on November 20, 1997.

On December 15, 1997 the commission provided an interim report to the 118th Legislature detailing the work that the commission had undertaken and their request for an extension into the next year. The interim report expressed the opinion of the commission that the issues posed by consideration of Maine's long-term care system were complex and interrelated and presented questions about overlapping areas of public policy and state budgeting, the relationships of different regulated industries, the impact of anticipated growth in managed health care, the operation of nursing facilities and nursing facility management. See Appendix B.

During the Second Regular and Second Special Sessions of the 118th Legislature representatives of the commission met with members of the Joint Standing Committee on Health and Human Services and presented their interim report. In addition, in February, 1998 four consumer representatives on the commission issued their own report to the committee. See Appendix C. The passage of Resolve of 1997, Chapter 129 extended the authority of the commission, added an additional member to represent consumers of nursing facility services, altered the commission's duties and provided a new deadline of November 20, 1998 for a report to the 118th Legislature.

As amended by the resolve in the Second Special Session, the duties of the commission include examination of the following issues concerning long-term care facilities:

1. The setting of rates for the different payers within the long-term care system for nursing facility services, including monthly charges and charges for resident services and supplies, and ensuring affordability;

2. The levels of profit guaranteed by the rate of reimbursement, a comparison of rates among the different states and financial stability within the system;

3. The advisability of rate equalization between private and public payers, implementation of rate equalization and what the possible benefits and detriments might be for nursing facility residents;

4. The case mix payment system for private paying patients;

5. The possibility of regulating the long-term care nursing facility industry in the manner of regulating public utilities;

6. The relationship between staffing levels and quality of care and maintaining high-quality care;

7. Mechanisms for providing consumer participation in decisions on the reimbursement for nursing facility care under the Medicaid program; and

8. Salaries, dividends and management fees in nursing facilities.

During its second term of work the commission met May 20, June 3 and 17, September 2 and 16, October 1, 14 and 28 and November 12, and November 16, 1998. Experts in the field of long-term care, quality of care and reimbursement issues met with the commission, both in person and by telephone conference call. Appendix D contains a list of members on the commission during the second season of its work. See Appendix E for Resolve of 1997, Chapter 129 which contains the appointment of the new member of the commission and the charge to the commission for its second season of work.

Commission members considered regulating the long-term care nursing facility industry in the manner in which public utilities are regulated and unanimously decided against the idea. With regard to salaries, dividends and management fees, the commission decided against making a recommendation.

II. REIMBURSEMENT OF NURSING FACILITIES

A. Overview

There were 8194 residents of nursing facilities, 93.3% of whom were over age 65, in Maine in 1996, the most recent year for which data were available to the commission. [1] They resided in 142 nursing facilities across the State, ranging in size from 17 residents in the facility to 280 residents.[2] Some of the nursing facilities are not-for-profit, some are for-profit; some are affiliated with hospitals; some are affiliated with independent living centers, assisted living or residential care facilities (formerly known as boarding homes), and some are not. Some are independent, and some are part of a larger corporate structure. All are licensed by the Maine State Department of Human Services and are subject to inspection by the department and by the federal Department of Health and Human Services Health Care Financing Administration (HCFA).

Residents of nursing facilities pay for their care, or have their care paid for, in several different ways. Some residents pay for their care themselves or another person or entity pays for

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[1] Across the States, 1998, Profiles of Long-term Care Systems, The Public Policy Institute, pg. 90, 1998.
[2] Nursing Facility Occupancy by Payment Source, Appendix F.

them. The care for some residents is paid for by health, long-term care or converted disability insurance. For statistical purposes these sources, excluding Medicare and Medicaid payments, are grouped into a category called private pay. In 1997 the proportion of residents whose care was private pay was 17%. See Appendix F for the proportions of nursing facility residents by payment source. In September, 1998 the proportion of residents in the private pay category was 20%.[3]

Private pay rates in Maine are set by the contract between the nursing facility and the resident, without participation or regulation by the State or federal governments. In some facilities private pay rates are close to the Medicare and Medicaid rates. In others the disparity is wider. See Appendix G for a list of private pay rates. The commission studied the rates at the different facilities and members expressed concern that a large disparity between private pay and public pay rates leads private pay residents to spend their savings faster. This means that those with moderate savings and income deplete their resources faster, thereby arriving sooner at the point of needing assistance from the Medicaid program. See section II on rate setting.

B. Insurance

Some residents have their care paid for by insurance. Health care insurance, including health maintenance organization contracts, pays for a small proportion of long-term care, primarily post-illness or accident admissions that are for rehabilitation purposes. Disability insurance may also be converted to pay for nursing care. A breakdown of the private pay category into actual cash payments and insurance payments is not available. The commission did not consider in any depth issues related to insurance other than long-term care insurance.

The chart below provides information on long-term care insurance policies and the decisions to be made in choosing the correct policy for the individual. Different policies provide coverage for the individual beneficiary according to capacity to perform activities of daily living, which are defined in each policy and which include such skills as eating, dressing and personal hygiene, cognitive impairment, and medical necessity. The younger the individual is when initially purchasing the policy, the lower the premium. As the long-term care insurance policy is purchased a year at a time insurance carriers must offer to renew all policies each year. The individual may purchase inflation protection to protect against premium increases above a set percentage. Otherwise premiums may increase, although not based on the individual's health. In choosing a policy the individual must balance anticipated needs, preferences for long-term care and personal resources and assets. In choosing benefit levels the individual must decide upon the length for which benefits will be provided and the amount per day of benefit. The fewer the benefits purchased, the higher the risk accepted by the individual and, it follows, the lower the premium.

[3] Information obtained from Deborah Couture, Department of Human Services, Bureau of Medical Services, November 19, 1998.

Long-term Care Insurance Decision Points

Elimination period	Daily benefit	Benefit duration
Definition: the period of time an individual must pay for care from other sources before the insurance benefit commences.	Definition: the amount of insurance benefit, stated as a dollar amount per day. Any charges for care that exceed the daily benefit must be paid from other sources.	Definition: the maximum period of time for which insurance benefits will be paid. Benefits may be paid during one or more periods of care, which are then added together.
Consumer decision	**Consumer decision**	**Consumer decision**
The duration of the elimination period should be planned after considering other sources of payment for care during that period. It can run from 0 to 730 days. Longer elimination periods lower premium costs but require other resources to pay during the time that they run.	Selecting the daily benefit requires a look into the future. First the individual must choose the type of facility or service benefit to be purchased, including the option of home care. Then the maximum daily benefit must be chosen. It should be sufficient, with any other additional income to the individual, to pay for anticipated care needs for the person. Another choice in this category is inflation protection to increase the average daily benefit each year when the policy renews. Less generous benefits lower premiums but may require assets or income to provide needed care outside the benefits of the policy.	The individual may purchase as short as 2 years of benefits (which may be used in one or more periods of long-term care) or as long as a lifetime of benefits. An individual who is receiving benefits under the policy does not pay premiums while receiving benefits. Choosing a shorter benefit period decreases premiums.

The commission studied long-term care insurance in Maine, which must be offered for care in a nursing facility or at home and which may include respite care or assisted living care. It may not require a hospital or skilled nursing care stay as a precondition to receiving benefits, or require care in a facility setting prior to receiving home care.

The commission also reviewed the tax deduction available on the Maine individual income tax for long-term care insurance premiums for certified policies. The deduction is available regardless of whether the taxpayer itemizes or files the short form tax return.

Commission members reviewed a wide array of information on long-term care insurance from the Bureau of Insurance, the American Health Care Association, the National Association of Insurance Commissioners and a number of commercial insurers, as well as articles from leading consumer magazines. See Appendix H for information from the Bureau of Insurance on long-term care insurance.

The commission also studied long-term care insurance purchase incentive programs in place in other states, detailed in Appendix I. These programs, which exist only with the approval of HCFA, allow special treatment for the assets of a person who has purchased and fully utilized a qualifying long-term care insurance policy. Assets may be disregarded upon application for assistance to the Medicaid program or in the process called Medicaid estate recovery, in which repayment is collected for the state and federal governments after the death of the person whose care was paid by Medicaid. In the model referred to as the Dollar for Dollar model the disregard is in the amount paid by the insurance policy. In the Total State Assets model all assets are disregarded, no matter the extent. There is also a combination model that blends the two approaches and grants partial disregard of assets.

State programs to encourage the purchase of long-term care insurance through incentives based on asset disregards in the Medicaid program depend on approval from HCFA. The options available to states for obtaining HCFA approval were significantly narrowed with the enactment of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93). Since the enactment of OBRA '93, no new states have enacted programs of the Total State Assets type. Missouri, North Dakota, Oregon and Rhode Island have not implemented insurance purchase incentive programs that they had enacted prior to OBRA'93. Colorado, Maryland and Michigan enacted programs but expressly made them conditional upon the repeal of the OBRA '93 provisions that restrict asset disregard. To date, the relevant provisions of OBRA '93 have not been repealed.

C. Medicare

Some residents have their care paid for by Medicare, the federal program for persons who are 65 years old or older or who are disabled and certain people with end stage renal disease. In 1997 these residents made up 11% of the residents in Maine's nursing facilities. In 1998 this percentage remained at 11%.[4] Medicare is not, however, a long-term care program, so it funds long-term care only after, and within 30 days of, a hospital stay of at least 3 days. Medicare long-term care benefits are limited to skilled nursing care for up to 100 days, with the first 20 days paid fully and the resident paying $95.50 per day for each of the remaining 80 days. Medicare funds are 100% federal funds.

Prior to July 1, 1998 Medicare paid for skilled nursing facility care on a cost reimbursement basis. Beginning July 1, 1998, Medicare began paying for nursing care through a prospective payment system that is based on the category of the resident's medical condition, determined according to Resource Utilization Groups-III (RUG-III). The new system will

[4] Information obtained from Deborah Couture, Department of Human Services, Bureau of Medical Services, November 19, 1998.

include for the first time payment for pharmaceuticals, medical supplies, some ambulance services, laboratory services and speech, occupational and physical therapy services. These services were previously billed separately, sometimes by a different provider, but are now part of the set rate paid to the nursing facility. Services that may be billed separately under the new system include services provided by physicians, physicians' assistants, nurse practitioners and clinical nurse specialists, psychologists and nurse anesthetists and charges for dialysis, hospice care and some ambulance services.[5]

Providers of nursing facility care are seriously concerned that the inclusion of the new category of charges in the set fee based on RUG-III will underpay the facilities. Providers of nursing facility care told the commission that the extent and fair reimbursement for the newly packaged services provided to the residents is of great concern. They feel that the costs of delivering these essential services are not adequately reflected in the new reimbursement formula since nursing facilities have not provided or monitored the costs of some included services, such as pharmaceuticals. The commission learned of the grave concerns of the nursing facility industry that the new prospective payment reimbursement system could underpay facilities, undermine their fiscal integrity and place patient care at risk.

D. Medicaid

The Medicaid program, established under Title XIX of the Social Security Act, provides reimbursement to nursing facilities for low-income persons with limited resources who qualify for inclusion in one of the Medicaid eligible categories. These categories include persons who are disabled or medically needy and certain Medicare beneficiaries. It is a joint federal-state program, funded in Maine with roughly 2/3 federal and 1/3 state money. In 1996 Medicaid long-term care expenditures in Maine totaled $342,667,000. Medicaid paid nursing facilities $213,614,000; home health care providers $13,677,000; and home and community-based services under Medicaid waivers $64,517,000.[6] The percentage of residents for whom care was paid by Medicaid decreased from 76% in 1993 to 72% in 1997.[7] By September, 1998 the percentage of Medicaid residents had decreased to 69%.[8]

Medicaid rates are calculated according to the Principles of Reimbursement for Nursing Facilities, a formula adopted by rulemaking within the Department of Human Services that is semi-prospective and is based on facility-specific base year allowable costs with limitations applicable to similar facilities that are referred to as peer group caps. The two peer groups are made up of hospital-based facilities and non-hospital-based facilities. A portion of the rate, the direct care component, is adjusted quarterly to reflect the facility's average case mix for Medicaid residents. This case mix is calculated based on assessments of the residents' needs for care using a method referred to as the Minimum Data Set (MDS 2.0). See Appendix J for a copy of the Principles of Reimbursement.

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[5] Stephanie Rice, CPA, Berry, Dunn, McNeil and Parker, in testimony before the commission, September 16, 1998.
[6] Across the States, supra, pg. 91.
[7] Nursing Facility Occupancy by Payment Source, Appendix F.
[8] Information obtained from Deborah Couture, Department of Human Services, Bureau of Medical Services, November 19, 1998.

The four cost components of Medicaid rates, listed in the first four rows of the chart below, are adjusted annually for inflation. They include direct care costs, indirect care costs, fixed costs and routine costs. Ancillary expenses, listed on the fifth row of the chart, include occupational, physical and speech therapy, medications and drugs and durable medical equipment. Ancillary expenses are separately and fully reimbursed on a fee-for-service basis. (Note the discussion above of these same ancillary expenses moving from a cost based reimbursement system to a prospective payment system under the federal Medicare program.)

Medicaid Rate Components

Category	Included costs	Limitations, application
Direct patient care	Nursing and ward clerk salaries and fringe benefits, excluding director of nursing. Activities personnel salaries and fringe benefits.	Quarterly case mix applied, based on MDS assessments. Facility costs are limited to median costs for all facilities plus 12%.
Fixed costs	Interest on long-term debt. Capital expenses. Depreciation on buildings and land. Rental expenses. Real estate and personal property taxes. Depreciation and amortization. Property, liability and malpractice insurance. Workers' compensation costs. Water and sewer connection charges. Return on equity (8%) for proprietary providers. Administrator in training salaries and fringe benefits, with prior approval.	This component is retrospective. Pass through at 100% reimbursement, except that adjustments are made for occupancy below certain levels: 90% for facilities with more than 60 beds and 85% for facilities with 60 or fewer beds.
Routine costs	All other operating expenses except ancillaries and those not included in the other 3 categories. Administrative expenses are capped. Management fees are not allowed.	This component is prospective. Facility costs are limited to median costs for all facilities plus 8%.
Ancillaries	Physical therapy. Occupational therapy. Speech therapy. Medications and drugs. Durable medical equipment.	This component is retrospective, fee-for-service.

Sanctions may be imposed and reimbursement reduced to nursing facilities with high error rates in the assessment of resident nursing needs (the MDS 2.0 assessment).[9] Quarterly sanctions are imposed for error rates above 35%, reducing reimbursement for direct care for a quarter by from 2% to 10%. Sanctions imposed under this provision have totaled $130,000, an amount considered by the Department of Human Services to be small in comparison to the avoided error rate and the consequent savings to the Medicaid program.[10] See Appendix K.

There is another area in which penalties may be applied to reimbursement from the Department of Human Services. If a facility completes the payment year with an occupancy rate below the standard applicable to facilities of its size, reimbursement for fixed costs is reduced to reflect an assumed occupancy rate.[11] For a facility with 60 or fewer beds, the occupancy rate is 85%. If a facility with 54 beds has a final occupancy rate of 82%, reimbursement for fixed costs is reduced from 100% of their total costs to 85% of their total costs. For a facility with more than 60 beds, the occupancy rate is 90%. If a facility with 154 beds has a final occupancy rate of 88%, reimbursement for fixed costs is reduced from 100% of their total costs to 90% of their total costs. The Department of Human Services considers this occupancy adjustment to be a money saver since without it fixed costs are allocated to a smaller number of residents, which would result in a higher per resident daily cost. The department also considers the occupancy adjustment to be a motivator to facilities to convert unused beds to other uses. The department estimates that the adjustment penalty saves the Medicaid program almost $3,000,000 per year.[12]

During its discussions commission members learned that Medicaid pays nursing facilities millions of dollars per year less than their actual allowable costs. Commission member Michael McNeil provided to the commission copies of a letter from himself to the Joint Standing Committee on Health and Human Services dated April 2, 1997 and accompanying information compiled by the accounting firm of Berry, Dunn, McNeil and Parker. He also provided to the commission copies of a letter from himself to Paula Valente, Executive Vice President of the Maine Health Care Association, dated July 24, 1998 and accompanying information. See Appendices L and M. In the letters Mr. McNeil informed the commission that Medicaid underpays nursing facilities because it caps allowable costs based on 1993 costs and because some real costs are not allowed by Medicaid at all, such as management fees.

The difference between Medicaid allowable costs and reimbursable costs amounted to $16,169,517 for 1996 for Maine's 142 nursing facilities. The Department of Human Services confirmed the shortfall figures in the $16,000,000 range and commission members agreed that the shortfall was caused in large part because of the 5-year old base year and in part because of the cap on allowable expenses. See Appendix N, Comparison of Reimbursable to Actual Costs from Michael McNeil, Berry, Dunn, McNeil and Parker, and Appendix O, Total Costs Schedule A versus G, from John Bouchard, Audit Division, Department of Human Services.

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[9] Principles of Reimbursement for Nursing Facilities, section 41.23.4, dated July 1, 1998.
[10] Medicaid Nursing Facility Reimbursement, pg. 8.
[11] Principles of Reimbursement for Nursing Facilities, section 44.10, dated July 1, 1998.
[12] Medicaid Nursing Facility Reimbursement, pg. 10.

III. RATE SETTING

A. Introduction

The commission was charged with examining the setting of rates for the different payers, the advisability of rate equalization between private and public payers and the case mix payment system for private paying patients. The commission studied the current methods used by Medicaid and Medicare for reimbursement of nursing facilities. See section II.

The commission reviewed presentations and submissions from a number of parties on rate setting and rate equalization. Information from Minnesota and North Dakota was informative on the subject and experts in the field were consulted to enable commission members to ask questions and obtain more information.

In reference to two bills before the Joint Standing Committee on Health and Human Services during the 118th Legislature, commission member Michael McNeil and the accounting firm of Berry, Dunn, McNeil and Parker suggest that there would be a need for a significant increase in the Medicaid budget if rate equalization were achieved via increasing the Medicaid rates to the same level as private pay rates. The exact amount of funding required would depend on the level at which rates were set.[13] See Appendix P. One estimate is that it would cost $18,340,000 per year to raise the Medicaid rate to the private pay rate.[14] The opposite method of reaching the equal rate goal would be to decrease the private pay rates, imposing the Medicaid rates as caps on private pay beds, thereby decreasing revenue to nursing facilities by the amount of the difference between Medicaid rates and private pay rates, multiplied by the numbers of residents in each category. There is no estimate for the option of increasing the Medicaid rates somewhat and decreasing the private pay rates somewhat, presumably because the point at which the two rates were to meet would determine the cost to all payers, both public and private.

B. Minnesota

Minnesota has had a rate equalization law since 1977, based on a cost-based reimbursement system, and is now beginning a new contract-based system. In Minnesota cost-based reimbursement is based on analysis of resident needs through a case-mix evaluation. Operating costs are included, excluding physician, therapy and drug costs. In general single bed rooms are considered a luxury and are not subject to rate equalization unless medically necessary. A reimbursement specialist with the Minnesota Department of Human Services, when asked about the effects of rate equalization, concluded that it had not had a measurable effect on the number of nursing facility beds per 1000 residents. High numbers of nursing facility beds per capita has been a concern to states because excess beds contribute to high costs in the system as a whole and are paid for in part by reimbursement for all occupied beds, including those paid for through the Medicaid program. Minnesota addressed the issue of excess bed capacity

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[13] Letter from Michael McNeil to Joint Standing Committee on Health and Human Services regarding LD 991 and 1291, dated April 2, 1997

[14] Letter from Michael McNeil to Joint Standing Committee on Health and Human Services regarding LD 991 and 1291, dated April 2, 1997

separately, and decreased the number of beds, via a moratorium on nursing facility beds certification in 1983 and a moratorium on nursing facility licensure in 1985.[15]

In 1995 Minnesota began work on a nursing home contract alternative payment project (hereinafter called the contract project). The Minnesota cost-based reimbursement system will switch to contract-based reimbursement over a 5-year period ending July 1, 2000. At present 218 of the 444 nursing facilities have enrolled in the contract project.[16] Contract rates are negotiated between the facility and the state Department of Human Services and depend in part on costs in the established base year of the facility. The contract rate is set at a base rate, adjusted annually for inflation. Other terms of the contract may include a lessening of state regulations and an exemption from rate equalization for short stay private pay residents. Plans now call for the use resident needs assessment through use of the Minimum Data Set (MDS) to track and evaluate resident clinical care. Eventually, standards are planned to allow measurement of quality of care and resident satisfaction. When the project is fully implemented, the nursing facility and the Department of Human Services will jointly set quality goals and the facility will be eligible for incentive payments of up to 5% of the contract amount for meeting the quality goals. On July 1, 2000 the old system of cost-based reimbursement will be replaced in full by the contract-based system. See section IV on quality of nursing facility care for a discussion of the measurement of quality of care and quality of life.

C. North Dakota

Rate equalization for nursing facility care became the law in North Dakota in 1990, using the same system design as in neighboring Minnesota. Rates are based on case-mix reimbursement. Single rooms are considered a luxury, unless medically necessary, and there are no limits on the charge for them. The system was instituted by raising the Medicaid rates to the level of private pay rates, at a significant cost to the state. Rate equalization has lowered profit margins to 3 to 5% and has not had a measurable effect of the ratio of beds per 1000 residents in North Dakota.[17]

D. Commission discussion

The commission spoke with experts around the country who are familiar with the reimbursement systems in place in Minnesota and North Dakota. Rate equalization appears to be on a different track from contract-based reimbursement, although the two systems could work together. Minnesota is moving away from rate equalization in its contract project by allowing an exception to rate equalization for short-term private pay residents. Commission members were told that public discussion of the Minnesota contract project had not included its effect on rate equalization.[18]

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[15] Conversation with Charles Osell, Reimbursement Specialist, Minnesota Department of Human Services, December 3, 1997.

[16] Conference call of commission with Patricia Cullen, Minnesota Health Care Providers, October 14, 1998.

[17] Telephone conversation with David Sack, Administrator of Institutional Reimbursement, North Dakota Department of Human Services, December 3, 1997.

[18] Conference call with Dr. Robert Kane, September 2, 1998.

Commission members listened with interest to a proposal by the Department of Human Services to begin work on performance-based reimbursement. Challenges to implementing a new system include the development of the performance standards, the most difficult of which will be the consumer and family satisfaction measurements, and the appropriation of funding with which to provide the financial rewards to high performing nursing facilities. See the recommendations in section VII.

IV. NURSING FACILITY FINANCIAL HEALTH

A. Introduction

Financial information about the condition of the nursing facility industry was provided to the commission from the Maine Health Care Association, commission member Michael McNeil, other commission members and the Department of Human Services. The information shows an industry that faces serious financial challenges. Some facilities are in serious financial difficulty and some are financially healthy. Significant change in reimbursement of nursing facilities began July 1, 1998 with the new Medicare reimbursement system and more change is coming.

Commission members are concerned that nursing facilities be adequately supported and reimbursed so that Maine residents have access to high quality long-term care services in their communities. These services should include facility-based and home and community-based services. A choice of the same high quality services should be available whether the resident qualifies for reimbursement through Medicare, Medicaid, another payer or pays privately. State regulation should adequately protect the public and be workable for the regulated providers. The long-term care system should serve as a model of cooperation among all interested parties. Reimbursement for publicly-paid care should be fair and prompt and should promote the public policy goals of the State. It should enable long-term care providers to deliver their services through well-trained and fairly paid staff whose work reflects the care, concern and respect due to recipients of that care. With these goals in mind the commission settled on the recommendations on financial health contained in section VII.

There are some commission members who felt that the financial health of the industry is dependent as much on the industry's willingness to adapt to the changing market and a changing regulatory environment. These commission members felt that this was just as important as state and federal reimbursement.

B. Medicare

In 1997, Medicare provided reimbursement for 11% of the residents in Maine's nursing facilities. This percentage has increased from 5% in 1993.[19] The Principles of Reimbursement require nursing facilities to certify for occupancy by persons whose care is reimbursed by Medicare different numbers of beds in different parts of the State, according to the numbers of

[19] Nursing Facility Occupancy by Payment Source, Appendix F.

Medicare recipients and patients in hospitals awaiting nursing facility admission and other relevant demographic information.[20] Access to nursing facility care reimbursed by Medicare is an important public policy goal in Maine, in part to maximize federal funds since Medicare funding is 100% federal funding and in part to assure Maine residents that the nursing facility care they need will be available to them as close to their home communities as possible.

The commission learned that the federal government has just changed the manner in which it reimburses for Medicare nursing facility care. The new prospective payment system is discussed in section II. All parties before the commission, and commission members themselves, concluded that the Medicare changes are significant and that the impact on Maine's long-term care facilities are expected to be negative, more specifically, less reimbursement for more comprehensive care undertaken by the facilities. This is of grave concern as it endangers the quality of care provided and access to nursing facility services across the State.

C. MED'94 and MED'96

In 1994 the Legislature undertook to decrease Maine's reliance on high cost institutional long-term care and to increase the number of choices for long-term care and the use of home and community-based care and services. To accomplish this the Legislature directed the Department of Human Services to revise its criteria for nursing facility admission reimbursed through the Medicaid program to focus on the individual's functional ability and medical and social needs.[21] The needs assessment was planned to achieve the purposes of the statutory charge, "to determine the most cost-effective and clinically appropriate level of long-term care services." The department undertook the revision and adopted a new assessment tool entitled the Medical Eligibility Determination, 1994, referred to as MED'94. This assessment tool was revised in 1996 to take into account Alzheimer's disease and other dementias, with the resulting assessment tool referred to as MED'96. Another change to the assessment process occurred when the Legislature required MED'96 assessments of all applicants for nursing facility care, not just those applying for Medicaid assistance or reasonably anticipated to make such an application within 180 days.[22]

Commission members learned that the average occupancy rate of nursing facilities decreased from 96% in 1993 to 84% in 1997.[23] During this time period the Department of Human Services adopted the MED'94/MED'96 assessment tool, shifted resources to home and community-based care and encouraged the development of other options for long-term care. The results were impressive. More than 500 new beds were created for residential and other specialized services during 1996 alone. By February, 1997 more than 20 nursing facilities "banked" more than 286 beds, taking them off-line for Medicaid reimbursement purposes while

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[20] 22 MRSA section 1812-H, subsection 2-A.
[21] 22 MRSA section 3174-I. See also Long-Term Care Reform, A Status Report, February, 1997, Department of Human Services, pgs. 1-4.
[22] 22 MRSA section 3174-I.
[23] Nursing Facility Occupancy by Payment Source, Appendix F.

retaining the right to an expedited certificate of need process if the facility decides to bring them back on-line.[24] By late 1998 the total of banked beds had reached 486.[25]

The shift in state policy regarding eligibility for nursing facility care, increased consumer choice and changes in state and federal regulations have been effective in more people receiving home and community-based care and have in part caused financial difficulties for the nursing facilities. As is most pertinent to the work of the commission, the number of nursing facility beds decreased from 10,139 in 1993 to 9,226 in 1997. See Appendix F. Nursing facility care as a proportion of the Maine's long-term care budget decreased from 85% in state fiscal year 1993-94 to 80% in state fiscal year 1995-96, while the percentage spent on boarding care increased from 5% to 7% and the percentage spent on home care increased from 10% to 13% in the same time period.[26] Since 1993 residential care level beds reimbursable through the Medicaid program grew by the following numbers:

- Alzheimer's care beds 301
- Geriatric care beds 1259
- Head injury care beds 12
- HIV-AIDS care beds 6
- Mental health care beds 89
- Total 1667[27]

D. Medicaid reimbursement

Reimbursement for nursing facility care through the Medicaid program has been discussed in section II. Commission members became convinced during the course of their work that the level of reimbursement provided by the Medicaid program does not adequately ensure quality care for nursing facility residents. Commission members concluded that the rates paid to nursing facilities are in danger of failing to meet the needs of residents and that recalculation of the base year rates used in the reimbursement formula is called for in accordance with the Principles of Reimbursement.[28] The commission discussed revising the Principles of Reimbursement and recommends a number of changes including re-basing, examining operating costs and tying caps for cost components to the size of the facility. The commission also recommends that the Department of Human Services study a number of reimbursement issues and undertake a pilot project to reimburse nursing facilities based on an outcome-based incentive system. See section VII.

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[24] Long-Term Care Reform, A Status Report, February, 1997, Department of Human Services, pg. 7.
[25] Information obtained from Catherine Cobb, Department of Human Services, Bureau of Elder and Adult Services, November 17, 1998.
[26] Long-Term Care Reform, A Status Report, February, 1997, Department of Human Services, pg. 4.
[27] Information obtained from Catherine Cobb, Department of Human Services, Bureau of Elder and Adult Services, November 17, 1998.

[28] Principles of Reimbursement, section 37.2, effective date July 1, 1998.

E. Employment issues

Information was presented to the commission connecting the recently healthy economy, near full employment and the relatively small size of Maine's nursing facilities to the financial stress they are experiencing. [29] Relatively small facilities, and Maine's rank 46th in size in the country, mean that facilities are not able to benefit from economies of scale. The cost of care in a home of under 50 beds runs 25% higher than the cost of care in a home with 200 and over beds.[30] Near full employment means that wages and benefits must be competitive with other employment or, as has been happening in Maine's nursing facilities, employees are harder to hire and harder to retain and staff turnover increases. The commission considered information showing that Maine's facilities have the 5th highest total compensation in the country and that employment costs represent 65% of the total operating expenses of the facilities.[31]

The current employment situation has a negative impact on patient care and staff morale and increases facility costs. The commission discussed ways to increase reimbursement to direct care workers in order to address this problem. See section VII for recommendations with regard to employment.

F. MHHEFA financing

Maine is a leader among the states in making affordable financing available to nursing facilities through the Maine Health and Higher Educational Facilities Authority (MHHEFA), as authorized in Title 22, Maine Revised Statutes, Chapter 413. Since its establishment in 1971 MHHEFA has made fixed rate, long term capital available to for-profit and not-for-profit higher educational and health care facilities. Two programs are available for nursing facilities: one operating in the national tax-exempt credit markets provides loans to not-for-profit nursing facilities and one operating in the national taxable credit market provides loans to proprietary nursing facilities.

On the tax-exempt financing side, through the pooling of borrowers and the moral obligation reserve fund credit enhancement, MHHEFA is able to purchase bond insurance and obtain interest rates based on a AAA credit rating, a rating which would not otherwise be available to some nursing facilities, if only because of their small size. The improved credit rating results in lower interest rates and savings for the facilities in repaying the loans. In addition, the pooling of borrowers allows the sharing of costs for common services such as printing, legal services, and credit rating service charges.

On the for-profit financing side, pooling borrowers has produced substantial savings because of the homogenizing effect of pooling, the moral obligation reserve fund credit enhancement and the sharing of common costs. Bond insurance has not been used in this portion of the business.

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[29] Attachment to letter Paula Valente dated July 24, 1998.
[30] Attachment to letter to Joint Standing Committee on Health and Human Services dated April 2, 1997.
[31] Attachment to letter to Paula Valente dated July 24, 1998.

Through the participation of the Maine Health and Higher Educational Facilities Authority nursing facilities have had access to loans for construction projects and refinancing of mortgages amounting to $155,392,811, of which $135,187,811 is currently outstanding. The amount of the outstanding balance, $135,187,811 at the time of the commission's final meeting, is the amount for which the moral obligation reserve fund is potentially liable. See Appendix P, MHHEFA, Taxable Reserve Fund Resolution, Outstanding Balances and Location and Appendix Q, Not for Profit Nursing Homes Outstanding Balances and Locations.

This financing mechanism results in loans to nursing facilities at lower interest rates than would otherwise be possible. Since most interest payments are reimbursable in full through the Medicaid program, the savings in interest translates into direct savings to the Medicaid budget. MHHEFA and commission member Michael McNeil provided financial information estimating that use of MHHEFA financing has saved the nursing facilities approximately $30,000,000 in interest expense over the lives of the loans and that this translates into a savings of approximately $23,000,000 for the Maine Medicaid program.[32] See Appendix R.

The Maine Health and Higher Educational Facilities Authority has assisted nursing facilities experiencing financial difficulties in meeting their financial obligations to MHHEFA. MHHEFA has done this by advancing funds under a forbearance agreement negotiated between MHHEFA and the institution, as shown on Appendix S, MHHEFA Taxable Nursing Home Advance and Payment History. MHHEFA presented information to the commission about its advance payments to nine nursing facilities, showing the repayments and balances due from each facility. MHHEFA foreclosed and ceased operations at one facility and is working on the sale of the property and licensed nursing beds. One facility is under contract for sale and the long-term plans include repayment of MHHEFA when the sale is concluded.

Some commission members questioned the wisdom of the State's providing moral obligation credit enhancement to for-profit institutions. These members are concerned that MHHEFA's involvement in the financing of long-term care facilities could lead to their having influence in policy questions properly reserved to the Legislature.

G. Overall financial health

Information on the overall financial status of Maine's nursing facilities came to the commission from commission member Michael McNeil and the accounting firm of Berry, Dunn, McNeil and Parker, based upon information from 117 non-hospital based nursing facilities. The letter and attachments in Appendix L show financial information and ratios for these 117 nursing facilities. This information shows an industry with current ratios of less than 1.0, declining total profit margins that hover below 1, and cumulative negative equity. In 1995 the total profit margin of Maine's nursing facilities was 1.80, which, compared to the national median of 3.79 placed Maine's facilities 37th in the nation.[33] Maine's facilities placed poorly once again in

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[32] "Estimated savings from use of moral obligation reserve fund program vs. traditional financing," from MHHEFA and letter to Paula Valente dated July 24, 1998.

[33] Attachment to letter to Paula Valente dated July 24, 1998.

median debt service coverage ratio in 1995, where the median ratio was 2.22 and Maine's ratio was 1.08, ranking Maine 46th in the country.[34]

Commission members learned that nursing facilities are putting their resources into care for their residents. Although the data is taken from different years, the commission benefited from the picture presented in the letter to the Joint Standing Committee on Health and Human Services dated April 2, 1997 and the attachments, all of which are included in Appendix L:

- 1996 total costs $141.25 per day
- 1996 Medicaid allowable costs $112.81 per day
- 1995 total costs $130.91 per day
- 1995 Medicaid allowable costs $105.94 per day
- 1994 total operating cost $ 98.47 per day
- 1994 direct care expense $ 35.54 per day
- 1994 indirect care expense $ 13.83 per day
- 1994 administrative and general expense $ 16.18 per day[35]

Commission member Michael McNeil brought to the attention of the commission figures included in the letter of July 24, 1998 to Paula Valente and updated those figures with percentages at the meeting on October 1, 1998. The figures show the following:

Amounts and Percentages of Medicaid Reimbursement for Selected Actual Costs and Allowable Costs in the Medicaid Program, 1996

	Actual Costs		Allowable Costs	
	Dollar amount	Percentage of total costs	Dollar amount	Percentage of total costs
Salaries, wages and fringe benefits	$85.32	57.7%	$73.25	62.7%
Administrative compensation	$2.45	1.65%	$2.81	2.4%
Owners and officers compensation	$ .09	.06%	0	0
Central office	$1.34	.9%	$ .93	.79%
Management fees	$ .92	.62%	0	0
Total cost per patient day	$147.81		$116.77	
Average direct care hours per resident day equals 3.9 hours.				

[34] Attachment to letter to Paula Valente dated July 24, 1998.

[35] Attachment to letter to the Human Services Committee dated April 2, 1997.

Commission members discussed the financial situation of the state's nursing facilities and agreed upon a number of recommendations to bring about positive change. See the recommendations in section VII.

V. QUALITY OF NURSING FACILITY CARE

Commission members studied the quality of nursing facility care at almost every meeting. Questions about quality and how to encourage and ensure it arose with regard to all of the other issues considered by the commission. Commission members agreed that quality of care is closely tied to staffing. They also agreed that staffing at a level to provide high quality care requires adequate reimbursement to the nursing facilities.

Some commission members felt the quality of nursing facility care is difficult to readily define. Some define it as an attribute of excellence, a feeling that you get when you walk through the door. Others say it is the provision of services and an environment so that residents feel positive and maintain dignity, control and independence while either improving, achieving or maintaining their highest functional level or slowing their level of decline. High quality care is individualized care. It is critical to the success of a nursing facility stay. With it the individual resident may achieve a high quality of life. High quality care is the TLC in long-term care.

The commission reviewed articles on quality of care and reams of material on quality measures and quality indicators. Since 1990 the federal government, through the Health Care Financing Administration, has been working to develop and use quality indicators, a system to measure the quality of care delivered in nursing facilities. See Appendices T and U for examples of articles on quality indicators. The quality indicators take information gained from the MDS assessment tool and provide an overview of the residents and the care provided in the nursing facility.[36] The Maine Medicaid program and Maine nursing facilities have participated in a demonstration project since 1993. Over the years the project has used between 30 and 37 quality indicators. Recent changes in the quality indicators signal a shift in the focus from problem resolution to assurance of quality services. The quality indicators include items related to physical functioning and allow examination of a facility's clinical policies, prevention techniques and quality improvement efforts. The quality indicators cover the following:

- accidents;
- behavioral and emotional patterns;
- clinical management;
- cognitive functioning;
- elimination and continence;
- mobility;
- infection control;
- nutrition and eating;
- physical functioning;

[36] Nursing Home Quality Indicator Development, pg 1.

- psychotropic drug use;
- resident or family participation in assessment;
- maintenance of family relationships;
- quality of life (which, the commission notes with interest, is measured by prevalence of daily physical restraints and prevalence of little or no activity);
- sensory function;
- communication; and
- skin care.

The commission considered the information gathered from the HCFA quality indicators to be very valuable information about nursing facilities and residents, but only half the answer to judging quality of nursing facility care. This is because of their focus on problem areas and their inability to reflect how consumers feel about their living situations, their care and the quality of their lives.

The Minnesota contract project proposes to use performance-based reimbursement for which outcomes information will be required. See Appendices V and W on the contract project. Research is currently being done in Minnesota and Wisconsin on anticipated outcomes for residents of nursing facilities. This requires establishing resident status and then articulating measurable outcomes for the nursing facility population. This function is difficult in nursing facilities because of the mix of resident conditions and prognoses. Dr. Robert Kane identified five clusters of residents, as follows:

- those in active recuperation or rehabilitation;

- those with chronic physical disabilities, who are likely to decline gradually over time;

- those with cognitive disabilities, who are likely to decline over time and to reside in the facility for a very long time;

- those in persistent vegetative states; and

- those in terminal states whose needs are primarily for hospice and ameliorative care.[37]

Outcomes can include the presence of positive physical conditions and the absence of negative ones (for example, the ability to walk as against the occurrence of falls), clinical measurements such as blood pressure levels and calculations of cost and cost-effectiveness. They reflect perceived health status, ability to perform activities of daily living, cognitive performance, affect, social activity and satisfaction with care and living environment. Used in this way outcomes incorporate into the evaluative process the health status of the resident and the resident's feelings and level of satisfaction with the care provided. See Appendices X and Y, "Assessing the Outcomes of Nursing Home Care" and "Assuring Quality in Nursing Home Care" by Dr. Robert Kane and others.

[37] Kane, "Assuring Quality in Nursing Home Care," pg 234.

In a research project described in "Assessing the Outcomes of Nursing-Home Patients" Dr. Kane and a group of partners worked with residents asking satisfaction related questions including questions about the following areas:

- whether the staff shows a personal interest;
- whether something is done about complaints;
- overall satisfaction;
- whether the nursing staff cares about the resident;
- whether help comes in a reasonable time;
- whether the facility is a cheerful place;
- whether the resident is able to keep personal possessions;
- whether life in the facility is boring;
- whether the food is good;
- whether the resident is able to see a physician when needed;
- whether the resident's room and surroundings are clean;
- whether the resident has enough privacy;
- whether the resident is able to choose his or her own bedtime;
- whether personal belongings have disappeared; and
- whether the amount of noise bothers the resident.

The researchers concluded that it is possible to measure value-based outcomes for nursing facility residents. In order to establish the outcomes information such as that listed above must be collected from residents, families of residents, providers of nursing facility care, regulators, legislators and the general public.

In separate research a group once again including Dr. Kane studied the prediction of outcomes for nursing facility residents. See Appendix Z, "Predicting the Outcomes of Nursing Home Patients." The study encountered varying degrees of success in predicting resident outcomes depending on the use of a scale score or the prediction of status changes. The study suggests proceeding with outcome-based reimbursement, compensating for actual costs in

nursing facilities and varying the outcome-based reward depending on the ability of the payer to pay. According to the authors a wealthy system that would like to encourage experimentation and place substantial risk on nursing facilities could place more funds in the outcome-based category. A more conservative system could augment the actual costs category and place just a small incentive payment in the outcome-based category. The study also suggests non-monetary rewards, such as positive publicity and decreased regulatory requirements, that are valuable to nursing facilities and should be considered.[38]

As discussed in section III, the Minnesota contract project has chosen two sets of measurements for outcomes and will use both in the determination of which nursing facilities are meeting their goals for delivering high quality care and therefore qualifying for the additional reward payment of up to 5% of their base contract amount. One of the two sets of measurements is based on a subset of quality indicators that are resident-level data chosen from the MDS assessment by the Center for Health Systems Research and Analysis at the University of Wisconsin-Madison. This set is slanted to the clinical side. The other set is quality of life measures which will be developed from resident surveys of satisfaction, refined into benchmarks for stated outcomes. Both sets of measurements are still under development.

Commission members supported a recommendation that provides mechanisms for input from residents and families on quality of care and directs the Department of Human Services to undertake pilot projects to reward high quality. They also support identifying regulatory barriers to high quality care and increasing the quality of care by addressing staffing issues. The issue of staffing needs and the challenges of a near full employment economy in some parts of the state are discussed in sections IV and VI.

VI. ADDITIONAL INFORMATION

During the course of its work the commission reviewed additional information that pertained to its duties and to the operation of nursing facilities, including recent reports on staffing ratios and paperwork reduction, an agreement between the Department of Human Services and the Maine Health Care Association and a petition presented at the November 12th meeting.

A. Minimum staffing ratios

Resolve of 1997, Chapter 34, established the Task Force on Minimum Staffing to review the minimum staffing required of nursing facilities, to consider increasing minimum staffing ratios and to make recommendations for changes in departmental rules concerning minimum staffing levels. The task force presented its report to the Joint Standing Committee on Health and Human Services August 19, 1997 and supplemented that with another report on March 2, 1998. See Appendix AA for a copies of the reports of the task force and the report of task force member Brenda Gallant. Its major findings included the following.

[38] Kane, "Assuring Quality in Nursing Home Care," pg. 236.

- Direct care licensed nursing staff, as recognized by the Principles of Reimbursement, are performing non-direct care functions. The task force recommended that the commission look into this issue.

- The case mix assessment data could be used to collect information on empirical staffing criteria based on fluctuating resident acuity.

- Increased patient acuity indicates a need for acuity-based staffing.

- Increasing CNA staffing could result in decreasing licensed nursing staff available for direct care.

- A question was raised about incentives for nursing facilities to save on direct care costs.

- Minimum staffing is a safety threshold, not a prescription for daily staffing and not "best practice."

- Factors in achieving best practice include staffing levels, staffing recruitment, training and retention, facility leadership and reimbursement to match staffing.

- Staffing ratios are an inexact response to the challenge of providing quality nursing facility care.

The Task Force on Minimum Staffing made the following recommendations:

- Implement new staffing ratios of 1:6 on the day shift, 1:10 on the evening shift and 1:15 on the night shift;

- Examine the availability of certified nursing assistants throughout the state; and

- The Commission to Examine Rate Setting and the Financing of Maine's Long-term Care Facilities should examine the issue of reimbursement for certified nursing assistants, focusing on reimbursement for direct and indirect care as opposed to routine services.

In addition to the report of the Task Force on Minimum Staffing, the Joint Standing Committee on Health and Human Services received a separate memorandum from one member, Brenda Gallant, the State Long Term Care Ombudsman, a copy of which is included in Appendix AA. In the memorandum Brenda Gallant disagreed with the staffing ratios recommended by the task force and provided additional information. She made her own set of recommendations, which included:

- Replace the concept of minimum staffing with a requirement that facilities staff to meet the needs of residents as determined by case mix assessments and require the Department of Human Services to adopt rules requiring such staffing; and

- Structure increased nursing facility reimbursement to address the shortage of certified nursing assistants, planned for targeted labor shortage areas.

Members of the commission considered the recommendations of the Task Force on Minimum Staffing. They agreed upon recommendations that new minimum staffing requirements be adopted that are tied to acuity and needs level of the residents and that ensure that direct care staff are available to meet residents' needs and that the Commissioner of Human Services present a proposal to implement and fund these requirements to the Joint Standing Committee on Health and Human Services by March 1, 1999.

B. Paperwork reduction

The commission also had an opportunity to review the report of the Task Force on Paperwork Reduction in Nursing Facilities, attached as Appendix BB. Established by Resolve of 1997, Chapter 71, the task force reported on January 1, 1997, having studied the problem of paperwork required for patient assessment, care and reimbursement in nursing facilities, the needs of the patient and family, the nursing and professional staff of the facility, the Department of Human Services and any other interested party and having searched for methods of meeting the legitimate needs of all parties in the most efficient and efficacious manner.

The task force was fortunate in that it was able to bring about change almost at the time that it identified problems and suggested solutions. The following accomplishments highlight the work of the task force.

- Duplications in the requirements of Department of Human Services Licensing and Certification and Principles of Reimbursement were eliminated.

- An intermediate step was inserted into the process for submitting the minimum data set plus (MDSPlus) information, allowing errors to be caught early and without penalty.

- The schedule for completing the MDSPlus was revised to comport with other reporting requirements.

- Requirements for verification of information on the MDSPlus were lessened.

- It was clarified that there is no standardized form required for response to a resident assessment protocol.

- The Department of Human Services Licensing and Certification agreed to accept facility staffing schedules instead of requiring transfer onto a state specified form.

- The task force developed a format for care plans that is being tested in a pilot project.

Members of the commission were interested in the issues posed by the Task Force on Paperwork Reduction in Nursing Facilities. They agreed on a recommendation that the Department of Human Services present to the Joint Standing Committee on Health and Human Services a plan to reduce paperwork in nursing facilities which will include consideration of the opportunities presented by advancing technology and the feasibility of linking data between the Minimum Data Set and Medical Eligibility Determination forms.

C. Department of Human Services agreement with the Maine Health Care Association

The commission also reviewed the agreement between Commissioner Kevin W. Concannon, of the Department of Human Services, and John C. Orestis, President of the Maine Health Care Association, dated January 30, 1998. See Appendix CC. In this agreement the department and the association agreed to work together to:

- develop management capacity in the nursing home industry to enable it to promote alternatives to traditional nursing homes and address human resource needs to improve the supply, availability and career development of health care workers;
- extend the initial medical assessment classification period from 30 to at least 90 days, with exceptions;
- revise, simplify and make consistent licensing rules for long-term care in different settings;
- seek amendment to restrictions on nursing facilities' providing home health care;
- design a demonstration project on flex beds; and
- modify requirements on depreciation, occupancy and acquisition cost to ease the reduction of nursing facility beds.

Commission members were interested in the agreement between the Department of Human Services and the Maine Health Care Association to work together on a project involving "flex beds" and endorse the proposal in their recommendations.

D. Petition to the Commission

At the November 12th meeting the commission received a petition asking for immediate improvements in four major areas of nursing facility care. The petition is included at Appendix DD. The four areas of concern are:

1. Staffing. Too few and often with too little training and supervision.
2. Lack of staff means there is no time to provide tender loving care, almost as important as physical attention.

3. Food. Little or no attention to individual preferences.
4. Lack of security and care for safety and well-being of residents in Alzheimer's units.

The petitions were accompanied by 2 letters to the commission and one letter to a nursing facility administrator which are included together as Appendix EE.

VII. RECOMMENDATIONS

The Commission believes that Maine residents should have access to high quality long-term care services in their homes and communities and in long-term care facilities close to their homes. To ensure that these services are available, long-term care facilities must be financially healthy and consumers must be able to plan for their care and to understand the services that are provided in the long-term care system. To these ends the commission makes the following recommendations:

1. Outcome-based incentives. The commission recommends that the Legislature direct the Department of Human Services to undertake pilot projects to reward high quality care in nursing facilities based on successful performance by the facilities. The commission suggests that successful performance be measured using quality indicators from the Minimum Data Set already in use and from consumer and family satisfaction surveys. The commission suggests that successful performance may be rewarded by means of financial rewards, favorable public information, decreased regulation by the State or in other ways. The commission cautions the department to preserve consumer choice in urban and rural settings to the extent practical, to avoid preserving, with financial or other assistance, facilities that perform poorly because of incompetence and to avoid inadvertently restricting access to care.

2. Reimbursement for nursing facility care through the Medicaid system. The commission is persuaded that reimbursement to nursing facilities through the Medicaid program may be inadequate to ensure high quality care to residents. The commission recognizes, however, that the need for more reimbursement for facilities needs to be balanced against the need to fund home and community based care. Therefore, the commission recommends that the Department of Human Services review the Principles of Reimbursement as well as information from facilities in order to identify the specific areas in which reimbursement is inadequate.

The commission recommends that the Legislature direct the Department of Human Services to develop new approaches to reimbursement targeted to specific problems, including the following, and report to the Legislature's Joint Standing Committee on Health and Human Services by February 1, 1999:

A) Examining operating costs to determine specific areas in which reimbursement may be inadequate. In doing so the department should consider the following options for reimbursement:

- reimbursing facilities' costs for medical directors at a level reflecting the increased acuity of nursing facility residents;
- merging the indirect and routine cost components;
- reimbursing for all aspects of direct care for residents, including medical supplies, in one cost category so that they may be adjusted by case mix;
- reviewing the most recent information from time studies being used for the Medicare prospective payment system and making a determination whether the time study presently in use reflects nursing costs in Maine's facilities and is appropriate for use; and
- studying employment markets, labor costs and turnover rates at facilities around the State and, for those facilities that are at or above direct care limits, developing methods for providing increased reimbursement. This study should be done in conjunction with the Department of Labor and should build upon the work already done by that department and by the Maine Health Care Association;

B) Re-basing reimbursement rates from 1993 to 1996 or the most recent complete audited year and adopting new medians and cost caps in order to keep up with the higher costs faced by facilities due to inflation, increased paperwork requirements, and higher resident acuity. In doing so the department should consider the following options for re-basing:
- re-basing costs with an emphasis on those most directly impacting high quality resident care; and
- re-basing cost components on a rolling schedule whether periodically or when a stated event occurs, such as when 50% of the facilities are over the cap;

C) Tying caps applicable to the different cost components to the size of the facility, placing higher caps on the smaller facilities, which are often in rural areas, in recognition of the higher costs faced by those facilities and the importance of maintaining access to nursing facility care in rural areas; and

D) Removing any reimbursement incentives that have unintended adverse impacts on resident care.

3. Minimum staffing requirements. The commission recommends that the Legislature direct the Department of Human Services to replace its current minimum staffing ratios with minimum staffing requirements that:

A) are tied to the acuity level of residents and to the other needs of residents that effect the quality of their lives; and

B) ensure that adequate numbers of direct care staff are available at all times to meet residents' needs.

The commission recommends that the Commissioner of Human Services present a proposal to implement and fund these new requirements to the Legislature's Joint Standing Committee on Health and Human Services by March 1, 1999.

4. Rate Setting. While some members of the commission support the concept of rate equalization, they recognize that legislation requiring nursing facilities to charge equal

rates to Medicaid residents and private payers could require additional legislative appropriations which would jeopardize needed funding for home and community based care. Accordingly, the commission does not recommend that equal rates be mandated at this time.

5. Paperwork reduction. The commission recommends that the Legislature direct the Commissioner of Human Services to report to the Joint Standing Committee on Health and Human Services by June 1, 1999 with a plan to reduce paperwork in nursing facilities which must include consideration of the opportunities presented by advancing technology and the feasibility of linking data between the Minimum Data Set (MDS 2.0) and Medical Eligibility Determination (MED'96) forms.

6. Interaction with consumers and families. The commission recommends that the Legislature take the following actions:

A) direct the Department of Human Services to improve the provision of information on long-term care services, costs and performance; and
B) strengthen and make more independent the Long-term Care Steering Committee by allocating more resources to it and changing its duties so that it advises the Commissioner and the Legislature.

7. Flex beds. The commission encourages the Department of Human Services and the Maine Health Care Association to continue their work on a proposal to allow the use of "flex beds," by which the commission means that beds licensed for long-term or residential care may be used to meet the changing needs of residents and may be reimbursed according to the level of care provided. The commission cautions that any proposal must not compromise the quality of life of a facility's residents.

8. Regulatory barriers to high quality care. The commission recommends that the Legislature direct the Commissioner of Human Services to study and identify regulatory barriers to high quality care and make recommendations for relief or modification of rules and report to the Joint Standing Committee on Health and Human Services by January 1, 2000.

9. Long-term care insurance information. The commission recommends that the Legislature direct the Bureau of Insurance to:

A) collect information on long-term care insurance and provide a report by March 1 each year to the Commissioner of Human Services, the Joint Standing Committee on Health and Human Services and the public. The information collected should include the number and types of policies purchased by consumers, the cost of premiums, daily benefit levels and the duration of benefits. Information should also be collected on policies paying benefits to or for consumers, including the types of policies, daily benefit levels and remaining duration of benefits; and
B) conduct a study of the use of individual income tax credits as incentives to encourage the purchase of long-term care insurance. The study should analyze

the effectiveness of tax credits in encouraging the purchase of long-term care insurance in other states and the anticipated cost to the State from establishing a tax credit for all or part of the premium cost of qualifying long-term care policies. The Bureau should provide a report to the Joint Standing Committee on Health and Human Services by January 1, 2000.

10. Report on changes in long-term care. The commission recommends that the Legislature direct the Commissioner of Human Services to consult with the Long-term Care Steering Committee, study changes in the delivery and financing of long-term care and report to the Joint Standing Committee on Health and Human Services by March 1, 2000. The report should cover changes in the delivery of long-term care in facilities and by home and community-based providers, changes in reimbursement systems including, but not limited to the changes in the Medicare reimbursement system, the use of "flex beds," the quality of care provided to residents of Maine, the growth in home and community-based care and the availability of services and providers in all parts of the State.

11. Medicare reimbursement system. The commission recommends that the Legislature pass a legislative resolution opposing the change to the proposed prospective payment reimbursement system that has been instituted in the federal Medicare program for the reasons that it is flawed in its structure and that its application will cause financial hardship for Maine's long-term care facilities and will reduce the quality of care provided to Maine's residents. The commission is concerned that the new reimbursement system will lower reimbursement for care, cause the loss of skilled nursing facility beds available under the Medicare program and restrict access to care for residents who are eligible for Medicare. Maine was one of six states participating in a demonstration project under the Medicare program. Nursing facilities in all states that participated in the demonstration project are in jeopardy because the system omitted reimbursement for Part B pharmaceuticals for providers in states that participated in the demonstration project. Commission members fear that the new reimbursement system will lower reimbursement for staffing to a national average, which is below the staffing level provided in Maine facilities, and thus will lower the quality of care provided in Maine.

VIII. IMPLEMENTING LEGISLATION

Emergency preamble. Whereas, Acts of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, the quality of care for residents in nursing facilities is threatened by high staff turnover, the burdens of excessive paperwork, and the current rates and methods of reimbursement used in the Medicare and Medicaid programs; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

Be it enacted by the People of the State of Maine as follows:

Sec. 1. Pilot projects on performance contracts in the nursing facility field. The Department of Human Services shall undertake pilot projects to reward high quality care in nursing facilities based on successful performance by the facilities. Successful performance must be measured using quality indicators from the Minimum Data Set already in use and from consumer and family satisfaction surveys. Successful performance may be rewarded by means of financial rewards, favorable public information, decreased regulation by the State or in other ways. The department shall be cautious to avoid inadvertently restricting access to care, to act in order to preserve consumer choice in urban and rural settings to the extent practical and to avoid preserving with financial or other assistance facilities that perform poorly because of incompetence.

Sec. 2. Report regarding Principles of Reimbursement. The Department of Human Services shall develop new approaches to reimbursement of nursing facilities under the Medicaid program targeted to specific problems, including the following, and shall report to the Legislature's Joint Standing Committee on Health and Human Services by February 1, 1999:

1) Examining operating costs to determine specific areas in which reimbursement may be inadequate. In doing so the department should consider the following options for reimbursement:
   - reimbursing facilities' costs for medical directors at a level reflecting the increased acuity of nursing facility residents;
   - merging the indirect and routine cost components;
   - reimbursing for all aspects of direct care for residents, including medical supplies, in one cost category so that they may be adjusted by case mix;
   - reviewing the most recent information from time studies being used for the Medicare prospective payment system and making a determination whether the time study presently in use reflects nursing costs in Maine's facilities and is appropriate for use; and
   - studying employment markets, labor costs and turnover rates at facilities around the State and, for those facilities that are at or above direct care limits, developing methods for providing increased reimbursement. This study should be done in conjunction with the Department of Labor and should build upon the work already done by that department and by the Maine Health Care Association;

2) Re-basing reimbursement rates from 1993 to 1996 or the most recent complete audited year and adopting new medians and new cost caps in order to keep up with the higher costs faced by facilities due to inflation, increased paperwork requirements, and higher resident acuity. In doing so the department shall consider the following options for re-basing:

- re-basing costs with an emphasis on those most directly impacting high quality resident care; and
- re-basing cost components on a rolling schedule whether periodically or when a stated event occurs, such as when 50% of the facilities are over the cap;

3) Tying caps applicable to the different cost components to the size of the facility, placing higher caps on the smaller facilities, which are often in rural areas, in recognition of the higher costs faced by those facilities and the importance of maintaining access to nursing facility care in rural areas; and

4) Removing any reimbursement incentives that have unintended adverse impacts on resident care.

Sec. 3. Minimum staffing requirements. The Department of Human Services shall replace its current minimum staffing ratios with minimum staffing requirements that:

- are tied to the acuity level of residents and to the other needs of residents that effect the quality of their lives; and
- ensure that adequate numbers of direct care staff are available at all times to meet residents' needs.

The Commissioner of Human Services shall present a proposal to implement and fund these new requirements to the Legislature's Joint Standing Committee on Health and Human Services by May 1, 1999.

Sec. 4. Report on paperwork reduction. The Commissioner of Human Services shall report to the Joint Standing Committee on Health and Human Services by June 1, 1999 with a plan to reduce paperwork in nursing facilities which must include consideration of the opportunities presented by advancing technology and the feasibility of linking data between the Minimum Data Set (MDS 2.0) and Medical Eligibility Determination (MED'96) forms.

Sec. 5. Initiatives to make the Medicaid program more consumer friendly. The Department of Human Services shall take action to improve the provision of information on long-term care services, costs and performance and to strengthen and make more independent the Long-term Care Steering Committee by allocating more resources to it.

Sec. 6. Report on regulatory barriers to high quality care. The Commissioner of Human Services shall study and identify regulatory barriers to high quality care and make recommendations for relief or modification of departmental rules and shall report to the Joint Standing Committee on Health and Human Services by January 1, 2000.

Sec. 7. Annual report. Beginning March 1, 2000 and annually thereafter and report due January 1, 2000. The Bureau of Insurance shall collect information on long-term care insurance and provide a report by March 1 each year to the Commissioner of Human Services, the Joint Standing Committee on Health and Human Services and the public. The information collected must include the number and types of policies purchased by consumers, the

cost of premiums, daily benefit levels and the duration of benefits. Information must also be collected on policies paying benefits to or for consumers, including the types of policies, daily benefit levels and remaining duration of benefit. The Bureau shall also conduct a study of the use of individual income tax credits as incentives to encourage the purchase of long-term care insurance. The study must analyze the effectiveness of tax credits in encouraging the purchase of long-term care insurance in other states and the anticipated cost to the State from establishing a tax credit for all or part of the premium cost of qualifying long-term care policies. The Bureau shall provide a report to the Joint Standing Committee on Health and Human by January 1, 2000.

Sec. 8. Report on changes in long-term care. The Commissioner of Human Services shall consult with the Long-term Care Steering Committee, study changes in the delivery and financing of long-term care and report to the Joint Standing Committee on Health and Human Services by March 1, 2000. The report must cover changes in the delivery of long-term care in facilities and by home and community-based providers, changes in reimbursement systems including, but not limited to the changes in the Medicare reimbursement system, the use of "flex beds," the quality of care provided to residents of Maine, the growth in home and community-based care and the availability of services and providers in all parts of the State.

Emergency clause. In view of the emergency cited in the preamble, this Act takes effect when approved.

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APPENDIX A

Resolve of 1997, Chapter 81

APPROVED

JUN 12 '97

BY GOVERNOR

CHAPTER

81

RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY-SEVEN

H.P. 486 - L.D. 657

Resolve, to Establish the Commission to Examine Rate Setting and the Financing of Long-term Care Facilities

Emergency preamble. Whereas, Acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, this resolve establishes the Commission to Examine Rate Setting and the Financing of Long-term Care Facilities; and

Whereas, this resolve is necessary as an emergency measure to afford adequate time for the issues to be appropriately addressed by the commission; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

Sec. 1. Commission established. Resolved: That the Commission to Examine Rate Setting and the Financing of Maine's Long-term Care Facilities, referred to in this resolve as the "commission," is established; and be it further

Sec. 2. Commission membership. Resolved: That the commission consists of the following 15 members:

1. Two members of the Senate, appointed by the President of the Senate, one representing the majority party and one representing the minority party;

2. Two members of the House of Representatives, appointed by the Speaker of the House, one representing the majority party and one representing the minority party; and

3. Eleven other members appointed as follows:

A. The following members appointed by the Governor:

(1) The chair, who must have experience with rate setting;

(2) One representative of the Department of Human Services;

(3) One representative of the Long-term Care Steering Committee;

(4) One representative of the Maine Health and Higher Educational Facilities Authority; and

(5) One representative of a commercial lending institution; and

B. The following members appointed jointly by the President of the Senate and the Speaker of the House of Representatives:

(1) One representative of the long-term care ombudsman program;

(2) One representative of the Maine Health Care Association;

(3) One representative of the Maine Hospital Association;

(4) One representative of providers of long-term care services who is familiar with the principles of reimbursement;

(5) One representative of consumers of long-term care services who is familiar with the principles of reimbursement; and

(6) One representative of the American Association of Retired Persons; and be it further

Sec. 3. Appointments; meetings. Resolved: That all appointments must be made no later than 30 days following the effective date of this resolve. The Executive Director of the Legislative Council must be notified by all appointing authorities once the selections have been made. Within 15 days after appointment of all members, the Chair of the Legislative Council shall call and convene the first meeting of the commission; and be it further

Sec. 4. Duties. Resolved: That the commission shall examine the following issues concerning long-term care facilities:

1. The setting of rates for the different payers within the long-term care system, including monthly charges and charges for resident services and supplies, and ensuring affordability;

2. The levels of profit guaranteed by the rate of reimbursement, a comparison of rates among the different states and financial stability within the system;

3. The advisability of rate equalization between private and public payers, implementation of rate equalization and what the possible benefits and detriments might be for nursing facility residents;

4. The case mix payment system for private paying patients;

5. The possibility of regulating the long-term care industry in the manner of regulating public utilities; and

6. The relationship between staffing levels and quality of care and maintaining high-quality care; and be it further

Sec. 5. Staff assistance. Resolved: That the commission may request staffing assistance from the Legislative Council; and be it further

Sec. 6. Compensation. Resolved: That the members of the commission are not entitled to compensation or reimbursement of any type, except that members of the commission who are Legislators are entitled to receive per diem and reimbursement for travel and other necessary expenses related to their attendance at meetings of the commission; and be it further

Sec. 7. Report. Resolved: That the commission shall submit its report, together with any necessary implementing legislation, to the Second Regular Session of the 118th Legislature no later than December 15, 1997. If the commission requires an extension, it may apply to the Legislative Council, which may grant the extension; and be it further

Sec. 8. Appropriation. Resolved: That the following funds are appropriated from the General Fund to carry out the purposes of this resolve.

	1997-98
LEGISLATURE	
Commission to Examine Rate Setting and the Financing of Maine's Long-term Care Facilities	
Personal Services	$1,100
All Other	1,500
Provides funds for the per diem and expenses of legislative members and miscellaneous costs, including printing, of the Commission to Examine Rate Setting and the Financing of Maine's Long-term Care Facilities.	
LEGISLATURE TOTAL	$2,600

Emergency clause. In view of the emergency cited in the preamble, this resolve takes effect when approved.

APPENDIX B

Interim Report of the Commission to Examine Rate Setting and the Financing of Maine's Long-term Care Facilities

STATE OF MAINE
118TH MAINE LEGISLATURE

COMMISSION TO EXAMINE RATE SETTING AND THE
FINANCING OF LONG-TERM CARE FACILITIES

Joseph M. Kozak, Chair

November 13, 1997

Honorable Elizabeth H. Mitchell
Chair, Legislative Council
118th Maine Legislature

Dear Speaker Mitchell:

I am writing on behalf of the Commission to Examine Rate Setting and the Financing of Long-term Care Facilities to request an extension of our reporting deadline.

As you know, the resolve establishing this study commission was signed into law as an emergency on June 12th. Under the terms of the resolve, the first meeting was to be held before the end of July. The resolve establishes a reporting deadline of December 15th.

As the Legislature clearly understood, the scope and magnitude of this study are significant. The issues surrounding rate setting for long-term care facilities are many, interrelated and difficult. The time-line established for the commission by the resolve provided some five months to undertake the study.

However, as you are well aware, the appointments to this commission were only recently completed. As a result, we were first convened on November 3, forty-two days before our deadline to issue a report.

Members of the commission are unanimously of the opinion that the issues raised by the study are complex, difficult and cannot be treated quickly or in a cursory manner. The commission has received data showing that that the nursing facilities in the state currently carry on the order of a quarter billion dollars of debt, a sizable chunk of which is backed by the State's moral obligation. The commission feels it would be imprudent to produce any recommendations that could impact the repayment of this debt without first undertaking a thorough examination of the industry and the financial implications of any changes we might recommend. This will obviously require substantial time.

Commission members are of the opinion that the commission has insufficient time to undertake a credible study and to produce a report that will be of use to the Legislature. We also note that the issues raised by the study are sufficiently interrelated that it seems inappropriate and counter-productive for us to focus on some subset of the issues for

study; a report on such a subset of issues would likely amount to little more than a recitation of the interrelationship of those issues with other issues not examined.

We have been meeting weekly in an effort to begin the examination of the issues. We have been reviewing data and have developed a better sense of the scope of the study and the time we feel is needed to complete it. We have reviewed data on the financial condition of the industry (including long-term debt, financial ratios and comparisons with other states), staffing levels, the quality of care assessment system and the case mix reimbursement system. The data is voluminous and raises as many important questions as it answers.

In the process of examining the data we have noted a number of issues not specifically identified in the resolve that we feel need to be examined in the course of any serious study of the subject. The list is dynamic but presently includes these issues:

- What is the interface of the long-term care industry with the rest of the health care industry (how do decisions affecting one impact the other)?
- What are the effects of regulatory requirements on the industry (e.g., nurse time spent filling out forms)?
- How should and does the State's moral-obligation backing of industry debt affect state policy decisions with regard to the industry?
- How viable and stable is the industry today?
- What is the quality of current industry management and how can it be assessed?
- How do staffing levels relate to quality of care?
- What are the financial effects of the recent federal repeal of the so-called Boren Amendment?
- How will managed care impact the industry and how will it affect the State's control over the quality of care?

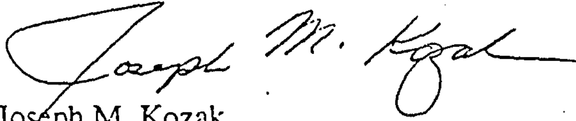
Based on our evaluation of the scope and magnitude of the study, the commission unanimously requests an extension until November 1998.

We are aware that the session begins in January. We are also aware that there are a number of issues associated with extending this study into the session, including the serious scheduling difficulties it will create for a number of members of the commission and the reduced availability of legislative staff.

We are asking for an extension to the next interim in order to avoid the difficulties associated with attempting to conduct the study during the session. This extension would allow us to set the work aside during the session and to recommence work in earnest after the session finished. Our report and recommendations would be available to the Legislature in the following session.

On behalf of the commission, I would like to thank the Council in advance for its consideration of this request. We look forward to the Council's decision and any further guidance it might care to provide to us in this matter.

Sincerely,



Joseph M. Kozak
Chair

cc: Members, Legislative Council
Sally Tubbesing
Commission members
Commission service list

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II - 2

118th Maine Legislature

Commission To Examine Rate Setting And The Financing Of Long-Term Care Facilities

Interim Report
December 15, 1997

Members:

Joseph M. Kozak, Chair
Senator Philip E. Harriman
Senator Rochelle Pingree
Representative Elaine Fuller
Representative Jean Ginn-Marvin
Francis Finnegan
Michael Goodwin
Harmon D. Harvey
Carolyn Kasabian
Michael McNeil
Judy McGuire
Hilton Power
Wayde Rankin
Betsy Sweet
Sally Wagley

Staff:

Jon Clark, Legislative Counsel
Jon Kachmar, Researcher
Office of Policy and Legal Analysis
13 State House Station
Augusta, ME 04333, Rm. 101/107/135
(207) 287-1670

Interim Report of the Commission to Examine Rate Setting and the Financing of Long-term Care Facilities

The Commission to Examine Rate Setting and the Financing of Long-term Care Facilities Commission, established by Resolves of 1997, Chapter 81 (copy attached as Appendix A), was directed to examine a variety of issues related to the long-term care industry and to issue its report with necessary legislation by December 15, 1997.

On November 13, 1997, the commission submitted a letter to the Legislative Council requesting an extension of its deadline until November 1998 (letter attached as Appendix B). On November 20, pursuant to the authority granted under Resolves of 1997, Chapter 81, Section 7, the Council approved the requested extension.

The commission was called to its first meeting on November 3, 1997. It held three subsequent informational meetings on November 12, 19 and December 3 in which it received voluminous data concerning various aspects of the long-term care industry. The commission will hold an additional planning session on December 17 and expects to resume its study in April, 1998, following the Second Regular Session of the 118th Legislature.

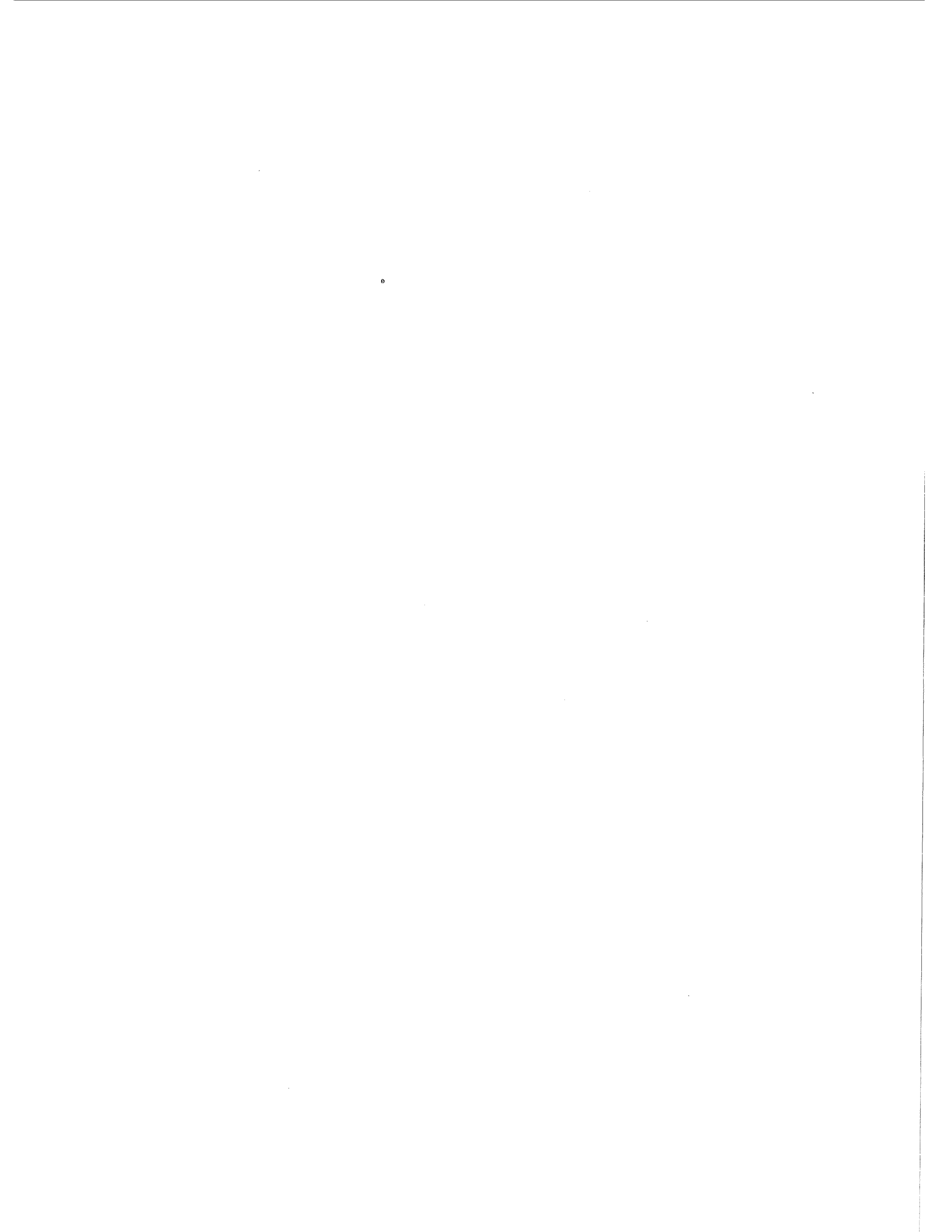
Findings and Recommendations

In order to complete its examination of the complex issues outlined in Resolves of 1997 Chapter 81, the commission finds it will require supplemental funding. The commission expects to need to hold ten to twelve meetings during the 1998 interim. It also finds that in order to obtain an adequate understanding of the complex issues surrounding rate setting for long-term are facilities, it will need to bring before it at least two expert consultants. The commission estimates that the cost of funding the expenses of the consultants, who will come from out of state, will be approximately $2,500 a person. In order to fund this expense, to continue to fund expenses and per diem for legislative members and to cover miscellaneous costs of copying and mailing materials, the commission recommends the commission receive supplemental funding of $10,000.

Pursuant to its authority under Resolves of 1997, Chapter 81, Section 7, attached to this report as Appendix C is draft legislation which implements the commission's recommendation for supplemental funding.

APPENDIX C

Report of four consumer members of the Commission to Examine Rate Setting and the Financing of Maine's Long-term Care Facilities, 1998



February 25, 1998

TO: Members, Joint Standing Committee on Health and Human Services

FROM: Harmon Harvey, Long Term Care Steering Committee
Hilton Power, American Association of Retired Persons
Betsy Sweet, Representing Consumers of Long Term Care Services
Sally Wagley, Long Term Care Ombudsman Program

RE: Preliminary Findings of Consumer Representatives on the "Commission to Examine Rate Setting and the Financing of Maine's Long Term Care Facilities"

Summary of Preliminary Findings

Note: The views expressed here are those of the authors and not those of the Rate Setting Commission as a whole.

1. Principles of fairness require the State to equalize rates charged to Medicaid and to private payors.

2. Short of rate equalization, changes should be made to State law and regulations to provide greater protection to private pay residents.

3. Central to the issue of rate equalization and its impact on the Medicaid budget is the adequacy of current Medicaid reimbursement to nursing homes; more time and information are needed to make an informed judgment on this issue.

4: The evidence on the profitability in the nursing home industry is contradictory; more information and analysis is needed before reimbursement is increased.

5. To the extent that profits are low, the nursing homes bear some responsibility.

6. The Legislature should examine the appropriateness of continued public financing of nursing homes though low-interest loans from the Maine Health and Higher Education Facilities Authority.

7. There is room for improvement in the quality of care in Maine nursing homes; the reimbursement system should provide incentives for quality.

8. The State should consider approaches to reimbursement which encourage creativity, innovation and competition on the part of nursing homes: such as quality incentive programs, the use of vouchers, and a simpler reimbursement system.

9. There should be more openness and consumer involvement in State reimbursement of nursing homes.

Introduction

Last fall, the four of us were appointed to this "Commission to Examine Rate Setting and the Financing of Maine's Long Term Care Facilities" as representatives of consumer interests. As you know, the Commission has been granted an extension until November 1998 to submit its report to the Legislature. The extension was requested due to the complexity of the issues involved and the long delay between adjournment of the Legislature and the completion of appointments to the Commission.

Several weeks ago, the Health and Human Services Committee requested that the Rate Setting Commission present a report to the Committee by March 1, 1998. We agree that the Committee and the Legislature should receive input from the Rate Setting Commission before the end of this session. To this end, we offer the following preliminary findings regarding the issues presented to the Commission. ***We emphasize that the views expressed here do not represent those of the Commission as a whole.***

Our examination of the issues presented in L.D. 657, "Resolve, to Establish the Commission to Examine Rate Setting and the Financing of Long Term Care Facilities," required us to balance a number of competing considerations: the quality of care in nursing facilities; the affordability of nursing home care, from the point of view of state taxpayers as well as private pay residents; the availability of funds for home and community based care; the impact of potential changes on the Medicaid budget; and the financial stability of a needed industry. Maine currently spends more than $273 million for long term care services, of which approximately 80 percent goes to nursing homes.

Discussion of Preliminary Findings

1. Principles of fairness require the State to equalize rates charged to Medicaid and to private payors.

One of the charges to the Rate Setting Commission was to examine the "affordability" of rates charged within the long-term care system. L.D. 657, Sec. 4, para.1. A focus of the public hearing on LD. 657 was the position of "private pay" residents in nursing homes, who occupy approximately 17 percent of Maine nursing home beds. (Letter from Michael McNeil to Health and Human Services Committee, 4/2/97.) These individuals are usually people of modest income do not qualify for Medicaid coverage of a nursing home stay because they have savings or countable assets in excess of either $2,000 for an individual or $3,000 for a couple. Most private pay residents eventually spend down all their assets in a matter of months or a few years at the most, to the point where they are impoverished and eligible for Medicaid.

From the perspective of these residents and their families, nursing home rates are not "affordable." This is borne out by calls to legislators, the Long Term Care Ombudsman Program and the Department of Human Services following the repeal of the gross receipts tax, when residents and their families were faced with rate increases rather than decreases in many nursing homes. (See "Final Report, Select Committee to Study Rate Increases in Nursing Homes, August 1996," Attachment B.)

Private pay residents have also complained about having to pay higher rates than those paid by Medicaid for the same services. At the time the Select Committee studied this issue, a review of nursing home rates by a consultant to the Maine Health Care Association showed that nursing homes charge private-pay residents as much as 39 percent more than they charge Medicaid residents. At the time the Select Committee held its hearings, private-pay rates were on average of 18.8 percent higher than Medicaid rates. (Final Report, Select Committee to Study Rate Increases in Nursing Homes, Attachment C, Table 1.) (The Rate Setting Commission did not receive more current data regarding differences in rates.) The disparity in rates may be a cause for cynicism for some residents and their families and may encourages people to attempt to shelter or transfer assets, thereby hastening their eligibility for Medicaid.

In response to suggestions that rates be equalized, the Maine Health Care Association has responded that the Medicaid rate is inadequate to cover the costs of providing quality care to residents; and that higher charges to private pay residents are necessary. Without this source of income, it is said, the quality of care will decline and facilities will close. (Michael McNeil letter, 4/2/97, p. 2.)

If Medicaid reimbursement is indeed inadequate, then fairness requires that the State stop shifting the cost to private pay residents and increase its payments for Medicaid residents. However, as detailed below, we consider the adequacy of Medicaid nursing home reimbursement to be an open question which needs far more scrutiny before an increase in Medicaid rates is approved. An extension of time and the ability to consult with disinterested experts on this topic would allow the Rate Setting Commission to give a more definitive answer to the Health and Human Services Committee. It would also allow the Commission to determine what cost, if any, there would be to the State if rate equalization were implemented.

2. Short of rate equalization, changes should be made to State law and regulations to provide greater protection to private pay residents.

Admission to a nursing home usually takes place in a crisis atmosphere, following an injury or illness or a hospitalization. Residents and families do not usually have the luxury of making a deliberate and reasoned choice of a nursing home. Those who do attempt to "comparison shop" for a facility providing quality care at a reasonable price may be confused by the facility's explanation of charges as well as by the agreement they

are required to sign on admission. They may not understand that, in addition to the per diem rate quoted by the facility, they may also face extra "a la carte" charges for items such as incontinence supplies, over-the-counter medication, and haircuts. These charges may come at a considerable mark-up from the retail price. Residents and their families, often confused about what is covered in the monthly rate and what is subject to an extra charge, may not challenge what seem like excessive charges. (Summary of 12/10/97 Rate Setting Commn mtg. by Jon Clark and Jon Kachmar, OPLA; Testimony of Brenda Gallant, Long Term Care Ombudsman Program, re L.D. 657, 4/1/97.)

Another difficulty faced by some private pay residents and their families comes in the form of a collection action by a facility against an unfortunate relative who signed on as a "responsible party" on an admissions contract. Some facilities do this even though federal regulations have forbidden the practice for many years. (Testimony of Brenda Gallant, 4/1/97.) Relatives who are pursued by facilities for payment often do not know their rights and may pay from their own pockets after a parent's life savings have been exhausted.

As the result of the passage of L.D. 991, "An Act to Address Issues Raised by the Select Committee to Study Rate Increases in Nursing Homes" last session, the Department of Human Services is currently developing a standardized contract which all facilities in the state will be required to use. This will make it easier for consumers and families to comparison shop. A list of residents' rights and a prohibition on pursuit of "responsible parties" for payment would also make residents' rights less vulnerable to overreaching by the facility.

We would like to see consumer protections for this group be taken a couple of steps further through regulatory changes which would accomplish the following:

- Require nursing homes to include within their per diem rate all those services and supplies which are covered under the Medicaid rate. This would allow consumers and their families to comprehend quickly and easily the package of services covered in the per diem rate and would enable them to make a quick comparison between the charges made by different facilities. This would also help consumers understand what "extras" they will be charged for once they spend down and become eligible for Medicaid.

- Require nursing homes to provide potential residents and families on admission with a list of "a la carte" charges. Also require at least 30 days notice to residents a la carte charges are increased. This would allow consumers and families to predict what the total charges will be and to develop a budget. We would like to see the Legislature direct that the Department adopt rules accomplishing these changes.

3. Central to the issue of rate equalization and its impact on the Medicaid budget is the adequacy of current Medicaid reimbursement to nursing homes; more time and information are needed to make an informed judgment on this issue.

Traditionally, consumer advocates have lobbied for increases in payments to health providers, on the theory that more money means greater access to care and better quality of care. In the field of long term care, however, the record shows that continual increases in the nursing home budget have meant fewer resources for home and community based care, which consumers strongly prefer. Moreover, there is little evidence that more reimbursement means better quality of care, without the right incentives.

National industry data indicate that Maine's level of reimbursement to its nursing homes is the sixth highest in the nation. (U.S. Administration on Aging, State Source Book, 1995.) Nevertheless, the Maine Health Care Association, asserts that the Medicaid program does not pay the full cost of caring for Medicaid residents. The Department of Human Services' "Principles of Reimbursement" pay only for "allowable costs," and place limits on the extent to which it will reimburse those allowable costs. On this basis, the Association claims that it loses $16.7 per year in caring for Medicaid residents. (Michael McNeil letter, 4/2/97, p. 2.) A discussion at the Rate Setting Commission indicates that the Department of Human Services may at some point in the near future seek an appropriation of approximately $6 million from the general fund in order to increase reimbursement to nursing homes. (Summary of 11/19/97 Commn mtg. by Jon Clark, OPLA.)

The purpose of the Principles of Reimbursement is to provide reimbursement to facilities which is adequate to provide quality care while providing incentives to hold costs down. (State of Maine Dept. of Human Services, Principles of Reimbursement for Nursing Facilities, Sec. 10.) While the possibility exists that alleged losses may be due to overly restrictive principles, it is also possible that the industry itself is responsible for its own losses, because of poor business practices and a refusal to recognize a changing market in which both consumers and third party payors (such as Medicaid) are seeking out less restrictive forms of care.

Simply put, more information is needed in order to determine whether current levels of Medicaid reimbursement are adequate to allow nursing homes to provide quality care. On this point, Rep. Elaine Fuller, a member of the Rate Setting Commission, requested that the Health Care Association provide detail on these alleged underpayments. (Summary, 12/17/97 Mtg. of Rate Setting Comm, by Jon Clark and Jon Kachmar, OPLA.) More time is needed for the Rate Setting Commission to review this information once it is provided.

In some respects, the rules of Medicaid reimbursement favor nursing homes:

- The rules allow for-profit facilities to keep an 8 percent return on equity. (Principles of Reimbursement, Sec. 44.6.) While it may be true that many facilities have very low equity and get little from this rule, this is a business decision for which facilities must take responsibility.

- The rules allow facilities to get reimbursed for their fixed costs (buildings, fixtures, equipment, motor vehicles, and the like) through "straight-line depreciation," which allows facilities to take excess depreciation in the early years of ownership of a facility. (Principles of Reimbursement, Sec. 44.26.) One strategy (stated explicitly in at lease one certificate of need application) that a facility may use is to buy a facility, take the excess depreciation, and then sell the facility after ten years, when returns from depreciation start to decline.

- Facilities are shielded to some extent from losses from low occupancy by State rules which allow facilities to spread their fixed costs over the number of beds actually occupied, applying a penalty only when the occupancy declines to less than 90 percent (85 percent for smaller facilities). Principles of Reimbursement, Section 44.9. The average occupancy rate for facilities as of fall of 1997 was 89 percent. (Nursing Facility Occupancy Rates, Dec. 1994 - Nov. 97, submitted by DHS Bureau of Medical Services, 11/10/97.)

- The Certificate of Need laws applicable to nursing homes provide some protection to the existing providers by keeping out potential competitors. (See 22 M.R.S.A. Section 301 et seq.)

Information from other states is inconclusive with respect to the likely impact of rate equalization on the Medicaid budget. While North Dakota reported an increase in reimbursement due to rate equalization, Minnesota did not believe that the Medicaid budget increases could be attributed solely to rate equalization. Contacts in Minnesota noted that any increase in Medicaid payments would be offset by the fact that private pay residents would "spend down" more slowly, postponing the day when they would need Medicaid. (Memo to Commn from Jon Kachmar, OPLA, 12/2/97.)

4. The evidence on the profitability in the nursing home industry is contradictory; more information and analysis is needed before reimbursement is increased.

One of the charges to the Rate Setting Commission in L.D. 657 was to examine "the levels of profit guaranteed by the rate of reimbursement. . . . and financial stability within the system." L.D. 657, Sec. 4, para. 2. These issues are crucial because the

nursing home industry in Maine, unlike other health care sectors such as hospitals, is dominated by for-profit providers, whose primary incentive in providing care is the rate of return. The level of profit potentially affects both the supply of care (i.e., the number of nursing homes who stay in business) and the quality of care (i.e., the resources that nursing homes have available to invest in qualified staff, food, physical plant, medical supplies, activities and the like).

With respect to profitability, the evidence is contradictory. Nursing home representatives provided the Rate Setting Commission with a plethora of evidence that the industry is in trouble: in 1994 profits were, on average 1.6 percent, compared with a national average of 3.5 percent; debt service coverage ratios were among the lowest (worst) in the country; and liquidity was the lowest (worst) in the country. (Maine Health Care Assn, Key Statistical and Financial Comparisons Abstract from 1996 Edition of "Guide to Nursing Home Industry,")

On the other hand, there are also signs that the nursing home business continues to be attractive to investors and that it does indeed generate revenue for owners and administrators, even if that revenue is not technically considered "profit." Those positive signals are:

- Salaries to administrators in 13 facilities were in the six figures in 1995. (See "Final Report, Select Committee to Study Rate Increases in Nursing Homes, August 1996," Attachment D, Nursing Facilities Administrative Costs, 1993-95.) (These salaries are considered a cost and do not show up as profit.)

- There has been brisk activity in the Bureau of Elder and Adult Services' Certificate of Need division, which reviews applications for purchase, construction or additions to nursing homes by companies both within and outside the state. Since 1998, there have been 17 applications for C.O.N., with capital costs totaling $58.5 million. (Information submitted by BEAS to Commission to Study Certificate of Need Laws, 1997.)

- A "Management Agreement" obtained from BEAS under the Freedom of Information Act shows payments of $48,000 per month by an out of state company to two owners of an in-state nursing home chain in exchange for the right to manage the facilities, control revenues and an option to buy.

We suspect that, while profits may appear low, some facilities may still be generating a good income for some individuals through high salaries, dividends and management fees. For this reason, a request has been made for information on the amount paid out by nursing homes for salaries, management fees and dividends, as well as how these items are reflected in the facilities' computation of profit and loss. (Summary of 11/19/97 Commission meeting, by Jon Clark, OPLA, p. 6.) Additional time is needed for the Rate Setting Commission to review this information once it has been obtained.

5. To the extent that profits are low, the nursing homes bear some responsibility.

We agree with the nursing home industry that one factor in the lower profits of Maine nursing homes is that Maine nursing homes are smaller and do not benefit from the economies of scale enjoyed by nursing homes in other states. We also agree that nursing home profits have been affected by the use of stricter medical criteria for Medicaid coverage of nursing homes care under the "MED 94/ 96" assessment tool, which has caused most facilities to have empty beds and therefore less revenue. We do not, however, think that State long term care policy should be driven by concerns for an industry's bottom line, but rather by the wise use of state funds for the care of elderly and disabled adults. It should be up to industry to adapt to a changing market and public policy.

To the extent that profits are low in some nursing homes, the providers themselves bear some responsibility. Industry practices which have contributed to low profits are:

- Many facilities have taken little interest in consumer demand for a less restrictive, more home-like environment. In spite of "MED 94," facilities were initially slow to convert beds to residential care and accordingly bear some responsibility for empty beds.
- Few providers have used their physical plant and staff to move into the home health industry, for which there is a strong need in rural parts of the state.
- Similarly, some providers have been slow to make their beds dually eligible for Medicare and Medicaid, even though they are required to by law.
- As stated above, some facilities have not chosen to build equity (as many Maine businesses do) but have taken full advantage of Maine reimbursement rules which allow them to extract excess depreciation, resulting in heavily leveraged businesses.

6. The Legislature should examine the appropriateness of continued public financing of nursing homes though low-interest loans from the Maine Health and Higher Education Facilities Authority.

Under Maine statute, nursing homes may apply to the Maine Health and Higher Education Facilities Authority (MHHEFA) for low-interest loans financed by public bonds. As of November 1, 1997, thirty-six nursing homes had outstanding loans

totaling $135,778,674. (Letter from Michael R. Goodwin, MHHEFA, to Rate Setting Commn, 11/17/97, with attachment.) According to the Maine Health Care Association, as of April 1997 there were 15 to 20 facilities that were unable to meet their required debt service coverage ratio. (Michael McNeil Letter, 4/2/97, p. 3.) According to Robert O. Lenna, Executive Director of MHHEFA, last April, five nursing homes were in arrears in the repayment of their loans, ranging from five to nine months. (Letter to Commn member Hilton Power, 4/30/97.)

Six of the MHHEFA loans, totaling $27,905,440, were made after the stricter medical eligibility criteria in the "MED 94" assessment tool was put into place, and after there were signs that the facilities were likely to experience low occupancy and therefore reduced revenue. (List attached to Michael Goodwin Letter to Rate Setting Commn.)

Last session, at the public hearings on the rate equalization bills, representatives of MHHEFA argued against adopting rate equalization on the ground that it would reduce nursing home profits and thereby impair the ability of the industry to re-pay its' loans to MHHEFA. (Testimony of Robert Dunn, MHHEFA, re L.D. 1219, "An Act to Prohibit Nursing Homes from Charging Private-Payor Patients More Than Medicaid Patients.") Similarly, the Maine Health Care Association interprets MHHEFA's enabling legislation, 22 M.R.S.A. Section 2072, as "preclud[ing] the Legislature from taking any action which could impair the ability of any bondholder under the MHHEFA program to meet their moral obligations under the bonds." (Michael McNeil Letter, 4/2/97, p. 3.)

It appears that we as a state are held hostage when we make loans of this type to nursing homes. By making these loans, we wed ourselves to perhaps outdated public policy which favors an industry's bottom line rather than good care for our citizens and sound fiscal policy. The State has gotten itself into a bind by making these loans to nursing facilities, particularly after public policy indicated a trend away from the use of nursing homes to home and community based care.

7. There is room for improvement in the quality of care in Maine nursing homes; the reimbursement system should provide incentives for quality.

Maine is thought by many to have good nursing homes, compared with other states in which care may be truly abominable. (Summary of 11/19/97 Commission mtg. by Jon Clark, OPLA, p. 3.) This is attributed to higher rates of reimbursement, high licensing standards and perhaps to a culture which values the elderly.

Nevertheless, we think that "better than other states" is not good enough and that we, as consumers, should have higher standards for the care of the elderly and disabled. Gerontological research indicates that problems like incontinence, depression, immobility and skin breakdown are by no means inevitable in old age. Yet the data on "quality indicators" kept by the Department of Human Services' case mix project

indicate that as of July 1997, 64.2 percent of nursing home residents were incontinent, 19.6 percent suffered from depression, and 8.9 percent had pressure ulcers. ("Multistate Nursing Home Case Mix and Quality Demonstration Maine: Quality Indicators," charts submitted by Alison Moore, R.N., DHS Bureau of Medical Services, 11/10/97.) In recent years, two entire facilities have been shut down or taken over because of widespread deficiencies in the quality of care. (These facilities Greene Acres, in Greene, and Russell Park Manor, in Lewiston.) Substantial fines have been levied against at least four others.

The following changes in Maine's approach to nursing home care should be considered as ways to enhance the quality of care in Maine nursing homes:

- The use of quality indicators has provided us with a wealth of reliable data on the quality of care and outcomes for residents in Maine nursing homes. As a supplement to this, we recommend the development and use of "quality of life" indicators which are less oriented toward medical care but focus more on resident choice in such matters as bedtime, mealtime, diet and activities. Such indicators are currently being developed in connection with the Department of Human Services' new case mix project for residential care facilities. (Information from Alison Moore, R.N., DHS, Bureau of Medical Services.)

- Address staffing problems in nursing homes. According to the Long Term Care Ombudsman, widespread staffing problems in Maine nursing homes seriously compromise the quality of care. Last session a task force on minimum staffing was established under L.D. 1133, "Resolve, to Ensure Quality Care to Residents of Nursing Facilities through the Establishment of a Task Force on Minimum Staffing." The task force is about to issue a report indicating an increase in minimum staff-to-resident ratios. While higher ratios will held, regulation should go a step further by requiring facilities to maintain adequate staff coverage to meet the needs of the particular mix of residents, based on their acuity.

- Identify reasons for high staff turnover in Maine nursing homes (estimated by some within the industry to be as high as 100 percent), and require facilities, as a condition of Medicaid reimbursement, to take corrective action.

- Look at opportunities in the reimbursement system to enable facilities to attract qualified staff. High employment rates in southern Maine are making it difficult for facilities to attract and retain certified nurses' assistants. The Legislature and the Department of Human Services should consider the use of "wage pass-throughs," under which money would be made available to facilities exclusively for the use of wages.

- Ensure that registered nurses who work in Maine nursing homes have training in gerontology. This might mean working with nursing schools in the state, as well as with nursing boards and organizations with respect to continuing education.

- Strengthen the Department's licensing and certification function, which is compromised. Ensure that deficiencies in nursing home care are penalized promptly and that fines are commensurate with the damage done. Recently, several facilities cited for deficiencies have been able to delay the payment of fines for as long as eight months.

- Ensure that administrators in facilities in which deficiencies are serious or widespread are held accountable by their licensing board.

8. The State should consider approaches to reimbursement which encourage creativity, innovation and competition in the nursing home industry: such as quality incentive programs, the use of vouchers, and a simpler reimbursement system. .

The extent and type of regulation of nursing homes in Maine may be stifling any inclination toward offering high quality care in a more home-like environment. There are a variety of alternatives to the way we now regulate and reimburse nursing homes. We have not studied any of them enough to recommend, at this point, that they be adopted, but we would like to see the Rate Setting Commission and eventually the Legislature consider the following possibilities:

- Eliminate Certificate of Need requirements for nursing homes, and allow new providers to enter the system, as long as they meet standards of competence and quality. This would encourage competition. (We acknowledge that the Commission to Study the Certificate of Need Laws has recommended a continuation of C.O.N. requirements applicable to nursing homes.)

- Consider letting the market work. Rather than reimburse facilities for empty beds by reimbursing them fully for their fixed costs, provide incentives for facilities to fill those beds. While this might mean fewer facilities in the state, those that would remain would be more financially stable and perhaps offer higher quality care. The state might then be able to offer quality nursing home care to our citizens within the current Medicaid budget, and continue to invest in home and community based care. The trade-off would be that consumers and families would not always be able to find a nursing facility close to home convenient for families to visit. We will encourage the Long Term Care Steering Committee to seek input from the public on these issues.

- Adopt a simpler Medicaid reimbursement system. . Rather than dog facilities every step of the way as to how they use Medicaid funds, we should consider allowing nursing homes more discretion as to how to spend the funds, while holding them to strict standards of quality. The current system, which provides reimbursement to facilities under four "cost components" (increased from two components in the late 1980's), offers facilities perverse incentives to divert direct care staff to activities which are of less direct benefit to residents, such as housekeeping and bookkeeping.

- Adopt a "quality incentive program" for facilities, under which facilities are rewarded for providing good outcomes for residents. The Department of Human Services currently has an initiative underway to adopt such an incentive program for residential care facilities, as part of its case mix project for those facilities. Quality would be measured by quality indicators, as well as quality of life indicators.

- Provide Medicaid recipients with vouchers which allow them to negotiate with facilities for a good care package at a reasonable price. Recipients could pocket any difference between the Medicaid rate and the monthly rate, to be used for goods and services which enhance the resident's health or quality of life. Such a voucher system would need to include a strong program of consumer education.

9. There should be more openness and consumer involvement in State reimbursement of nursing facilities.

L.D. 657 directed the Commission to consider "the possibility of regulating the long-term care system in the manner of regulating public utilities." Sec. 4, para. 5. We were unable to reach consensus with respect to the formation of a P.U.C. for long term care facilities. We did agree, however, that the public interest is just as strong with respect to long term care rate setting as it is with respect to rates for electric power, affecting access to and quality of nursing home care, as well as the availability of home and community based care. The promulgation of rules governing nursing home rates, as well as negotiations over how those rules apply to different providers, are generally a matter for providers and the Department of Human Services. Our hope is that a structure for formal consumer involvement can be developed.

APPENDIX D

List of members of the Commission

COMMISSION TO EXAMINE RATE SETTING AND THE FINANCING OF LONG-TERM CARE FACILITIES

Chapter 81, Resolves of 1997

Membership

Appointments by the Governor

Joseph M. Kozak, **Chair**
P.O. Box 358
Manchester, Maine 04351
Tel: 621-4390

Harmon D. Harvey — Representing Long-term Care Steering Committee
7 Mayflower Lane
Hallowell, Maine 04347
Tel: 622-6896

Michael Goodwin — Representing Maine Health & Higher Educational Facilities Authority
MEH
P.O. Box 2268
45 University Drive
Augusta, Maine 04330
Tel: 622-9386

Michael McNeil — Representing Commercial Lending Institutions
Berry, Dunn, McNeil & Parker
100 Middle Street
Portland, Maine 04112
Tel: 775-2387

Francis Finnegan — Representing Department of Human Services
Bureau of Medical Services
11 State House Station
Augusta, Maine 04333-0011
Tel: 287-2674

Appointments by the President

Sen. Rochelle Pingree — Senate Member
92 Mills Street
North Haven, Maine 04853
Tel: 867-0966

Sen. Philip Harriman — Senate Member
P.O. Box 790
Yarmouth, Maine 04906
Tel: 846-0799

Appointments by the Speaker

Rep. Elaine Fuller Pond Road P.O. Box 187 Manchester, Maine 04351 Tel: 622-0293	House Member
Rep. Jean Ginn Marvin Cranbrook Drive Cape Elizabeth, Maine 04107 Tel: 799-6283	House Member
Deborah Williams 121A Main Street Topsham, Maine 04086 Tel: 775-5258	Consumers of Nursing Facility Service

Joint Appointments

Sally Wagley Levey & Wagley, P.A. 53 Main Street P.O. Box 7 Winthrop, Maine 04364-0007 Tel: 377-6966	Representing Long-term Care Ombudsman Program
Ms. Judy McGuire Administrator, Long Term Care and Residential Services Cove's Edge, RR2, Box 4600 Damariscotta, Maine 04543 Tel: 563-4603	Representing Providers of Long-term Care Services
Ms. Carolyn Kasabian Vice President of Finance St. Mary's Regional Medical Center Lewiston, Maine 04243 Tel: 777-8100	Representing Maine Hospital Association
Ms. Betsy Sweet P.O. Box 71 Hallowell, Maine 04347 Tel: 623-0718	Representing Consumers of Long-term Care Services
Mr. Wayde Rankin North Country Associates P.O. Box 1408 Lewiston, Maine 04240 Tel: 786-3554	Representing Maine Health Care Association
Mr. Hilton Powers AARP 5 Atwood Lane Brunswick, Maine 04011 Tel: 725-8669	Representing American Association of Retired Persons

Staff: Jane Orbeton & Heather Henderson, Office of Policy and Legal Analysis

APPENDIX E

Resolve of 1997, Chapter 129

APPROVED

APR 16 '98

BY GOVERNOR

CHAPTER

129

RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY-EIGHT

H.P. 1534 - L.D. 2161

Resolve, to Extend the Commission to Examine Rate Setting and the Financing of Maine's Long-term Care Facilities

Emergency preamble. Whereas, Acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, this resolve is necessary as an emergency measure to provide funding for the Commission to Examine Rate Setting and the Financing of Maine's Long-term Care Facilities to continue its work immediately following the Second Regular Session of the 118th Legislature; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

Sec. 1. Resolve 1997, c. 81, §2 is amended to read:

Sec. 2. Commission membership. Resolved: That, except as provided in section 2-A, the commission consists of the following 15 members:

1. Two members of the Senate, appointed by the President of the Senate, one representing the majority party and one representing the minority party;

2. Two members of the House of Representatives, appointed by the Speaker of the House, one representing the majority party and one representing the minority party; and

3. Eleven other members appointed as follows:

A. The following members appointed by the Governor:

(1) The chair, who must have experience with rate setting;

(2) One representative of the Department of Human Services;

(3) One representative of the Long-term Care Steering Committee;

(4) One representative of the Maine Health and Higher Educational Facilities Authority; and

(5) One representative of a commercial lending institution; and

B. The following members appointed jointly by the President of the Senate and the Speaker of the House of Representatives:

(1) One representative of the long-term care ombudsman program;

(2) One representative of the Maine Health Care Association;

(3) One representative of the Maine Hospital Association;

(4) One representative of providers of long-term care services who is familiar with the principles of reimbursement;

(5) One representative of consumers of long-term care services who is familiar with the principles of reimbursement; and

(6) One representative of the American Association of Retired Persons; and be it further

Sec. 2. Resolve 1997, c. 81, §2-A is enacted to read:

Sec. 2-A. Additional member. Resolved: That, after the effective date of this section, the Speaker of the House of Representatives shall appoint one additional member of the commission who represents consumers of nursing facility services; and be it further

Sec. 3. Resolve 1997, c. 81, §§3, 4 and 7 are amended to read:

Sec. 3. Appointments; meetings. Resolved: That, except as provided in section 2-A, all appointments must be made no later than 30 days following the effective date of this resolve. The Executive Director of the Legislative Council must be notified by all appointing authorities once the selections have been made. Within 15 days after appointment of all members, the Chair of the Legislative Council shall call and convene the first meeting of the commission; and be it further

Sec. 4. Duties. Resolved: That the commission shall examine the following issues concerning long-term care facilities:

1. The setting of rates for the different payers ~~within the long-term care system~~ for nursing facility services, including monthly charges and charges for resident services and supplies, and ensuring affordability;

2. The levels of profit guaranteed by the rate of reimbursement, a comparison of rates among the different states and financial stability within the system;

3. The advisability of rate equalization between private and public payers, implementation of rate equalization and what the possible benefits and detriments might be for nursing facility residents;

4. The case mix payment system for private paying patients;

5. The possibility of regulating the ~~long-term care~~ nursing facility industry in the manner of regulating public utilities; ~~and~~

6. The relationship between staffing levels and quality of care and maintaining high-quality care; ~~and be it further~~

7. Mechanisms for providing consumer participation in decisions on the reimbursement for nursing facility care under the Medicaid program; and

8. Salaries, dividends and management fees in nursing facilities; and be it further

Sec. 7. Report. Resolved: That the commission shall submit its report, together with any necessary implementing legislation, to the ~~Second Regular Session of the~~ 118th Legislature no later than

~~December 15, 1997~~ November 20, 1998. If the commission requires an extension, it may apply to the Legislative Council, which may grant the extension; and be it further

Sec. 4. Retroactivity. Resolved: That that section of this resolve that amends Resolve 1997, c. 81, section 7 applies retroactively to December 15, 1997; and be it further

Sec. 5. Appropriation. Resolved: That the following funds are appropriated from the General Fund to carry out the purposes of this resolve.

	1997-98
LEGISLATURE	
Commission to Examine Rate Setting and the Financing of Maine's Long-term Care Facilities	
Personal Services	$2,640
All Other	4,860
Provides funds for the per diem and expenses of legislative members, funding for consultants and miscellaneous costs of the Commission to Examine Rate Setting and the Financing of Maine's Long-term Care Facilities.	
LEGISLATURE TOTAL	$7,500

Emergency clause. In view of the emergency cited in the preamble, this resolve takes effect when approved.

APPENDIX F

Nursing facility occupancy by payment source, 1993, 1995, 1997

Nursing Facility Occupancy
By Payment Source
1993, 1995, 1997

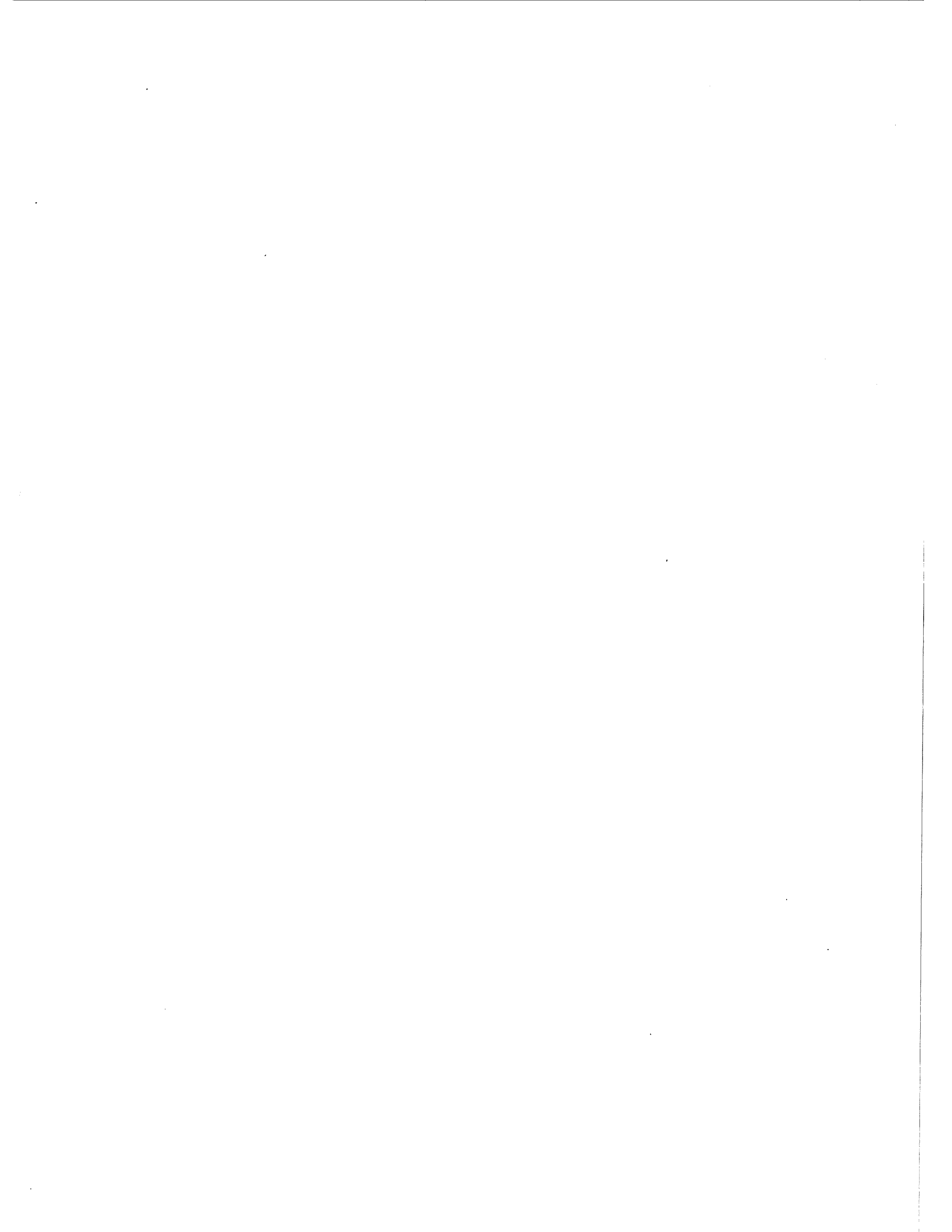
	Medicaid		Medicare		Other		Total Residents	Total Beds	Occupancy Rate
Date	Count	%	Count	%	Count	%			
12/93	7,362	76%	506	5%	1,871	19%	9,739	10,139	96%
12/95	6,522	75%	816	9%	1,410	16%	8,748	9,969	88%
12/97	5,595	72%	839	11%	1,320	17%	7,754	9,266	84%

Source: Muskie Institute Case Mix Demonstration Project: Resident Counts by Source of Payment
Bureau of Medical Services: Division of Licensing and Certification: Total Beds

File Name: nfoccup939597.lwp

APPENDIX G

Private pay rates as submitted by the provider, Fall, 1998



	Private rates as submitted by the Provider			
		Effective Date	Semi Prvt.	Prvt.
1	Amenity Manor	01/01/96	142.00	147.00
2	Aroostook Medical Center The(AHC)	01/01/97	119.00	N/A
3	Aroostook Medical Center The(CGH)	01/01/97	130.00	N/A
4	Auburn Nursing Home	01/01/97	121.00	130.00
5	Augusta Convalescent Center	04/01/98	128.00	n/a
6	Bangor City Nursing Facility	08/30/96	144.00	N/A
7	Bangor Convalescent Center	04/01/98	137.00	156.50
8	Atlantic Rehab. (Barnard NH)	01/01/98	115.50	N/A
9	Barron Center	07/01/96	142.00	160.00
10	Birch Grove Nursing Care Center	01/01/96	131.00	N/A
11	Bodwell - Mid Coast Hospital	10/01/97	325.00	N/A
12	Bolster Heights Health Care	07/01/97	120.00	125.00
13	Borderview Manor	01/01/96	129.00	145.00
14	Brentwood Manor	04/01/98	157.00	175.00
15	Brewer Rehab & Living Center	04/01/98	152.00	168.00
16	Bridgton Hlth. Care Center	01/01/97	143.00	N/A
17	Brunswick Convalescent Center	01/01/96	146.00	150.00
18	Calais Regional Hospital	10/01/94	250.00	N/A
19	Camden Health Care Center	01/01/97	129.00	143.00
20	Caribou Nursing Home	01/01/98	138.00	153.00
21	Cedar Ridge Nursing Care Center	01/01/98	145.00	175.00
22	Cedars Nursing Care Center	07/01/95	161.00	188.00
23	Charles A. Dean Memorial Hospital	07/01/97	127.00	N/A
24	Clover Manor, Inc.	12/01/95	140.00	157.00
25	Coastal Manor	01/01/96	130.00	N/A
26	Collier's Health Care Center	01/01/98	129.00	137.00
27	Colonial Acres Nursing Home	01/01/98	119.00	N/A
28	Country Manor Nursing Home	02/01/98	135.00	142.00
29	Courtland Living Center	07/01/98	141.00	154.00
30	Cove's Edge	11/01/98	177.00	204.00
31	Cummings Health Care Facility	09/01/92	120.00	N/A
32	Dexter Nursing Home	01/01/98	118.00	N/A
33	Dionne Commons (Brunswick CC)	01/01/96	146.00	150.00
34	Dixfield Health Care Center	07/01/97	116.50	N/A
35	Eastport Memorial Nursing Home	03/01/94	126.00	131.00
36	Edgewood Manor	07/01/98	147.00	161.00
37	Evergreen Manor	01/01/97	122.00	136.00
38	Falmouth By The Sea	01/01/98	165.00	225.00
39	Fieldcrest Manor Nursing Home	04/01/98	144.00	156.00
40	Forest Hill Manor	08/01/97	125.00	N/A
41	Freeport Nursing Home	01/01/97	132.00	147.00
42	Fryeburg Health Care Center	01/01/97	137.00	163.00
43	Gardiner Nursing Home	01/01/96	103.00	117.00
44	Gorham House	01/01/93	170.00	180.00
45	Gorham Manor	07/15/95	177.00	187.00
46	Greenwood Center	07/01/97	155.00	170.00
47	Harbor Hill	01/01/97	136.00	145.00
48	Harbor Home	06/01/98	150.00	160.00
49	Hawthorne House	01/01/98	144.00	156.00
50	Heritage Manor	07/01/98	129.00	136.00
51	Hibbard Nursing Home	12/01/96	120.00	140.00
52	High View Manor	08/01/96	108.00	119.00
53	Hillcrest Manor Division - Newton Center Rehab.	06/01/98	140.00	175.00
54	Homestead, Inc.	06/01/96	150.00	160.00
55	Island Nursing Home	07/01/96	123.95	127.22
56	Jackman Region Health Center	05/07/96	N/A	115.56
57	Katahdin Nursing Home	07/01/98	140.00	N/A

	Private rates as submitted by the Provider			
		Effective Date	Semi Prvt.	Prvt.
58	Ken. Long Term Care G.Birch	07/01/98	130.00	n/a
59	Kennebec Long Term Care Glenridge	07/01/98	130.00	n/a
60	Kennebec Valley Medical Center Gardiner	07/01/98	260.00	n/a
61	Kennebunk Nursing Home	09/01/98	152.00	180.00
62	Knox Center for Long Term Care	04/01/98	142.00	157.00
63	Lakewood Manor Nursing Home	01/01/96	134.00	155.00
64	Lamp Nursing Home The		closed	
65	Ledgeview Nursing Home	04/01/96	120.00	175.00
66	Ledgewood Manor	09/01/93	120.00	120.00
67	Madigan Estates	09/01/95	115.00	135.00
68	Maine Stay Nursing Home	10/01/95	152.00	170.00
69	Maine Veterans Home-Augusta	07/01/98	155.00	165.00
70	Maine Veterans Home - Bangor	07/01/97	165.00	175.00
71	Maine Veterans Home-Caribou	07/01/97	150.00	160.00
72	Maine Veterans Home-Scar.	07/01/98	165.00	175.00
73	Maine Veterans Home - South Paris	07/01/97	165.00	175.00
74	Maplecrest Living Center	07/01/98	146.00	173.00
75	Market Square Health Center	01/01/98	135.00	N/A
76	Marshall's Health Care Facility	12/01/95	125.00	150.00
77	Marshwood Nursing Care Center	01/01/97	116.00	120.00
78	Mercy Home	08/11/93	136.25	136.25
79	Mere Point Nursing Home	01/01/97	139.00	151.00
80	Merrill Memorial Manor	01/01/97	127.00	132.00
81	Montello Manor	01/01/96	145.00	150.00
82	Mountain Heights Health Care Facility	05/01/96	133.00	N/A
83	Mt. St. Joseph Nursing Home	02/01/96	150.00	165.00
84	Narraguagus Bay Health Care Facility	11/01/95	143.00	169.00
85	Nicholson's Nursing Home	07/01/94	95.00	N/A
86	Norway Convalescent Center	04/01/98	145.00	183.00
87	Oak Grove Nursing Care Ctr.	10/01/94	139.00	166.00
88	Oceanview Nursing Home	01/01/98	143.00	157.00
89	Odd Fellow's Home of Maine	03/01/98	130.00	140.00
90	Orchard Park Living Center	07/01/98	154.00	167.00
91	Orono Nursing Home, Inc.	10/01/97	126.00	147.00
92	Parkview Nursing Home	02/01/98	140.00	160.00
93	Penobscot Nursing Home	01/01/96	107.50	115.50
94	Penobscot Valley Hospital	01/01/90	240.00	
95	Pine Point Nursing Care Center	10/01/94	160.50	181.90
96	Pleasant Hill Health Facility	02/01/98	135.00	
97	Presque Isle Nursing Home	01/01/96	140.00	153.00
98	Riverridge	11/01/94	155.15	187.25
99	Riverwood HCC(Renaissance)	01/01/98	129.00	n/a
100	Robinson's Hlth. Care Facility	02/01/98	140.00	N/A
101	Ross Manor	01/01/98	149.00	163.00
102	Rumford Community Home	08/01/98	125.00	139.00
103	Russell Park Manor	07/01/97	128.90	139.64
104	Sandy River Nursing Care Ctr.	10/01/94	139.10	160.50
105	Sanfield Living Center	07/01/96	133.00	142.00
106	Sanford Health Care Facility	11/01/95	130.00	150.00
107	Seaside Nursing and Ret. Home	04/01/98	152.25	176.50
108	Sebasticook Valley Health Care facility	05/01/95	119.00	130.00
109	Seville Park Plaza	01/01/98	132.00	137.00
110	Shore Village Nursing Center	04/01/98	143.00	157.00
111	So. Portland Nursing Home	01/01/97	140.19	N/A
112	Somerset Manor	07/01/98	142.00	151.00
113	Sonogee Estates	07/01/98	142.00	163.00
114	Southridge Living Center	07/01/98	144.00	157.00

	Private rates as submitted by	the Provider		
		Effective	Semi	
		Date	Prvt.	Prvt.
115	Springbrook Nursing Care Center	02/01/95	145.00	165.00
116	St. Andre Health Care Facility	02/01/95	120.00	130.00
117	St. Andrews Hospital	08/01/96	160.00	N/A
118	St. Joseph Nursing Home	01/27/98	125.00	135.00
119	St. Joseph's Manor	08/01/98	171.00	187.00
120	St. Marguerite D'Youville Pav.	01/01/98	126.00	133.00
121	Stillwater Health Care	02/01/98	135.00	170.00
122	Summit House Health Care Ctr.		Rates are adjusted monthly. Se	
123	Sunrise Residential Care Facility	07/18/93	125.00	135.00
124	Tallpines Health Care Facility	09/01/95	144.00	162.00
125	Trull Nursing Home	09/01/98	118.23	131.41
126	Varney Crossing Nursing Care Center	08/01/98	145.00	168.00
127	Victorian Villa Nursing Home	01/01/95	114.00	120.00
128	Viking ICF The	10/12/95	155.00	207.00
129	Westgate Manor	07/01/97	150.00	170.00
130	Willows Nursing Care Center The	10/01/94	135.00	162.00
131	Winship Green Nursing Center	04/01/98	150.00	n/a
132	Woodford Park Nursing Care	04/05/98	150.00	160.00
133	Woodlawn Nursing Home	01/01/98	142.00	156.00
134	York Hospital	07/01/96	205.00	215.00

APPENDIX H

Information from the Bureau of Insurance on long-term care insurance

The Role of Private Insurance in Financing Long-Term Care

Presentation to the Commission to Examine Rate Setting and the Financing of Maine's Long-term Care System

September 16, 1998

Rick Diamond
Ruth Cottle
Bureau of Insurance

Types of Insurance

- Long-Term Care Insurance
  - Covers nursing home care and home health care
- Nursing Home Care Insurance
  - Covers nursing home care
- Life Insurance
  - May cover long-term care through acceleration of death benefit
- Disability Income Insurance
  - May convert to long-term care coverage

- Benefit limitations
  - Elimination period
  - Maximum benefit period
  - Maximum daily benefit
  - Lifetime maximum
- Inflation Protection
  - Optional
  - Must offer 5% compound
  - Most use fixed percentage

- Federal
  - Must be federally qualified policy
  - Must itemize deductions and have health care expenses exceeding 7½% of income
- State
  - Must be certified long-term care policy
  - Not necessary to itemize
- Differences between federal qualification standards and state certification requirements

APPENDIX I

Chart of long-term care incentive programs

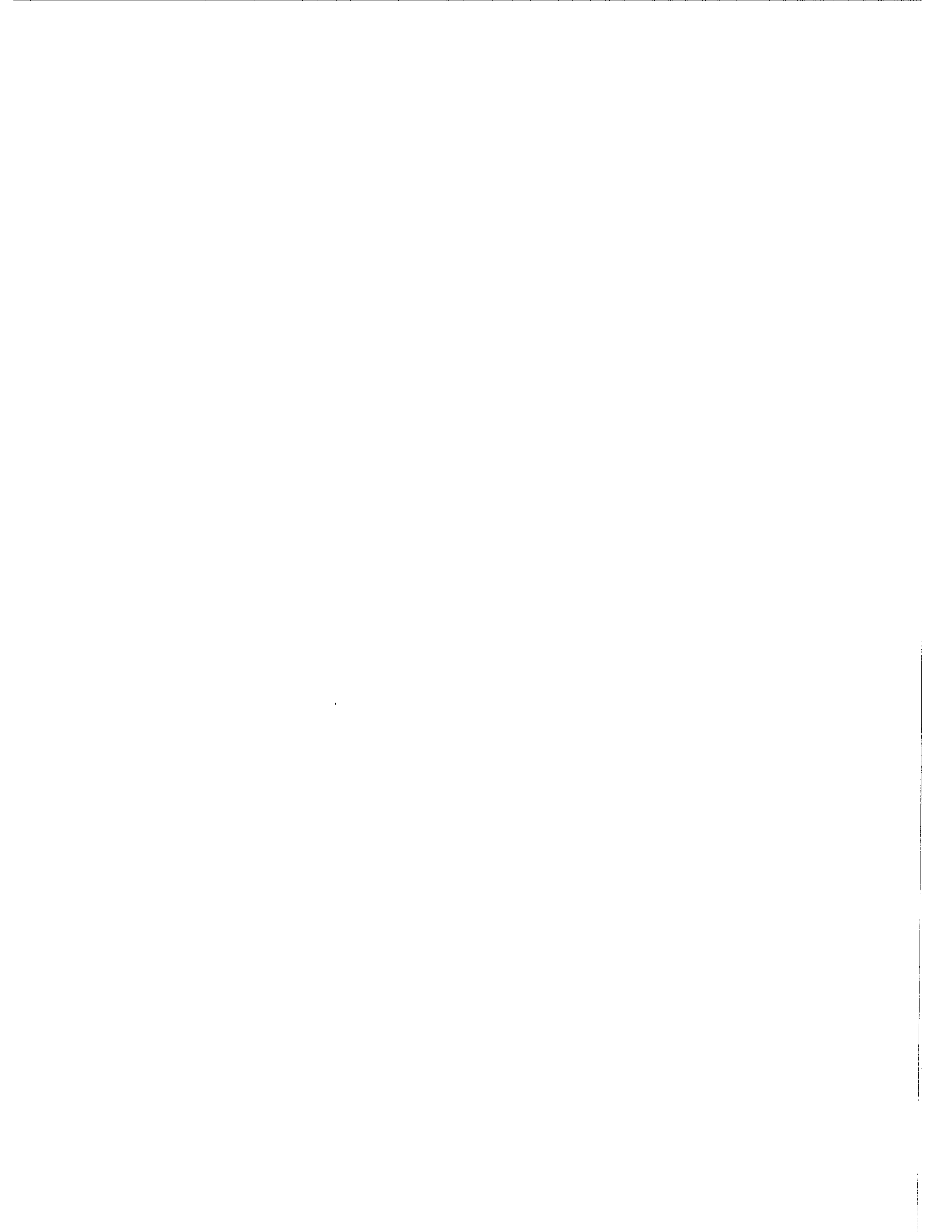
State and Federal Incentives to Encourage the Purchase of Long-term Care Insurance

Jurisdiction	Tax Deduction or Credit		Incentive program to encourage the purchase of qualifying long-term care insurance		Group purchase offered to employees
	Deduction	Credit	Disregard of assets or income for Medicaid eligibility?	Protection of assets from Medicaid estate recovery?	
Federal	Yes. Deduction subject to caps calculated by total amount of premium and comparison with adjusted gross income.		NA	NA	Yes. Employee may purchase for self or family members. Employer does not contribute to premium.
Alabama	Yes	No	NA	NA	
California (Dollar for Dollar)	No	No	Yes. Amount paid by the policy for long-term care is disregarded.	Yes, amount paid by the policy for long-term care is exempt.	Yes. Offered to state and county employees and retirees.
Connecticut (Dollar for Dollar)	No	No	Yes. Amount paid by the policy for long-term care is disregarded.	Yes, amount paid by the policy for long-term care is exempt.	Yes. Offered to state employees.
Illinois (combination of Dollar for Dollar and Total State Assets)	No	No	Yes	No.	
Indiana (combination of Dollar for Dollar and Total State Assets)	No	No	Yes. After full payment by a qualifying insurance policy, all assets are disregarded.	Yes. All assets.	
Iowa (Dollar for Dollar)	No	No	Yes. Amount paid by the policy for long-term care is disregarded.	Yes, amount paid by the policy for long-term care is exempt.	
Maine	Yes	No	NA	NA	
Massachusetts (hybrid)	No	No	Some asset disregard, otherwise standard Medicaid eligibility.	Yes, protection for some disregarded assets.	
New York (Total State Assets)	No	No	Yes. After full payment by a qualifying insurance policy, all assets are disregarded.	Yes. All assets.	
North Dakota	No	Yes, tax credit up to $100.	*	*	
Washington (Dollar for Dollar)	No	No	Yes. Amount paid by the policy for long-term care is disregarded.	No	

OBRA '93 prohibits states from exempting assets from Medicaid estate recovery. State programs encouraging the purchase of long-term care that were approved prior to the effective date of OBRA '93 are allowed. As a result of OBRA '93, Missouri, North Dakota*, Oregon and Rhode Island did not implement their programs. Colorado, Maryland and Michigan enacted programs conditional on the repeal of the provisions of OBRA '93 prohibiting exemption from Medicaid estate recovery).

APPENDIX J

Medicaid Principles of Reimbursement for Nursing Facilities



10-144: DEPARTMENT OF HUMAN SERVICES
Chapter 101: MAINE MEDICAL ASSISTANCE MANUAL
Chapter III:
Section 67: PRINCIPLES OF REIMBURSEMENT FOR NURSING FACILITIES

STATE OF MAINE

DEPARTMENT OF HUMAN SERVICES

PRINCIPLES OF REIMBURSEMENT

FOR

NURSING FACILITIES

EFFECTIVE JULY 1, 1998

Maine Medical Assistance Manual, Chapter III, Section 67
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INTRODUCTION
GENERAL PROVISIONS

10 PURPOSE
The purpose of these principles is to comply with Section 1902 (a) (13) (A) of the Social Security Act and the Rules and Regulations published thereunder (42 CFR Part 447), namely: to provide for payment of nursing care facility services (provided under Maine's Medicaid Program in accordance with Title XIX of the Social Security Act) through the use of rates which are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. These principles incorporate the requirements concerning nursing home reform provisions set forth by the Omnibus Budget and Reconciliation Act of 1987 (OBRA '87). Accordingly, these rates take into account the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well being of each Medicaid resident.

11 AUTHORITY
The Authority of the Department of Human Services to accept and administer any funds which may be available from private, local, State or Federal sources for the provision of the services set forth in the Principles of Reimbursement is established in Title 22 of the Maine revised Statutes Annotated, Section 10 and 12. The regulations themselves are issued pursuant to authority granted to the Department of Human Services by Title 22 of the Maine Revised Statutes Annotated Section 42(1).

12 GENERAL DESCRIPTION OF THE RATE SETTING SYSTEM
A prospective case mix payment system for nursing facilities is established by these rules in which the payment rate for services is set in advance of the actual provision of those services. The rate is established in a two step process. In the first step, a facility's base year cost report is reviewed to extract those costs which are allowable costs. A facility's costs may fall into an allowable cost category, but be determined unallowable because they exceed certain limitations. Once allowable costs have been determined and separated into four components - direct, indirect, routine and fixed costs, the second step is accomplished in which the costs which must be incurred by an efficiently and economically operated facility are identified.

13 EFFECTIVE DATE
These principles apply to reimbursement for all nursing facility services occurring on or after July 1, 1998.

14 REQUIREMENTS FOR PARTICIPATION IN MEDICAID PROGRAM
14.1 Nursing facilities must satisfy all of the following prerequisites in order to be reimbursed for care provided to Medicaid recipients:
14.11 be licensed and certified by the Maine Department of Human Services, pursuant to Title 22, Section 1811 and 42 CFR, Part 442, Subpart C, and
14.12 have a provider Agreement with the Department of Human Services, as required by 42 CFR, Part 442, Subpart B.
14.2 Medicaid payments shall not be made to any facility that fails to meet all the requirements of Subsection 14.1.

15 RESPONSIBILITIES OF OWNERS OR OPERATORS
The owners or operators of a nursing facility shall prudently manage and operate a residential health care program of adequate quality to meet its residents' needs. Neither the issuance of a per diem rate, nor final orders made by the Commissioner or a duly authorized representative shall in any way relieve the owner or operator of a nursing facility from full responsibility for compliance with the requirements and standards of the Department of Human Services or Federal requirements and standards.

16 DUTIES OF THE OWNER OR OPERATOR
In order to qualify for Medicaid reimbursement the owner or operator of a nursing facility, or a duly authorized representative shall:
16.1 Comply with the provisions of sections 15 and 16 and this section setting forth the requirements for participation in the Medicaid Program.
16.2 Submit master file documents and cost reports in accordance with the provisions of sections 30 and 32 of these Principles.
16.3 Maintain adequate financial and statistical records and make them available when requested for inspection by an authorized representative of the Department of Human Services, the state, or the Federal government.

16.4 Assure that annual records are prepared in conformance with Generally Accepted Accounting Principles (GAAP), except where otherwise required.
16.5 Assure that the construction of buildings and the maintenance and operation of premises and programs comply with all applicable health and safety standards.
16.6 Submit, such data, statistics, schedules or other information which the Department requires in order to carry out its functions. Failure to supply the required documentation may result in the Department imposing the deficiency per diem rate described in Section 152 of these Principles.

20 ACCOUNTING REQUIREMENTS
20.1 ACCOUNTING PRINCIPLES
20.11 All financial and statistical reports shall be prepared in accordance with Generally Accepted Accounting Principles (GAAP), consistently applied, unless these rules require specific variations in such principles and Medicare Provider Reimbursement Regulations HIM-15.

20.12 The provider shall establish and maintain a financial management system which provides for adequate internal control assuring the accuracy of financial data, safeguarding of assets and operation efficiency.
20.13 The provider shall report on an accrual basis, unless it is a state or municipal institution that operates on a cash basis. The provider whose records are not maintained on an accrual basis shall develop accrual data for reports on the basis of an analysis of the available documentation. The provider shall retain all such documentation for audit purposes.

21 PROCUREMENT STANDARDS
21.1 Providers shall establish and maintain a code of standards to govern the performance of its employees engaged in purchasing Capital Assets. Such standards shall provide, and providers shall implement to the maximum extent practical, open and free competition among vendors. Providers are encouraged to participate in group purchasing plans when feasible.
21.2 If a provider pays more than a competitive bid for a Capital Asset an amount over the lower bid which cannot be demonstrated to be a reasonable and necessary expenditure it is a nonallowable cost. In situations not competitively bid, providers must act as a prudent buyer as referenced in Subsection 24.2 in these principles.
See cost to related organizations Section 24.9.

22 COST ALLOCATION PLANS AND CHANGES IN ACCOUNTING METHODS
With respect to the allocation of costs to the nursing facility and within the nursing facility, the following rules shall apply:
22.1 Providers that have costs allocated from related entities included in their cost reports shall include as a part of their cost report submission, a summary of the allocated costs, including a reconciliation of the allocated costs to the entity's financial statements which must also be submitted with the Medicaid cost report. In the case of a home office, related management company, or real estate management company, this would include a completed Home Office Cost Statement which show the costs that are removed which are unallowable. The provider shall submit this reconciliation with the Medicaid cost report. If the nursing facility is a Medicare provider, the Medicare Home Office Cost report may be used to identify the unallowable costs that are removed, if the Medicare Home Office Cost report is completed in sufficient detail to allow the Department to make its findings.
22.2 No change in accounting methods or basis of cost allocation may be made without prior written approval of the Bureau of Medical Services.
22.3 Any application for a change in accounting method or basis of cost allocation, which has an effect on the amount of allowable costs or computation of the per diem rate of payment, shall be made within the first 90 days of the reporting year. The application shall specify:
22.31 the nature of the change;
22.32 the reason for the change;
22.33 the effect of the change on the per diem rate of payment; and
22.34 the likely effect of the change on future rates of payment.
22.4 The Department of Human Services shall review each application and within 60 days of the receipt of the application approve, deny or propose modification of the requested change. If no action is taken within the specified period, the application will be deemed to have been approved.
22.5 Each provider shall notify the Department of Human Services of changes in statistical allocations or record keeping required by the Medicare Intermediary.
22.6 The capital component (any element of fixed cost that is included in the price charged by a supplier of goods or services) of purchased goods or services, such as plant operation and maintenance, utilities, dietary, laundry, housekeeping, and all others, whether or not acquired from a related party, shall be considered as costs for the particular good or service and not classified as Property and Related costs (fixed costs) of the nursing facility.
22.7 Costs allocated to the nursing facility shall be reasonable and necessary, as determined by the Maine Department of Human Services pursuant to these rules.
22.8 It is the duty of the provider to notify the Division of Audit within 5 days of any change in its customary charges to the general public. A rate schedule may be submitted to the Department by the nursing facility to satisfy this requirement if the schedule allows the Department the ability to determine with certainty the charge structure of the nursing facility.
22.9 All year end accruals must be paid by the facility within six (6) months after the end of the fiscal year in which the amounts are accrued. If the accruals are not paid within such time, these amounts will be deducted from allowable costs incurred in the first field or desk audit conducted following that six month period.
22.10 The unit of output for cost finding shall be the costs of routine services per patient day. The same cost finding method shall be used for all long-term care facilities. Total allowable costs shall be divided by the actual days of care to determine the cost per bed day. Total allowable costs shall be allocated based on the occupancy data reported and the following statistical bases:
22.10.1 Nursing Salaries. Services provided and hours of nursing care by licensed personnel and other nursing staff.
22.10.2 Other Nursing Costs. Nursing salaries cost allocations.
22.10.3 Plant operation and maintenance. Square feet serviced.
22.10.4 Housekeeping. Square feet serviced.
22.10.5 Laundry. Patient days, or pounds of laundry whichever is most appropriate.
22.10.6 Dietary. Number of meals served.
22.10.7 General and Administrative and Financial and Other Expenses. Total accumulated costs not including General and Administrative and Financial Expense.

23 ALLOWABILITY OF COST

23.1 If these principles do not set forth a determination of whether or not a cost is allowable or sufficiently define a term used reference will be made first, to the Medicare Provider Reimbursement Manual (HIM-15) guidelines followed by the Internal Revenue Service Guidelines in effect at the time of such determination if the HIM-15 is silent on the issues.

24 COST RELATED TO PATIENT CARE

24.1 Principle. Federal law requires that payment for long term care facility services provided under Medicaid shall be provided through the use of rates which are reasonable and adequate to meet costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. Costs incurred by efficiently and economically operated facilities include costs which are reasonable, necessary and related to patient care, subject to principles relating to specific items of revenue and cost.

24.2 Costs must be ordinary and necessary and related to patient care. They must be of the nature and magnitude that prudent and cost conscious management would pay for a specific item or service.

24.3 Costs must not be of the type conceived for the purpose of circumventing the regulations. Such costs will be disallowed under Section 26.

24.4 Costs that relate to inefficient, unnecessary or luxurious care or unnecessary or luxurious facilities or to activities not common and accepted in the nursing home field are not allowable.

24.5 Compensation to be allowable must be reasonable and for services that are necessary and related to patient care and pertinent to the operation of the facility. The services must actually be performed and must be paid in full. The compensation must be reported to all appropriate state and federal tax authorities to the extent required by law for income tax, social security, and unemployment insurance purposes.

24.6 Costs which must be incurred to comply with changes in federal or state laws and regulations and not specified in these regulations for increased care and improved facilities which become effective subsequent to October 1, 1993 are to be considered reasonable and necessary costs. These costs will be reimbursed as a fixed cost until the Department calculates the Statewide peer group mean cost of compliance from the facility's fiscal year data following the fiscal year the cost was originally incurred. Following the second fiscal year the facility will be reimbursed the statewide average cost of compliance. The statewide average cost for this regulation/law will be built into the appropriate cost component in subsequent years.

24.7 Costs incurred for patient services that are rendered in common to Medicaid patients as well as to non-Medicaid patients, will be allowed on a pro rata basis, unless there is a specific allocation defined elsewhere in these Principles.

24.8 Lower of Cost or Charges. In no case may payment exceed the facility's customary charges to the general public for the lowest semi-private room rate in the nursing facility. These charges must be billed to private pay residents during the operating period they are incurred.

24.9 Cost to Related Organizations Principle. Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable costs of the provider at the cost to the related organization. However, such costs must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere. Providers should reference Section 21 of these Principles.

25 UPPER PAYMENT LIMITS

25.1 Aggregate payments to nursing facilities pursuant to these rules may not exceed the limits established for such payments in 42 CFR. §447.272, using Medicare principles of reimbursement.

25.2 If the Division of Audit projects that Medicaid payments to nursing facilities in the aggregate will exceed the Medicare upper limit, the Division of Audit shall limit some or all of the payments to providers to the level that would reduce the aggregate payments to the Medicare upper limit as set forth in subsection 25.4.

25.3 In computing the projections that Medicaid payments in the aggregate are within the Medicare Upper Limit, any facility exceeding 112% of the State mean allowable routine service costs, may be notified that additional information is required to determine allowable costs under the Medicare Principles of Reimbursement including any exceptions as stated in 42 CFR 413.30(f). This information may be requested within 30 days of the effective date of these regulations, and thereafter, at the time the interim rates are set.

25.4 Facility Rate Limitations if Aggregate Limit is Exceeded. If the Department projects that the Medicaid payments to nursing homes in the aggregate exceed the Medicare upper limit, the Department shall limit payments to those facilities whose projected Medicaid payments exceed what would have been paid using Medicare Principles of Reimbursement. The Department will notify the facilities when the Department projects that the Medicaid payments to nursing homes in the aggregate exceed the Medicare upper limit and that the Department must limit payments to those facilities to the level that would reduce the aggregate payments to the Medicare upper limit.

26 SUBSTANCE OVER FORM

The cost effect of transactions that have the effect of circumventing these rules may be adjusted by the Department on the principle that the substance of the transaction shall prevail over the form.

27 RECORD KEEPING AND RETENTION OF RECORDS

27.1 Each provider must maintain complete documentation, including accurate financial and statistical records, to substantiate the data reported on the cost report, and must, upon request, make these records available to the Department, or the U.S. Department of Health and Human Services, and the authorized representatives of either agency.

27.2 Complete documentation means clear evidence of all of the financial transactions of the provider and affiliated entities, including but not limited to census data, ledgers, books, invoices, bank statements, canceled checks, payroll records, copies of governmental filings, time records, time cards, purchase requisitions, purchase orders, inventory records, basis of apportioning costs, matters of provider ownership and organization, resident service charge schedule and amounts of income received by service, or any other record which is necessary to provide the Commissioner with the highest degree of confidence in the reliability of the claim for reimbursement. For purposes of this definition, affiliated entities shall extend to realty,

management and other entities for which any reimbursement is directly or indirectly claimed whether or not they fall within the definition of related parties.

27.3 The provider shall maintain all such records for at least three years from the date of filing, or the date upon the which the fiscal and statistical records were to be filed, whichever is the later. The Division of Audit shall keep all cost reports, supporting documentation submitted by the provider, correspondence, workpapers and other analysis supporting audits for a period of three years. In the event of litigation or appeal involving rates established under these regulations, the provider and Division of Audit shall retain all records which are in any way related to such legal proceeding until the proceeding has terminated and any applicable appeal period has lapsed.

27.4 When the Department of Human Services determines that a provider is not maintaining records as outlined above for the determination of reasonable cost under the program, the Department, upon determination of just cause, shall send a written notice to the provider that in thirty days the Department intends to reduce payments, unless otherwise specified, to a 90% level of reimbursement as set forth is Section 152 of these Principles. The notice shall contain an explanation of the deficiencies. Payments shall remain reduced until the Department is assured that adequate records are maintained, at which time reimbursement will be reinstated at the full rate from that time forward. If, upon appeal, the provider documents that there was not just cause for the reduction in payment, all withheld amounts will be restored to the provider.

30 FINANCIAL REPORTING

31 MASTER FILE

The following documents concerning the provider or, where relevant, any entity related to the Provider, will be submitted to the Department at the time that the cost report is filed. Such documents will be updated to reflect any changes on a yearly basis with the filing of a cost report. Such documents shall be used to establish a Master file for each facility in the Maine Medicaid program:

31.1 Copies of the articles of incorporation and bylaws, of partnership agreements of any provider or any entity related to the provider;

31.2 Chart of accounts and procedures manual, including procurement standards established pursuant to Section 21;

31.3 Plant layout if available;

31.4 Terms of capital stock and bond issues;

31.5 Copies of long-term contracts, including but not limited to leases, pension plans, profit sharing and bonus agreements;

31.6 Schedules for amortization of long-term debt and depreciation of plant assets;

31.7 Summary of accounting principles, cost allocation plans, and step-down statistics used by the provider;

31.8 Related party information on affiliations, and contractual arrangements;

31.9 Tax returns of the nursing facility; and

31.10 Any other documentation requested by the Department for purposes of establishing a rate or conducting an audit.

If any of the items listed in Subsections 31.1 - 31.10 are not submitted in a timely fashion the Department may impose the deficiency per diem rate described in Section 152 of these Principles.

32 UNIFORM COST REPORTS

32.1 All long-term care facilities are required to submit cost reports as prescribed herein to the State of Maine Department of Human Services, Division of Audit, State House Station 11, Augusta, ME, 04333. Such cost reports shall be based on the fiscal year of the facility. If a nursing facility determines from the as filed cost report that the nursing facility owes moneys to the Department of Human Services, a check equal to 50% of the amount owed to the Department will accompany the cost report. If a check is not received with the cost report the Department may elect to offset the current payments to the facility until the entire amount is collected from the provider.

32.2 Forms. Annual report forms shall be provided or approved for use by long-term care facilities in the State of Maine by the Department of Human Services.

32.3 Each long-term care facility in Maine must submit an annual cost report within three months of the end of each fiscal year on forms prescribed by the Division of Audit. If available, the long-term care facility can submit a copy of the cost report on a computer disk. The inclusive dates of the reporting year shall be the 12 month period of each provider's fiscal year, unless advance authorization to submit a report for a lesser period has been granted by the Director of the Division of Audit. Failure to submit a cost report in the time prescribed above may result in the Department imposing the deficiency per diem rate described in Section 152.

32.4 Certification by operator. The cost report is to be certified by the owner and administrator of the facility. If the return is prepared by someone other than the facility, the preparer must also sign the report.

32.5 The original and one copy of the cost report must be submitted to the Division of Audit. All documents must bear original signatures.

32.6 The following supporting documentation is required to be submitted with the cost report:

32.61 Financial statements,

32.62 Most recently filed Medicare Cost Report (if a participant in the Medicare Program),

32.63 Reconciliation of the financial statements to the cost report.

32.7 Cents are omitted in the preparation of all schedules except when inclusion is required to properly reflect per diem costs or rates.

33 ADEQUACY AND TIMELINESS OF FILING

33.1 The cost report and financial statements for each facility shall be filed not later than three months after the fiscal year end of the provider. When a provider fails to file an acceptable cost report by the due date, the Department may send the provider a notice by certified mail, return receipt requested, advising the provider that all payments are suspended on receipt of the notice until an acceptable cost report is filed. Reimbursement will then be reinstated at the full rate from that time forward but, reimbursement for the suspension period shall be made at the deficiency rate of 90%.

33.2 The Division of Audit may reject any filing which does not comply with these regulations. In such case, the report shall be deemed not filed, until refiled and in compliance.
33.3 Extensions for filing of the cost report beyond the prescribed deadline must be requested as follows:
33.31 All requests for extension of time to file a cost report must be in writing, and must be received by the Division of Audit 15 days prior to the due date. The provider must clearly explain the reason for the request and specify the date on which the Division of Audit will receive the report.
33.32 The Division of Audit will not grant automatic extensions. Such extensions will be granted for good cause only, at the Director of the Division of Audits sole discretion, based on the merits of each request. A "good cause" is one that supplies a substantial basis for the delay or an intervening action beyond the providers control. The following are not considered "good cause"; ignorance of the rule, inconvenience, or a cost report preparer engaged in other work.

34 REVIEW OF COST REPORTS BY THE DIVISION OF AUDIT
34.1 Uniform Desk Review
34.11 The Division of Audit shall perform a uniform desk review on each cost report submitted.
34.12 The uniform desk review is an analysis of the provider's cost report to determine the adequacy and completeness of the report, accuracy and reasonableness of the data recorded thereon, allowable costs and a summary of the results of the review. The Division of audit will schedule an on-site audit or will prepare a settlement based on the findings determined by the uniform desk review.
34.13 Uniform desk reviews shall be completed within 180 days after receipt of an acceptable cost report filing, including financial statements and other information requested from the provider except in unusual situations, including but not limited to, delays in obtaining necessary information from a provider.
34.14 Unless the Division of Audit intends to schedule an on-site audit, it shall issue a written summary report of its findings and adjustments upon completion of the uniform desk review.

34.2 On-site Audit
34.21 The Division of Audit will perform on-site audits, as considered appropriate, of the provider's financial and statistical records and systems.
34.22 The Division of Audit will base its selection of a facility for an on-site audit on factors such as but not limited to: length of time since last audit, changes in facility ownership, management, or organizational structure, random sampling, evidence or official complaints of financial irregularities, questions raised in the uniform desk review, failure to file a timely cost report without a satisfactory explanation, and prior experience.
34.23 The audit scope will be limited so as to avoid duplication of work performed by a facility's independent public accountant, provided such work is adequate to meet the Division of Audits requirements.
34.24 Upon completion of an audit, the Division of Audit shall review its draft findings and adjustments with the provider and issue a written summary of such findings.

35 SETTLEMENT OF COST REPORTS
35.1 Cost report determinations and decisions, otherwise final, may be reopened and corrected when the specific requirements set out below are met. The Division of Audits decision to reopen shall be based on: (1) new and material evidence submitted by the provider or discovered by the Department; or, (2) evidence of a clear and obvious material error.
35.2 Reopening means an affirmative action taken by the Division of Audit to re-examine the correctness of a determination or decision otherwise final. Such action may only be taken:
35.21 At the request of either the Department, or a provider within the applicable time period set out in paragraph 35.5; and,
35.22 When the reopening may have a material effect (more than one percent) on the provider's Medicaid rate payments.
35.3 A correction is a revision (adjustment) in the Division of Audits determination, otherwise final, which is made after a proper re-opening. A correction may be made by the Division, or the provider may be required to file an amended cost report.
35.4 A determination or decision may only be re-opened within three years from the date of notice containing the Division of Audits determination, or the date of a decision by the Commissioner or a court, except that no time limit shall apply in the event of fraud or misrepresentation.
35.5 The Division of Audit may also require or allow an amended cost report any time prior to a final audit settlement to correct material errors detected subsequent to the filing of the original cost report or to comply with applicable standards and regulations. Once a cost report is filed, however, the provider is bound by its elections. The Division of Audit shall not accept an amended cost report to avail the provider of an option it did not originally elect.

37 REIMBURSEMENT METHOD
37.1 Principle. Nursing care facilities will be reimbursed for services provided to recipients under the program based on a rate which the Department establishes on a prospective basis and determines is reasonable and adequate to meet the costs which must be incurred by an efficiently and economically operated facility in order to provide care and services in conformity with applicable State and Federal laws, regulations and quality and safety standards.
37.2 Nursing facilities costs will be periodically rebased by the Department of Human Services when the Commissioner of the Department of Human Services determines that the rates paid to nursing facilities are in danger of failing to meet the residents needs or are in excess of costs which must be incurred by economic and efficient nursing facilities.

40 COST COMPONENTS
40.1 In the prospective case mix system of reimbursement, allowable costs are grouped into cost categories. The nature of the expenses dictate which costs are allowable under these Principles of Reimbursement. The costs shall be grouped into the following four cost categories:
40.11 Direct Patient Care Costs,
40.12 Indirect Patient Care Costs,
40.13 Routine Costs, and
40.14 Fixed Costs.

Sections 41- 49 describe the cost centers in each of these categories, the limitations and allowable costs placed on each of these cost centers.

41 DIRECT PATIENT CARE COST COMPONENT
The basis for reimbursement within the direct care cost component is a resident classification system that groups residents into classes according to their assessed conditions and the resources required to care for them.
41.1 Direct patient care costs include salary, wages, and benefits for:
41.11 registered nurses,
41.12 licensed practical nurses,
41.13 nurse aides,
41.14 patient activities personnel,
41.15 ward clerks,
41.16 payroll tax,
41.17 the following fringe benefits for the positions listed above: payroll taxes, qualified retirement plan contributions, group health, dental, and life insurance's, cafeteria plans and flexible spending plans,
41.18 the salary and related benefits of the position of Director of Nursing shall be excluded from the calculation of direct patient care costs and shall be included in the indirect patient care cost component.

41.2 Resident assessments
The Resident Assessment Instrument (RAI) is the assessment tool approved by the Department of Human Services to provide a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. It is comprised of the Minimum Data Set currently specified for use by HCFA (hereinafter, referred to as "MDS") and the Resident Assessment Protocols (RAPs).
The MDS provides the basis for resident classification into one of 44 case mix classification groups. An additional unclassified group is assigned when assessment data are determined to be incomplete or in error. Resident assessment protocols (RAPs) are structured frameworks for organizing MDS elements and gathering additional clinically relevant information about a resident that contributes to care planning.
All residents admitted to a Nursing Facility (NF), regardless of payment source, shall be assessed using the MDS.
41.21 Schedule for MDS submissions
Facilities shall submit by the 25th day of the month a copy of the MDS assessments and discharge log. MDS assessments with a start date and discharges dated between and including the 16th day of the prior month and the 15th day of the current month must be submitted to the Department of Human Services or the Department's designated agent. Beginning October 1, 1994 all submissions must be made on electronic media. Failure to submit on electronic media on or after October 1, 1994 may result in reimbursement as described in Section 152.
41.22 Electronic Submission of the MDS Information
Effective with the implementation of version 2.0 of the MDS by the Bureau of Medical Services, all submissions must be made via electronic submission/modem. No paper copies will be accepted by the Department. Should extraordinary conditions arise whereby the nursing facility is unable to submit electronically, a request to submit MDS information via diskette shall be submitted to the Bureau of Medical Services. This request must be made a minimum of five (5) days prior to the required date of submission of the MDS assessment data.
41.23 Quality review of the MDS process
41.23.1 Definitions
(1) "MDS assessment review" is a review conducted at nursing facilities (NFs) by the Maine Department of Human Services, for review of assessments submitted in accordance with Section 41.2 to ensure that assessments accurately reflect the resident's clinical condition.
(2) "Effective date of the Rate" is the first day of the payment quarter.
(3) "Assessment review error rate" is the percentage of unverified Case Mix Group Record in the drawn sample. Samples shall be drawn from Case Mix Group Record completed for residents who have Medicaid reimbursement.
(4) "Verified Case Mix Group Record" is a NF's completed MDS assessment form, that has been determined to accurately represent the resident's clinical condition, during the MDS assessment review process. Verification activities include reviewing resident assessment forms and supporting documentation, conducting interviews, and observing residents.

(5) "Unverified Case Mix Group Record" is one which, for reimbursement purposes, the Department has determined does not accurately represent the resident's condition, and therefore results in the resident's inaccurate classification into a case mix group that increases the case mix weight assigned to the resident.
(6) "Unverified MDS Record" is one which, for clinical purposes, does not accurately reflect the resident's condition.
41.23.2 Criteria for Assessment Review
NFs may be selected for a MDS assessment review by the Department based upon but not limited to any of the following:

(1) The findings of a licensing and certification survey conducted by the Department indicate that the facility is not accurately assessing residents.
(2) An analysis of the case mix profile of NFs included but not limited to changes in the frequency distribution of their residents in the major categories or a change in the facility average case mix score.
(3) Prior resident assessment performance of the provider, including, but not limited to, ongoing problems with assessments submission deadlines, error rates, and incorrect assessment dates.

41.23.3 Assessment Review Process
(1) Assessment reviews shall be conducted by staff or designated agents of the Department.
(2) Facilities selected for assessment reviews must provide reviewers with reasonable access to residents, professional and non-licensed direct care staff, the facility assessors, clinical records, and completed resident assessment instruments as well as other documentation regarding the residents' care needs and treatments.
(3) Samples shall be drawn from MDS assessments completed for residents who have Medicaid reimbursement.
(4) At the conclusion of the on-site portion of the review process, the Departments reviewers shall hold an exit conference with facility representatives. Reviewers will share written findings for reviewed records.

41.23.4 Sanctions
The Department shall compute the quarterly facility average case mix index, as described in Section 80.3 of these principles. The following sanctions shall be applied to the allowable case mix adjusted direct care cost component for the subsequent quarter for all Medicaid residents of the facility, for which the following assessment review error rates are determined. Such sanctions shall be a percentage of the total direct care cost component after the case mix index and upper limit has been applied.
(1) A 2% decrease in the total direct care cost component will be imposed when the NF assessment review results in a an error rate of 35.853% or greater, but is less than 40.569%.
(2) A 5% decrease in the total direct care cost component will be imposed when the NF assessment review results in an error rate of 40.569% or greater, but is less than 45.284%.
(3) A 7% decrease in the total direct care cost component will be imposed when NF assessment review results in an error rate of 45.284% or greater, but is less than 50%.
(4) A 10% decrease in the total direct care cost component will be imposed when the NF assessment review results in an error rate of 50% or greater.

41.23.5 Failure to complete reassessments by the nursing facility staff within 7 days of a written request by staff of the Bureau of Medical Services may result in the imposition of the deficiency per diem as specified in Principle 152 of these Principles of Reimbursement. Completed MDS assessments, as defined in Section 41.2, shall be submitted to the Department or its designee on the regular submission schedule, as outlined in Section 41.21.

41.23.6 Appeal Procedures: A facility may administratively appeal a Bureau of Medical Services rate determination for the direct care cost component. An administrative appeal will proceed in the following manner:
(1) Within 30 days of receipt of rate determination, the facility must request, in writing, an informal review before the Director of the Bureau of Medical Services or his/her designee. The facility must forward, with the request, any and all specific information it has relative to the issues in dispute. Only issues presented in this manner and time frame will be considered at an informal review or at a subsequent administrative hearing.
(2) The Director of his/her designee shall notify the facility in writing of the decision made as a result of the informal review. If the facility disagrees with the results of the informal review, the facility may request an administrative hearing before the Commissioner or a presiding officer designated by the Commissioner. Only issues presented in the informal review will be considered at the administrative hearing. A request for an administrative hearing must be made, in writing, within 30 days of receipt of the decision made as a result of the informal review.
(3) To the extent the Department rules in favor of the facility, the rate will be corrected.
(4) To the extent the Department upholds the original determination of the Bureau of Medical Services, review of the results of the administrative hearing is available in conformity with the Administrative Procedures Act, 5 M.R.S.A. §11001 et seq.

41.3 Allowable costs for the Direct Patient Care component of the rate shall include:
41.31 Direct Patient Care Cost. The base year costs for direct patient care costs shall be the actual audited direct patient care costs incurred by the facility in the fiscal year beginning on or after October 1, 1992 (subject to upper limits). Bonuses are not recognized as allowable costs by the Department.

For nursing facilities that began their first year of operations in a fiscal year beginning on or after October 1, 1993 and are not subject to Section 80.6 of these Principles of Reimbursement the pro-forma cost report supplied with the approved certificate of need shall be the basis for computing the Medicaid rate; subject to upper limits in all cost components.
This determination will exclude any compensation that does not reasonably represent annual, ongoing wage and salary expenses. Contractual labor will be included in the calculation of the number of hours of labor provided in the base year. Costs for contractual labor in the base year will be an allowable cost up to the average hourly wage paid for similar staff within the nursing facility

42 INDIRECT PATIENT CARE COST COMPONENT

42.1 Allowable cost for the Indirect Patient Care Cost component shall include reasonable costs associated with expenses related to indirect patient care. The base year costs for the indirect patient care component shall be the costs incurred by the facility in the fiscal year beginning on or after October 1, 1992.(subject to upper limits). Indirect patient care costs include:

42.11 food, vitamins and food supplements,
42.12 director of nursing, and fringe benefits,
42.13 social services, and fringe benefits,
42.14 medical supplies, equipment and drugs which are supplied as part of the regular rate of reimbursement. See Maine Medical Assistance Manual, Section 67, Appendix #1. Excluded are costs which are an integral part of another cost center.
42.14.1 Inventory items shall include, but are not limited to, medical supplies and food.

42.2 These types of consultative services will be considered as part of the allowable indirect patient care costs and be built into the base year indirect patient care cost components subject to the limitations outlined in subsections 42.21 - 42.23.

42.21 Pharmacist Consultants

Pharmacist consultant fees paid directly by the facility in the base year, will be included in the indirect patient care cost component for inclusion in the facilities per diem rate. In addition to any pharmacist consultant fees included in the base year rate, up to $2.50 per month per resident shall be allowed for drug regimen review.

42.22 Dietary Consultants

Dietary Consultants professionally qualified, may be employed by the facility or by the Department. The allowable amounts paid by the nursing facility to Dietary Consultants in the base year when reasonable and non-duplicative of current staffing patterns will be built into the base year indirect patient care cost component for inclusion in the facilities per diem computation.

42.23 Medical Directors

The base year costs of a Medical Director, who is responsible for implementation of resident care in the facility, is an allowable cost. The base year allowable cost will be established and limited to $1,200.

43 ROUTINE COST COMPONENT

All allowable costs not specified for inclusion in another cost category pursuant to these rules shall be included in the Routine cost component subject to the limitations set forth in these Principles. The base year costs for the routine patient care component shall be the costs incurred by the facility in the fiscal year beginning on or after October 1, 1992 (subject to upper limits).

43.1 Principle. All expenses which providers must incur to meet state licensing and federal certification standards are allowable.

43.2 All inventory items used in the provision of routine services to patients are required to be expensed in the year used. Inventory in excess of the amount used are not an allowable cost. Inventory items shall include, but are not limited to: linen and disposable items.

43.3 Allowable costs shall also include all items of expense efficient and economical providers incur for the provision of routine services. Routine services means the regular room, dietary and nursing services, and the use of equipment and facilities.

43.4 Allowable costs for the Routine component of the rate shall include but not be limited to costs reported in the following functional cost centers on the facility's cost report.

43.41 fiscal services, (not to include accounting fees)
43.42 administrative services and professional fees not to exceed the administrative and management ceiling,
43.43 plant operation and maintenance including utilities,
43.44 grounds,
43.45 laundry and linen,
43.46 housekeeping,
43.47 medical records,
43.48 subscriptions related to patient care,
43.49 all employee education, except wages related to initial and on-going nurse aide training as required by OBRA,
43.410 dietary, excluding food,
43.411 motor vehicle operating expenses,
43.412 clerical,
43.413 transportation, (excluding depreciation),
43.414 office supplies/telephone,
43.415 conventions and meetings within the state of Maine,
43.416 EDP bookkeeping/payroll,
43.417 fringe benefits,
43.418 payroll taxes,
43.419 one association dues, the portion of which is not related to lobbying

See the explanations in Section 43.42.1 - 43.44 for a more complete description of allowable cost in each cost center.

43.42.1 Allowable Administration and Management Expenses.

43.42.11 Principle. A ceiling shall be placed on reimbursement for all compensation for administration and policy making functions and all expenses incurred for management and financial consultation, including accounting fees that are incurred by a related organization or the facility's operating company. Any compensation received by the individual who is listed as the administrator on the facility's license for any other services such as nursing, cooking, maintenance, bookkeeping and the like shall also be included within this ceiling.

This ceiling shall be increased quarterly by the inflationary factor as defined in Section 91 to reflect the rate of inflation from July 1, 1995 to the appropriate quarter. To establish the prospective rate for nursing facilities the administrative ceiling in effect at the beginning of a facility's fiscal year will apply to the entire fiscal year of that facility.

43.42.12 For fiscal years beginning on or after July 1, 1995, the statewide average professional accounting costs by bed size (0-30, 31-50, 51-100, over 100) will be included in the administrative and policy - planning ceiling. Only those reasonable, necessary and proper accounting costs which appropriate to the operation of patient care facilities are considered allowable accounting costs and will be included in the determination of the state wide average.

43.42.2 Ceiling. The administration and policy-planning ceiling that is in effect as of July 1, 1995 is listed below. The ceiling shall be increased quarterly to reflect the rate of inflation from July 1, 1995, to the appropriate quarter.

*up to 30 beds: $37,772 plus $637 for each licensed bed in excess of 10;
*31 to 50 beds: $54,240 plus $545 for each licensed bed in excess of 30;
*51 to 100 beds: $67,432 plus $364 for each licensed be in excess of 50; and
*over 100 beds: $90,757 plus $273 for each licensed bed in excess of 100.

In the case of an individual designated as administrator in more than one (1) facility, the Department shall combine the number of beds in these facilities and apply one hundred and twenty percent (120%) of the above schedule. The total allowance will be prorated to each facility based on the ratio of the facility's number of beds to the combined number of beds for all facilities under the direction of the administrator.

43.42.3 Administration Functions. The administration functions include those duties which are necessary to the general supervision and direction of the current operations of the facility, including, but not limited to, the following:

43.42.3.1 Central Office operational costs for business managers, controllers, reimbursement managers, office managers, personnel directors and purchasing agents are to be included in the administrative and policy-planning ceiling according to an allocation of those costs on the basis of all licensed beds operated by the parent company.

43.42.3.2 Policy Planning Function. The policy planning function includes the policy-making, planning and decision-making activities necessary for the general and long-term management of the affairs of the facility, including, but not limited to the following:

a) financial management, including accounting fees
b) establishment of personnel policies
c) planning of patient admission policies
d) planning of expansion and financing

43.42.3.3 This ceiling is not to include any Director of Nursing, Dietary Supervisor, or other department head, whose prime duties are not of an administrative nature but who may be responsible for hiring or purchasing for their Department.

43.42.3.4 All other regulations specific to administrative functions in Nursing Facilities that are included in State Licensing Regulations and all other State and Federal regulations.

43.42.4 Dividends and Bonuses. Bonuses, dividends, or accruals for the express purpose of giving additional funds to the administrator, owners, or other employees throughout the entire facility, whether or not they are part of the administrative and management ceiling, will not be recognized as allowable costs by the Department.

43.42.5 Management fees. Management fees charged by a parent company or by an unrelated organization or individual are not allowable costs and are not considered part of the administrative and management ceiling.

43.42.6 Corporate Officers and Directors. Salaries paid to corporate officers and directors are not allowable costs unless they are paid for direct services provided to the facility such as those provided by an administrator or other position required by licensing regulations and included in the staffing pattern which are necessary for that facility's operation.

43.42.7 Central Office Operational Costs. Central office bookkeeping costs and related clerical functions that are not included in the administration and policy-planning ceiling may be allocated to each facility on the basis of total patient census limited to the reasonable cost of bookkeeping services if they were performed by the individual facility.

43.42.7.1 All other central office operational costs other than those listed above in this principle are considered unallowable costs.

43.42.8 Laundry services including personal clothing for Medicaid patients.

43.42.9 Cost of Educational Activities

43.42.9.1 Principle. An appropriate part of the net cost of educational activities is an allowable cost. Appropriate part means the net cost of the activity apportioned in accordance with the methods set forth in these Principles. Expenses for education activities may be evaluated as to appropriateness, quality and cost and may or may not be included as an allowable cost based on the findings.

43.42.9.2 Orientation, On-the-Job Training, In-Service Education and Similar Work Learning. Orientation, on-the-job training, in-service education and similar work learning programs are not within the scope of this principle but, if provided by a staff person, are recognized as normal operating costs for routine services in accordance with the principles relating thereto.

43.42.9.3 Basic Education. Educational training programs which a staff member must successfully complete in order to qualify for a position or a job shall be considered basic education. Costs related to this education are not within the scope of reimbursement.

43.42.9.4 Educational Activities. Educational activities mean formally organized or planned workshops, seminars, or programs of study usually engaged in by the staff members of a facility in order to enhance the quality of resident care within the facility. These continuing education activities are distinguished from and do not include orientation, basic education programs, on-the-job training, in-service education and similar work learning programs.

43.42.10 Net Cost. The net cost means the cost of an activity less any reimbursement for them from grants, tuition and specific donations. These costs may include: transportation (mileage), registration fees, salary of the staff member if replaced, and meals and lodging as appropriate.

43.43 Motor Vehicle Allowance. Cost of operation of one motor vehicle necessary to meet the facility needs is an allowable cost less the portion of usage of that vehicle that is considered personal. A log which clearly documents that portion of the automobiles use for business purposes is required. Prior approval from the Division of Audit is required if additional vehicles are needed by the nursing facility.

43.44 Dues are allowed only if the nursing facility is able to provide auditable data that demonstrates what portion of the dues is not used for lobbying efforts by the agency receiving the dues payments.

43.5 Principle. Research Costs incurred for research purposes, over and above patient care, are not includable as allowable costs.

43.6 Grants, Gifts, and Income from Endowments

43.61 Principle. Unrestricted grants, gifts and income from endowments should not be deducted from operating costs in computing reimbursable costs. However, unrestricted Federal or State grants or gifts received by a facility will be used to reduce the operating costs of that facility. Grants, gifts, or endowment income designated by a donor for paying specific operating costs should be deducted from the operating costs or group of costs.

43.61.1 Unrestricted grants, gifts, income from endowment. Unrestricted grants, gifts, and income from endowments are funds, cash or otherwise, given to a provider without restriction by the donor as to their use.

43.61.2 Designated or restricted grants, gifts and income from endowments. Designated or restricted grants, gifts and income from endowments are funds, cash or otherwise, which must be used only for the specific purpose designated by the donor. This does not refer to grants, gifts or income from endowments which have been restricted for a specific purpose by the provider.

43.62 Donations of Produce or Other Supplies. Donations of produce or supplies are restricted gifts. The provider may not impute a cost for the value of such donations and include the imputed cost in allowable costs. If an imputed cost for the value of the donation has been included in the provider's costs, the amount included is deleted in determining allowable costs.

43.63 Donation of Use of Space. A provider may receive a donation of the use of space owned by another organization. In such case, the provider may not impute a cost for the value of the use for the space and include the imputed cost in allowable costs. If an imputed cost for the value of the donation has been included in the provider's cost, the amount included is deleted in determining allowable costs.

43.7 Purchase Discounts and Allowances and Refunds of Expenses.

43.71 Principle. Discounts and allowances received on purchases of goods or services are reductions of the costs to which they relate. Similarly, refunds of previous expense payments are reductions of the related expense.

43.71.1 Discounts. Discounts, in general, are reductions granted for the settlement of debts.

43.71.2 Allowances. Allowances are deductions granted for damages, delay, shortage, imperfections, or other causes, excluding discounts and returns.

43.71.3 Refunds. Refunds are amounts paid back or a credit allowed on account of an over-collection.

43.72 Reduction of Costs. All discounts, allowances, and refunds of expenses are reductions in the cost of goods or services purchased and are not income. When they are received in the same accounting period in which the purchases were made or expenses were incurred, they will reduce the purchases or expenses of that period. However, when they are received in a later accounting period, they will reduce the comparable purchases or expenses in the period in which they are received.

43.73 Application of Discounts Purchase discounts have been classified as cash, trade, or quantity discounts. Cash discounts are reductions granted for the settlement of debts before they are due. Trade discounts are reductions from list prices granted to a class of customers before consideration of credit terms. Quantity discounts are reductions from list prices granted because of the size of individual or aggregate purchase transactions. Whatever the classification of purchase discounts, like treatment in reducing allowable costs is required. In the past, purchase discounts were considered as financial management income. However, modern accounting theory holds that income is not derived from a purchase, but rather from a sale or an exchange, and the purchase discounts are reductions in the cost of whatever was purchased. The true cost of the goods or services is the net amount actually paid for them. Treating purchase discounts as income would result in an overstatement of costs to the extent of the discount.

43.74 All discounts, allowances, and rebates received from the purchases of goods or services and refunds of previous expense payments are clearly reductions in costs and must be reflected in the determination of allowable costs. This treatment is equitable and is in accord with that generally followed by other governmental programs and third-party organizations paying on the basis of costs.

43.8 Principle. Advertising Expenses. The reasonable and necessary expense of newspaper or other public media advertisements for the purpose of securing necessary employees is an allowable cost. No other advertising expenses are allowed.

43.9 Insurance. Reasonable and necessary costs of insurance involved in operating a facility are considered allowable costs (real estate insurance including liability and fire insurance are included as fixed costs - see subsection 44.1.4). Premiums paid on property not used for patient care are not allowed. Reasonable health insurance premiums on employees are an allowable cost. Qualified retirement plans and life insurance plans for employees are an allowable cost. Life insurance's premiums related to insurance on the lives of officers and key employees where the provider is a direct or indirect beneficiary are not allowable costs. A provider is a direct beneficiary where, upon the death of the insured officer or key employee the insurance proceeds are payable directly to the provider. An example of a provider as an indirect beneficiary is the case where insurance on the lives of officers is required as part of a mortgage loan agreement entered into for a building program, and, upon the death of an insured officer the

proceeds are payable to the lending institution as a credit against the loan balance. In this case, the provider is not a direct beneficiary because it does not receive the proceeds directly, but is, nevertheless, an indirect beneficiary since its liability on the loan is reduced.
43.10 Legal Fees. Legal fees to be allowable costs must be directly related to patient care. Fees paid to the attorneys for representation against the Department of Human Services are not allowable costs. Retainers paid to lawyers are not allowable costs. Legal fees paid for organizational expenses, are to be amortized over a 60 month period.
43.11 Costs Attributable to Asset Sales. Costs attributable to the negotiation or settlement of a sale or purchase of any capital asset (by acquisition or merger) are not allowable costs. Included among such unallowable costs are: legal fees, accounting and administrative costs, appraisal fees, costs of preparing a certificate of need, banking and broker fees, good will or other intangibles, travel costs and the costs of feasibility studies.
43.12 Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable cost.

44 FIXED COSTS COMPONENT
44.1 All allowable costs not specified for inclusion in another cost category pursuant to these rules shall be included in the Fixed Cost component subject to the limitations set forth in these Principles. The base year costs for the fixed cost component shall be the costs incurred by the facility in the most recently audited fiscal year. Fixed Costs include:
44.1.1 depreciation on buildings, fixed and movable equipment and motor vehicles,
44.1.2 depreciation on land improvements and amortization of leasehold improvements,
44.1.3 real estate and personal property taxes,
44.1.4 real estate insurance, including liability and fire insurance,
44.1.5 interest on long term debt,
44.1.6 return on equity capital for proprietary providers,
44.1.7 rental expenses,
44.1.8 amortization of finance costs,
44.1.9 amortization of start-up costs and organizational costs,
44.1.10 motor vehicle insurance,
44.1.11 facility's liability insurance, including malpractice costs and workers compensation,
44.1.12 administrator in training,
44.1.13 water & sewer fees necessary for the initial connection to a sewer system/water system,
44.1.14 portion of the acquisition cost for the rights to a nursing facility license.
See the explanations in Sections 44.2 - 44.10 for a more complete description of allowable costs in each of these cost centers.
44.2 Principle. An appropriate allowance for depreciation on buildings and equipment is an allowable cost. The depreciation must be:
44.2.1 Depreciation. Allowance for Depreciation Based on Asset Costs.
44.2.2 Identified and recorded in the provider's accounting records.
44.2.3 Based on historical cost and prorated over the estimated useful life of the asset using the straight-line method.
44.2.4 The total historical cost of a building constructed or purchased becomes the basis for the straight line depreciation method. Component depreciation is not allowed except on those items listed below with their minimum useful lives:

Electric Components	20 years
Plumbing and Heating Components	25 years
Central Air Conditioning Unit	15 years
Elevator	20 years
Escalator	20 years
Central Vacuum Cleaning System	15 years
Generator	20 years

44.22 Any provider using the component depreciation method that has been audited and accepted for cost reporting purposes prior to April 1, 1980, will be allowed to continue using this depreciation mechanism.
44.23 Where an asset that has been used or depreciated under the program is donated to a provider, or where a provider acquires such assets through testate or intestate distribution, (e.g., a widow inherits a nursing facility upon the death of her husband and becomes a newly certified provider;) the basis of depreciation for the asset is the lessor of the fair market value, or the net book value of the asset in the hands of the owner last participating in the program. The basis of depreciation shall be determined as of the date of donation or the date of death, whichever is applicable.
44.24 Special Reimbursement Provisions for Energy Efficient Improvements
44.24.1 For the Energy Efficient Improvements listed below which are made to existing facilities, depreciation will be allowed based on a useful life equal to the higher of the term of the loan received (only if the acquisition is financed) or the period by the limitations listed below:
CAPITAL EXPENDITURE
Up to $5,000.00 - Minimum depreciable period 3 years
From $5001.00-$10,000.00 - Minimum depreciable period 5 years
$10,000.00 and over - Minimum depreciable period 7 years

44.24.2 The above limitations are minima and if a loan is obtained for a period of time in excess of these minima the depreciable period becomes the length of the loan, provided that in no case shall the depreciable period exceed the useful life as spelled out in the American Hospital Association's "Estimated Useful Lives of Depreciable Hospital Assets".

44.24.3 If the total expenditures exceeds $25,000.00, then prior approval for such an expenditure must be received in writing from the Department. A request for prior approval will be evaluated by the Department on the basis of whether such a large expenditure would decrease the actual energy costs to such an extent as render this expenditure reasonable. The age and condition of the facility requesting approval will also be considered in determining whether or not such an expenditure would be approvable.

44.24.4 The reasonable Energy Efficient Improvements are listed below:

1. Insulation (fiberglass, cellulose, etc.)
2. Energy Efficient Windows or Doors for the outside of the facility, including insulating shades and shutters.
3. Caulking or Weather stripping for windows or doors for the outside of the facility.
4. Fans specially designed for circulation of heat inside the building.
5. Wood and Coal burning furnaces or boilers (not fireplaces).
6. Furnace Replacement burners that reduce the amount of fuel used.
7. Enetrol or other devices connected to furnaces to control heat usage.
8. A Device or Capital Expenditures for modifying an existing furnace that reduces the consumption of fuel.
9. Solar active systems for water and space heating.
10. Retrofitting structures for the purpose of creating or enhancing passive solar gain, if prior approved by the Department regardless of amount of expenditure. A request for prior approval will be evaluated by the Department on the basis of whether energy costs would be decreased to such an extent as to render the expenditure reasonable. The age and condition of the facility requesting approval will be also considered.
11. Any other energy saving devices that might qualify as Energy Efficient other than those listed above must be prior approved by the Department for this Special Reimbursement provision. The Department will evaluate a request for prior approval under recommendations from the Division of Energy Programs on what other items will qualify as an energy efficient device and that the energy savings device is a reliable product and the device would decrease the energy costs of the facility making the expenditure reasonable in nature.

44.24.5 In the event of a sale of the facility the principle payments as listed above will be recaptured in lieu of depreciation.

44.25 Recording of depreciation. Appropriate recording of depreciation encompasses the identification of the depreciable assets in use, the assets' historical costs, the method of depreciation, estimated useful lives, and the assets' accumulated depreciation. The American Hospital Association's "Estimated Useful Lives of Depreciable Hospital Assets" 1983 edition is to be used as a guide for the estimation of the useful life of assets.

44.25.1 For new buildings constructed after April 1, 1980 the minimum useful life to be assigned is listed below:

Wood Frame, Wood Exterior	30 years
Wood Frame, Masonry Exterior	35 years
Steel Frame, or Reinforced Concrete Masonry Exterior	40 years

If a mortgage obtained on the property exceeds the minimum life as listed above, then the terms of the mortgage will be used as the minimum useful life.

44.25.2 For facilities providing two levels of care the allocation method to be used for allocating the interest, depreciation, property tax, and insurance will be based on the actual square footage utilized in each level of care. However, when new construction occurs that is added on to an existing facility the complete allocation based on square footage will not be used. Discrete costing will be used to determine the cost of the portion of the building used for each level of care and related fixed cost will be allocated on the basis of that cost.

44.26 Depreciation method. Proration of the cost of an asset over its useful life is allowed on the straight-line method.

44.27 Funding of depreciation. Although funding of depreciation is not required, it is strongly recommended that providers use this mechanism as a means of conserving funds for replacement of depreciation assets, and coordinate their planning of capital expenditures with area wide planning of activities of community and state agencies. As an incentive for funding, investment income on funded depreciation will not be treated as a reduction of allowable interest expense.

44.28 Replacement reserves. Some lending institutions require funds to be set aside periodically for replacement of fixed assets. The periodic amounts set aside for this purpose are not allowable costs in the period expended, but will be allowed when withdrawn and utilized either through depreciation or expense after considering the usage of these funds. Since the replacement reserves are essentially the same as funded depreciation the same regulations regarding interest and equity will apply.

44.28.1 If a facility is leased from an unrelated party and the ownership of the reserve rests with the lessor, then the replacement reserve payment becomes part of the lease payment and is considered an allowable cost in the year expended. If for any reason the lessee is allowed to use this replacement reserve for the replacement of the lessee's assets then during that year the allowable lease payment will be reduced by that amount. The Lessee will be allowed to depreciate the assets purchased in this situation.

44.28.2 If a rebate of a replacement reserve is returned to the lessee for any reason, it will be treated as a reduction of the allowable lease expense in the year review.

44.29 Gains and Losses on disposal of assets. Gains and losses realized from the disposal of depreciable assets are to be included in the determination of allowable costs. The extent to which such gains and losses are includable is calculated on a proration basis recognizing the amount of depreciation charged under the program in relation to the amount of depreciation, if any, charged or assumed in a period prior to the provider's participation in the program, and in the current period.

44.29.1 The recapture will be made in cash from the seller. During the first eight years of operation, all depreciation allowed on buildings and fixed equipment by the Department will be recaptured from the seller in cash at the time of the sale. From the 9th to the 15th year all but 3% per year will be recaptured and from the 16th to the 25th year, all but 8% per year will be recaptured, not to exceed 100%. Accumulated depreciation is recaptured to the extent of the gain on the sale.

44.29.2 The buyer must demonstrate how the purchase price is allocated between depreciable and non-depreciable assets. The cost of land, building and equipment must be clearly documented. Unless there is a sales agreement specifically detailing each piece of moveable equipment, the gain on the sale will be determined by the total selling price of all moveable equipment compared to the book value at the time of the sale. No credits are allowed on moveable equipment.

44.29.3 Accumulated depreciation is recaptured to the extend of the gain on the sale. In calculating the gain on the sale the entire purchase price will be compared to net book value unless the buyer demonstrates by an independent appraisal that a specific portion of the purchase price reflects the cost of non-depreciable assets.

44.29.4 Depreciation will not be recaptured if depreciable assets are sold to a purchaser who will not use the assets for a health care service for which future Medicare, Medicaid, or State payments will be received. The purchaser must use the assets acquired within five years of the purchase. The purchaser will be liable for recapture if the purchaser violates the provisions of this rule.

44.210 Limitation on the participation of capital expenditures. Depreciation, interest, and other costs are not allowable with respect to any capital expenditure in plant and property, and equipment related to patient care, which has not been submitted to the designated planning agency as required, or has been determined to be consistent with health facility planning requirements.

44.3 Purchase, Rental, Donation and Lease of Capital Assets

44.3.1 Purchase of facilities from related individuals and/or organization Where a facility, through purchase, converts from a proprietary to a nonprofit status and the buyer and seller are entities related by common and/or ownership, the purchaser's basis for depreciation shall not exceed the seller's basis under the program, less accumulated depreciation if the following requirements are met:

44.3.1.1(A) Where a facility is purchased from an individual or organization related to the purchaser by common control and/or ownership; or

44.3.1.1(B) Where a facility is purchased after April 1, 1980 by an individual related to the seller as:

(1) a child
(2) a grandchild
(3) a brother or sister
(4) a spouse of a child, grandchild, or brother or sister, or
(5) an entity controlled by a child, grandchild, brother, sister or spouse of child, grandchild or combination brother or sister thereof; or

44.3.1.2 Accumulated depreciation of the seller under the program shall be considered as incurred by the purchaser for purposes of computing gains and applying the depreciation recapture rules Subsection 44.29 to subsequent sales by the buyer. There will be no recapture of depreciation from the seller on a sale between stipulated related parties since no set-up in the basis of depreciable assets is permitted to the buyer.

44.3.1.3 One-time exception to subsection 44.3.1.2 At the election of the seller, subsection 44.3.1.1 will not apply to a sale made to a buyer defined in subsection 44.3.1.2 if:

(a) the seller is an individual or any entity owned or controlled by individuals or related individuals who were selling assets to a "related party" as defined in subsection 44.3.1.1 or 44.3.1.2, and
(b) the seller has attained the age of 55 before the date of such sale or exchange; and
(c) during the twenty-year period ending on the day of the sale, the seller has owned and operated the facility for periods aggregating ten years or more; and
(d) the seller has inherited the facility as property of a deceased spouse to satisfy the holding requirements under subsection 44.3.1.3c
(e) if the seller makes a valid election to be exempted from the application of 44.3.1.2 the allowable basis of depreciable assets for reimbursement of interest and depreciation expense to the buyer will be determined in accordance with the historical cost as though the parties were not related. This transaction is subject to depreciation recapture if there is a gain on the sale.

44.3.1.4 The one exception to subsection 44.3.1.2 applies to individual owners and not to each facility. If an individual owns more than one facility he must make the election as to which facility he wished to apply this exception to.

44.3.1.5 Limitation in the application of subsection 44.3.1.3

44.3.1.5.1 Subsection 44.3.1.3 shall not apply to any sale or exchange by the seller if an election by the seller under subsection 44.3.1.3 with respect to any other sale or exchange has taken place.

44.3.1.5.2 Subsection 44.3.1.3 shall not apply to any sale or exchange by the seller unless the seller:

44.3.1.5.2.1 immediately after the sale has no interest in the nursing home (including an interest as officer, director, manager or employee) other than as a creditor, and

44.3.1.5.2.2 does not acquire any such interest within 10 years after the sale of this or any other facility and

44.3.1.5.2.3 agrees to file an agreement with the Department of Human Services to notify the Department that any acquisition as defined by the subsection 44.3.1.5.2.2 has occurred.

44.3.1.6 If subsection 44.3.1.5.2 is satisfied, subsection 44.3.1.1 and subsection 44.3.1.2 will also be satisfied.

44.3.1.7 If the seller acquires any interest defined by subsection 44.3.1.5.2.2, then pursuant to the agreement the basis will revert to what the seller's basis would be if the seller had continued to own the facility, the amounts paid by the Title XIX program for depreciation, interest and return of owner's equity from the increase in basis will be immediately recaptured, and an interest rate of

nine percent per annum on recaptured moneys will be paid to the Department for sellers' use of Title XIX moneys. A credit against this, of the original amount of depreciation recapture from the seller, will be allowed, with any remaining amount of the original depreciation recapture becoming the property of the Department.

44.3.2 Basis of assets used under the program and donated to a provider. Where an asset that has been used or depreciated under the program is donated to a provider, the basis of depreciation for the asset shall be the lesser of the fair market value or the net book value of the asset in the hands of the owner last participating in the program. The net book value of the asset is defined as the depreciable basis used under the program by the asset's last participating owner less the depreciation recognized under the program.

44.3.3 Allowances for depreciation on assets financed with Federal or Public Funds. Depreciation is allowed on assets financed with Hill Burton or other Federal or Public Funds.

44.4 Leases And Operations Of Limited Partnerships

44.4.1 Information and Agreements Required for Leases. If a provider wishes to have costs associated with leases included in reimbursement:

44.4.1.1 A copy of the signed lease agreement is required.

44.4.1.2 An annual copy of the federal income tax return of the lessee will be made available to Representatives of the Department and of the U.S. Department of Health and Human Services in accordance with Section 27.

44.4.1.3 If the lease is for the use of a building and/or fixed equipment, the articles and bylaws of the corporation, trust indenture partnership agreement, or limited partnership agreement of the lessor is required.

44.4.1.4 If the lease is for the use of a building and/or fixed equipment, the annual federal income tax return of the lessor will be made available to representatives of the Department and the U.S. Department of Health and Human Services in accordance with section 27.

44.4.1.5 A copy of the mortgage or other debt instrument of the lessor will be made available to representatives of the Department and the U.S. Department of Health and Human Services. The lessor will furnish the Department of Human Services a copy of the bank computer printout sheet on the lessor's mortgage showing the monthly principle and interest payments.

44.4.1.6 The lease must be for a minimum period of 25 years if an unrelated organization is involved. If the lessor was to sell the property within the 25 year period to a nursing home operator or the lessee, the historical cost for the new owner would be determined in accordance with the definition of historical costs, and the portion of the lease payment made in lieu of straight line depreciation will be recaptured in accordance with subsection 44.29.

44.4.2 Lease Arrangements Between Individuals or Organizations Related by Common Control and/or Ownership. A provider may lease a facility from a related organization within the meaning of the Principles of Reimbursement. In such case, the rent paid to the lessor by the provider is not allowed as a cost. The provider, however, would include in its costs the costs of ownership of the facility. Generally, these would be costs of the lessor such as depreciation, interest on the mortgage, real estate taxes and other expenses attributable to the leased facility. The effect is to treat the facility as though it were owned by the provider.

44.4.3 Leased Arrangement Between Individuals or Organizations Not Related by Common Control or Ownership. A provider may lease a facility from an unrelated organization within the meaning of the Principles of Reimbursement. The allowable cost between two unrelated organizations is the lesser of:

44.4.3.1 The actual costs calculated under the assumption that the lessee and the lessor are related parties; or

44.4.3.2 The actual lease payments made by the lessee to the lessor.

44.4.3.3 The above principle applies unless the lessor refinances and reduces the cost of ownership below the cost of lease payments and the lessee remains legally obligated to make the same lease payment despite the refinancing. This limitation of the general rule shall not apply to any lease entered into, renewed, or renegotiated after January 1, 1990. If this limitation applies, the allowable cost shall be the actual lease payments made by the lessee to the lessor.

44.4.3.4 If the cost as defined in subsection 44.4.3.2 are less than the costs as defined in subsection 44.4.3.1, then the difference can be deferred to a subsequent fiscal period. If in a later fiscal period, costs as defined in section 44.4.3.2 exceed costs as defined in section 44.4.31, the deferred costs may begin to be amortized. Amortization will increase allowable costs up to the level of the actual lease payments for any given year. These deferred costs are not assets of the provider for purposes of calculating allowable costs of interest or return of owners equity and, except as specified, do not represent assets that a provider or creditor of a provider may claim is a monetary obligation from the Title XIX program.

44.4.3.5 A lease payment to an unrelated party for moveable furnishings and equipment is an allowable cost, but it shall be limited to the cost of ownership.

44.4.4 Sale and Leaseback Agreements-Rental Charges. Rental costs specified in sale and leaseback agreements incurred by providers through selling physical plant facilities or equipment to a purchaser not connected with or related to the provider, and concurrently leasing back the same facilities or equipment, are includable in allowable cost.

However, the rental charge cannot exceed the amount which the provider would have included in reimbursable costs, had he retained legal title to the facilities or equipment, such as interest on mortgage, taxes, depreciation, insurance and maintenance costs.

44.5 Interest Expense

44.5.1 Principle. Necessary and proper interest on both current and capital indebtedness is an allowable cost.

44.5.2 Interest. Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the costs incurred for funds borrowed for a relatively short term, usually one (1) year or less, but in no event more than fifteen (15) months. This is usually for such purposes as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as acquisition of facilities and equipment, and capital improvements. Generally, loans for capital purposes are long-term loans. Except as provided in subsection 44.5.4.6, interest does not include interest and penalties charged for failure to pay accounts when due.

44.5.3 Necessary. In order to be considered "necessary", interest must:

44.5.3.1 Be incurred on a loan made to satisfy a financial need of the provider. Loans which result in excess funds or investments would be considered unnecessary; and

44.5.3.2 Be reduced by investment income except where such income is from gifts, whether restricted or unrestricted, and which are held separate and not commingled with other funds. Income from funded depreciation is not used to reduce interest expense.

44.5.3.3 Proper. Proper requires that interest:

44.5.3.3.1 Be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made.

44.5.3.3.2 Be paid to a lender not related through control or ownership, or personal relationship to the borrowing organization.

44.5.3.4 Refinancing. Any refinancing of property mortgages or loans on fixed assets must be prior approved by the Department. If prior approval is not obtained any additional interest costs or finance charges will not be allowed.

44.5.4 Borrower-lender relationship

44.5.4.1 To be allowable, interest expense must be incurred on indebtedness established with lenders or lending organizations not related through control, ownership or personal relationship to the borrower. Presence of any of these factors could affect the "bargaining" process that usually accompanies the making of a loan, and could thus be suggestive of an agreement with higher rates of interest or of unnecessary loans. Loans should be made under terms and conditions that a prudent borrower would make in arm's-length transactions with lending institutions. The intent of this provision is to assure that loans are legitimate and needed, and that the interest rate is reasonable. Thus, interest paid by the provider to partners, stockholders, or related organizations of the provider would not be allowed. However, interest on first or second mortgages held by stockholders, owners, relatives or related organizations of the provider, will be treated as an allowable cost if it is in line with the interest rates charged by lending institutions at the inception of the loan. Where the owner uses his own funds in a business, it is reasonable to treat the funds as invested funds or capital, rather than borrowed funds. Therefore, where interest on loans by partners, stockholders, or related organizations is disallowed as a cost solely because of the relationship factor, the principal of such loans shall be treated as invested funds in the computation of the provider's equity capital.

44.5.4.2 Exceptions to the general rule regarding interest on loans from controlled sources of funds. Where the general fund of a provider borrows from a donor-restricted fund and pays interest to the restricted fund, this interest expense is an allowable cost. The same treatment is accorded interest paid by the general fund on money borrowed from the funded depreciation account of the provider. In addition, if a provider of a facility operated by members of a religious order borrows from the order, interest paid to the order is an allowable cost. Interest paid by the provider cannot exceed interest earned by the above subject funds.

44.5.4.3 Where funded depreciation is used for purposes other than improvement, replacement, or expansion of facilities or equipment related to patient care, or payment of long-term debt principle once the principle payment exceeds the straight-line depreciation allowed under the Principles of Reimbursement, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation.

44.5.4.4 Loans not reasonably related to patient care. Loans made to finance that portion of the cost of acquisition of a facility that exceeds historical cost are not considered to be for a purpose reasonably related to patient care.

44.5.4.5 Interest expense of related organizations. Where a provider leases facilities from a related organization and the rental expense paid to related organization is not allowable as a cost, costs of ownership of the leased facility are allowable as in interest cost to the provider. Therefore, in such cases, mortgage interest paid by the related organization is allowable as an interest cost to the provider.

44.5.4.6 Interest on Property Taxes. Interest charged by a municipality for late payment of property taxes is an allowable cost when the following conditions have been met:

44.5.4.6.1 The rate of interest charged by the municipality is less than the interest which a prudent borrower would have had to pay in the money market existing at the time the loan was made;

44.5.4.6.2 The payment of property taxes is deferred under an arrangement acceptable to the municipality;

44.5.4.6.3 The late payment of property taxes results from the financial needs of the provider and does not result in excess funds; and

44.5.4.6.4 Approval in writing has been given by the Department prior to the time period in which the interest is incurred. Any requests for prior approval must be received by the Department at least two weeks prior to the desired effective date of the approval.

44.5.4.7 Limitation on the participation of capital expenditures. Interest is not allowable with respect to any capital expenditure in plant and property, and equipment related to patient care, which did not receive a required Certificate of Need Review approval.

44.5.5 The Department will make adjustments to the nursing facility's fixed cost component of the per diem rate to reflect the effect of refinancing which results in lower interest payments.

44.6 Return on Equity Capital of Proprietary Providers

44.6.1 Principle. A reasonable return on equity capital invested and used in the provision of patient care is allowable as an element of the reasonable cost of covered services furnished to the beneficiaries by proprietary providers. The amount on an annual basis is eight percent (8%).

44.6.2 For purposes of this subpart, the term "propriety providers" means providers, whether sole proprietorships, partnerships or corporations organized and operated with the expectation of earning profits for the owners, as distinguished from providers organized and operated on a non-profit basis.

44.6.3 For the purpose of computing the allowable return, the provider's equity capital means:

44.6.3.1 The provider's investment in plant and property and equipment related to patient care (net of depreciation) and funds deposited by a provider who leases plant, property, or equipment related to patient care and is required by the terms of the lease to deposit such funds (net or noncurrent debt related to such investment or deposited funds) and,

44.6.3.2 Net working capital maintained for necessary and proper operation of patient care activities.

44.6.3.3 Notwithstanding anything in Subsection 44.6.3.1 and 44.6.3.2 debt representing loans from partners, stockholders, or related organizations, on which interest payments would be allowable as costs but for Subsection 44.5.4.1 is included in computing the amount of

equity capital in order that the proceeds from such loans be treated as a part of the provider's equity capital. In computing the amount of equity capital upon which a return is allowable, investment in facilities is recognized on the basis of the historical cost.

44.6.4 Acquisitions. For facilities or tangible assets acquired, the excess of the purchase price paid for a facility or assets over (1) the historical cost of the tangible assets, or (2) the cost basis of the tangible asset, whichever is applicable, is not includable in the computation of equity capital. Loans made to finance such excess portion of the cost of such acquisitions are similarly not includable in the computation of equity capital.

44.6.5 Computation of return on equity capital. For purposes of computing the allowable return, the amount of equity capital is the average investment during the reporting period. Return on investment as an element of allowable costs is subject to apportionment in the same manner as other elements of allowable costs.

44.6.6 Unapproved capital expenditures. With respect to any capital expenditure, a provider's investment in plant, property and equipment related to patient care, and funds deposited by a provider which leases plant, property, or equipment related to patient care which are found to be expenditures which have not been submitted to the designated planning agency as required, or have been determined to be inconsistent with health facility planning requirements, are not included in the provider's equity capital for computing the allowance for a reasonable return on equity capital.

44.6.7 Exclusion from Computation of Average Equity Capital. For the purpose of computing average equity capital, the following are examples of items not to be included in the computation:

44.6.7.1 Notes and loans receivable from owners or related organizations.

44.6.7.2 Goodwill.

44.6.7.3 Unpaid capital surplus.

44.6.7.4 Treasury Stock.

44.6.7.5 Unrealized capital appreciation surplus.

44.6.7.6 Cash surrender value of life insurance policies.

44.6.7.7 Prepaid premiums on life insurance policies.

44.6.7.8 Assets acquired in anticipation of expansion and not presently used in the provider's operation or in the maintenance of patient care activities during the rate period.

44.6.7.9 Inter-company accounts.

44.6.7.10 The portion of the value of any motor vehicle that is attributed to personal use.

44.6.7.11 Any other assets not directly related to or necessary for the provision of patient care to publicly-aided patients.

44.6.7.12 Funded Depreciation.

44.6.7.13 Accrued interest on related party loans and cash invested in money market accounts or savings accounts for a period of over six months.

44.7 Worker's Compensation Insurance premiums paid to an admitted carrier; application fees, assessments and premiums paid to an authorized fully-funded trust; and premiums paid to an individual self-insured program approved by the State of Maine for facility fiscal years that began on or after October 1, 1992, and deductibles paid by facilities related to such cost are allowable fixed costs. Estimated amounts for workers compensation insurance audit premiums will not be accepted as an allowable cost. The Department will require the facility to be a prudent and cost conscious buyer of worker's compensation insurance. In those instances where the Department finds that a facility pays more than the usual and customary rate or does not try to minimize costs, in the absence of clear justification, the Department may exclude excess costs in determining allowable costs under Medicaid. Allowable costs are subject to an experience modifier of 1.4; that is, cost associated with an experience modifier of 1.4 or under are allowable. Workers compensation costs incurred above the experience modifier of 1.4 shall be considered unallowable and will be settled at time of audit.

44.7.1 The costs of Loss-Prevention and Safety Services are allowable costs to a maximum of $40.00 per covered employee per year for nursing facilities with an experience modifier greater than .9. The costs of Loss-Prevention and Safety Services are allowable costs to a maximum of $70.00 per covered employee per year for nursing facilities with an experience modifier equal to or less than .9. Allowable costs shall include the cost of educational programs and training classes, transportation to and from those classes, lodging when necessary to attend the classes, materials needed in the preparation and presentation of the classes (when held at the nursing facility), and equipment (e.g.: lifts) which lead towards accomplishing the established goals and objectives of the facility's safety program. Non-allowable costs include salaries paid to individuals attending the safety classes and personal gifts such as bonuses, free passes to events or meals, and gift baskets.

44.7.2 The wages and fringes paid to workers engaged in formal Modified or Light-Duty Early-Return-To-Work Programs are allowable costs only to the extent that they cause a nursing facility to exceed its staffing pattern. Rehabilitation eligibility assessments are a cost to a limit of $300.00 per indemnity claimant. (Rehabilitation services provided to eligible injured workers are to be paid for by their employers insurer.)

44.8 Administrator in Training. The reasonable salary of an administrator in training will be accepted as an allowable cost for a period of six months provided there is a set policy, in writing, stating the training program to be followed, position to be filled, and provided that this individual obtain an administrator's license and serve as an administrator of a facility in the State of Maine. Prior approval in writing, from the Department, must be issued in advance of the date of any salary paid to an administrator in training. A request for prior approval must be received by the Department at least two (2) weeks prior to the desired effective start date of the administrator in training program. Failure to receive approval from the Department for the Administrator in Training salary will deem that salary an unallowable cost at time of audit. Failure to become an administrator within one year following completion of the examination to become a licensed administrator will result in the Department of Human Services recovering 100% of the amount allowed of the administrator in training. If the administrator in training discontinues the training program for any reason or fails to take the required examination to become a licensed administrator, 100% of the amount allowed will be recovered by the Department.

44.9 Acquisition Costs. Fifty percent of the acquisition cost of the rights to a nursing facility license shall be approved as a fixed cost in those situations where the purchaser acquires the entire existing nursing facility license of a provider and delicenses all or a significant portion (at least

50%) of the beds associated with that license. This amount will be amortized over a ten (10) year period, beginning with the subsequent fiscal year after completion of the acquisition. This acquisition cost will not include any fees (eg: accounting, legal) associated with the acquisition.

44.10 Occupancy Adjustment. To the extent that fixed costs are allowable, such cost will be adjusted for providers whose annual level of occupancy is less than ninety percent (90%). The adjustment to the fixed cost component shall be based upon a theoretical level of occupancy of ninety percent (90%). The 90% occupancy rate adjustment will be applied to fixed costs for facilities fiscal years beginning on or after 7/1/95, and shall be cost settled at the time of audit. For all new providers coming into the program, the 90% occupancy adjustment will not apply for the first 30 days of operation. It will, however, apply to the remaining months of their initial operating period. To the extent that fixed costs are allowable, such cost will be adjusted for providers with 60 or fewer beds whose annual level of occupancy is less than eighty-five percent (85%). The adjustment to the fixed cost component shall be based upon a theoretical level of occupancy of eighty-five percent (85%). The 85%_occupancy rate adjustment will be applied to fixed costs for facilities fiscal years beginning on or after 7/1/97, and shall be cost settled at the time of audit. For all new providers of sixty (60) or fewer beds coming into the program, the 85% occupancy adjustment will not apply for the first 30 days of operation. It will, however, apply to the remaining months of their initial operating period.

50 PUBLIC HEARING

The State of Maine will provide for public hearings as necessary in our State Plan, according to State procedures.

60 WAIVER

The failure of the Department to insist, in any one or more instances, upon the performance of any of the terms or conditions of these Principles, or to exercise any right under these principles, or to disapprove of any practice, accounting procedure, or item of account in any audit, shall not be construed as a waiver of future performance of the right. The obligation of the Provider with respect to future performance shall continue, and the Department shall not be stopped from requiring such future performance.

70 SPECIAL SERVICE ALLOWANCE

70.1 Principle. A special ancillary service is to be distinguished from a service generally provided in the nursing facility.

70.1.1 A special ancillary service is that of an individual nature required in the case of a specific patient. This type of service is limited to professional services such as physical therapy, occupational therapy, and speech and hearing services. Special services of this nature must be billed monthly to the Department as separate items required for the care of individual recipients.

71 OMNIBUS RECONCILIATION ACT OF 1987 (OBRA 87)

OBRA 1987 has eliminated the distinction between ICFs and SNFs and the method of payment by such classifications. The statute provides for only one type of nursing facility. All nursing homes are now classified as a "nursing facility" with a single payment methodology.

80 ESTABLISHMENT OF PROSPECTIVE PER DIEM RATE

80.1 Principle. For facility fiscal years beginning on or after July 1, 1995 the Department will establish a prospective per diem rate to be paid to each facility until the end of its fiscal year. Each nursing facility's cost components for the fiscal year that begins on or after October 1, 1992, as determined from the audited cost report (or as filed cost report until an audit is completed) will be the basis for the base year computations (subject to upper limits).

The base year direct, indirect and routine patient care cost component costs will be trended forward using the inflationary factors from the table "HCFA Nursing Home Without Capital Market Basket" from the publication Health Care Costs published by DRI/McGraw-Hill as described in Section 91. Inflation factor data for salaries will be acquired from the Maine Health Care Facility Economic Trend Factor. The inflation factors will be based on the most recent DRI publications available at the times the rates are determined. Beginning October 1, 1993 the determination of the direct care cost component of each facility's base year rate will be computed by calculating the facility's case mix adjusted cost per day pursuant to Section 80.3. The 1992 (fiscal year beginning on or after 10/1/92) base year indirect component costs, will be used to compute the median costs, upper limits and incentive payments that will be the basis for computing each facility's rate. The 1992 fiscal year (beginning on or after 10/1/92) routine care component costs, adjusted for the 1993 statewide average accounting fees, will be the basis for computing the median routine care component costs and upper limits that will be the basis for computing each facility's rate. The nursing facility's direct, indirect and routine cost components allowable rate will be inflated to the end of the nursing facilities current fiscal year. The prospective rate shall consist of four components : the direct patient care cost component as defined in Section 41; the indirect patient care cost component as defined in Section 42, the routine cost component as defined in Section 43, and the fixed cost component as defined in Section 44.

80.2 FIXED COST COMPONENT

The fixed cost component shall be determined from the most recent audited or, if more recent information is approved by the Department, it shall be based on that more recent information using allowable costs as identified in Section 44. As described in Section 44, fixed costs will be adjusted for providers whose annual level of occupancy is less than ninety percent (90%). The adjustment to fixed costs shall be based upon a theoretical level of occupancy of ninety percent (90%). For all new providers coming into the program, the 90% occupancy adjustment will not apply for the first 30 days of operation. It will, however, apply to the remaining months of their initial operating periods. To the extent that fixed costs are allowable, such cost will be adjusted for providers with 60 or fewer beds whose annual level of occupancy is less than eighty-five percent (85%). The adjustment to the fixed cost component shall be based upon a theoretical level of occupancy of eighty-five percent (85%). The 85% occupancy rate adjustment will be applied to fixed costs for facilities fiscal years beginning on or after 7/1/97, and shall be cost settled at the time of audit. For all new providers of sixty_(60) or fewer beds coming into the program, the 85% occupancy adjustment will not apply for the first 30 days of operation. It will, however, apply to the remaining months of their initial operating period.

80.3 DIRECT PATIENT CARE COST COMPONENT

80.3.1 Case Mix Reimbursement System

80.3.1.1 The direct resident care cost component utilizes a case mix reimbursement system. Case mix reimbursement takes into account the fact that some residents are more costly to care for than others. Thus the system requires:

(a) the assessment of residents on the Department's approved form - MDS as specified in Section 41.2.;

(b) the classification of residents into groups which are similar in resource utilization by use of the case mix resident classification groups as defined in Section 80.3.2.;

(c) a weighting system which quantifies the relative costliness of caring for different classes of residents by direct care staff to determine a facility's case mix index.

80.3.2 Case mix resident classification groups and weights

There are a total of 45 case mix resident classification groups, including one resident classification group used when residents can not be classified into one of the 44 clinical classification groups.

Each case mix classification group has a specific case mix weight as follows:

RESIDENT CLASSIFICATION GROUP	CASE MIX WEIGHT
REHABILITATION	
REHAB VERY HI/ADL 14-18	2.171
REHAB VERY HI/ADL 8-13	1.605
REHAB VERY HI/ADL 4-7	1.427
REHAB HI/ADL 15-18	2.022
REHAB HI/ADL 12-14	1.623
REHAB HI/ADL 8-11	1.491
REHAB HI/ADL 4-7	1.350
REHAB MED/ADL 16-18	1.886
REHAB MED/ADL 8-15	1.426
REHAB MED/ADL 4-7	1.337
REHAB LOW/ADL 12-18	1.350
REHAB LOW/ADL 4-11	1.202
EXTENSIVE	
EXTENSIVE 3/ADL 7-18	3.968
EXTENSIVE 2/ADL 7-18	2.424
EXTENSIVE 1/ADL 7-18	1.673
SPECIAL CARE	
SPECIAL CARE/ADL 17-18	1.534
SPECIAL CARE/ADL 14-16	1.375
SPECIAL CARE/ADL 7-13	1.279
CLINICALLY COMPLEX	
CLIN. COMP W/DEP/ADL 17-18	1.356
CLIN. COMP ADL 17-18	1.323
CLIN. COMP W/DEP/ADL 11-16	1.193
CLIN. COMP/ADL 11-16	1.128
CLIN. COMP W/DEP/ADL 6-10	1.127
CLIN. COMP/ADL 6-10	0.996
CLIN. COMP W/DEP/ADL 4-5	0.958
CLIN. COMP/ADL 4-5	0.799
IMPAIRED COGNITION	
COG. IMPAIR W/RN REHAB/ADL 6-10	1.021
COG. IMPAIR/ADL 6-10	0.919
COG. IMPAIR W/RN REHAB/ADL 4-5	0.794
COG. IMPAIR/ADL 4-5	0.688
BEHAVIOR PROBLEMS	
BEHAVE PROB W/RN REHAB/ADL 6-10	1.021
BEHAVE PROB/ADL 6-10	0.900
BEHAVE PROB W/RN REHAB/ADL 4-5	0.715
BEHAVE PROB/ADL 4-5	0.610
PHYSICAL FUNCTIONS	
PHYSICAL W/RN REHAB/ADL 16-18	1.145
PHYSICAL/ADL 16-18	1.099
PHYSICAL W/RN REHAB/ADL 11-15	1.076
PHYSICAL/ADL 11-15	1.008
PHYSICAL W/RN REHAB/ADL 9-10	0.918
PHYSICAL/ADL 9-10	0.896

PHYSICAL W/RN REHAB/ADL 6-8	0.807
PHYSICAL/ADL 6-8	0.716
PHYSICAL W/RN REHAB/ADL 4-5	0.686
PHYSICAL ADL 4-5	0.563
UNCLASSIFIED	0.563

80.3.3 Base Year Direct Resident Care Cost Component

80.3.3.1 Source of base year cost data. The source for the direct resident care cost component of the base year cost data is the audited cost report (as filed cost report until an audit is completed) for the nursing facilities fiscal year beginning on or after October 1, 1992. At the point of time that audited report data is available for the base year, the nursing facility rate for subsequent quarters will be based on those figures. Recalculation of the upper limits shall not occur until subsequent rebasing of all components occurs.

80.3.3.2 Case Mix Index

The Bureau of Medical Services shall compute each facility's case mix index for the base year as follows:

(a) For each facility the number of Medicaid residents in each case mix classification group shall be determined from the most recent MDS completed for all residents as of March 31, 1993.

(b) For each facility, the Bureau will multiply the number of Medicaid residents in each case mix classification group excluding the residents in the unclassified group by the case mix weight for the relevant classification group.

(c) The sum of these products divided by the total number of Medicaid residents excluding the residents in the unclassified group equals the facility's case mix index.

80.3.3.3 Base year case mix adjusted Medicaid cost per day

Each facility's direct resident care case mix adjusted cost per day will be calculated as follows:

(a) The facility's direct resident care cost per day, as specified in Section 80.3.3.1, is divided by the facility's base year case mix index to yield the case mix adjusted cost per day.

80.3.3.4 Array of the base year case mix adjusted cost per day

For each peer group, the Bureau shall array all nursing facilities case mix adjusted costs per day inflated to June 30, 1995 from high to low and identify the median.

Facilities that have level A deficiencies cited by the Division of Licensing and Certification in the base year are excluded from the array for purposes of identifying the median.

80.3.3.5 Limits on the base year case mix adjusted cost per day

The upper limit on the base year case mix adjusted cost per day shall be the median plus fifteen per cent (15%). The upper limit on the base year case mix adjusted cost per day shall be the median plus twelve per cent (12%) for the facilities fiscal year that begins on or after July 1, 1995.

80.3.3.6 Each facility's case mix direct care rate shall be the lesser of the limit in Section 80.3.3.5. or the facility's base year case mix adjusted cost per day.

80.3.4 Quarterly Calculation of the Direct Resident Care Component

The Bureau of Medical Services shall compute the direct resident care cost component for each facility on a quarterly basis.

80.3.4.1 Calculation of the case mix index

The Bureau of Medical Services shall compute each facility's case mix index for the rate period as follows:

For each facility the number of Medicaid residents in each case mix classification group shall be determined from the assessment date on the MDS on all Medicaid residents in the facility as of the 15th day of the prior quarter (e.g. For a October 1 rate, the facility's case mix index would be computed using the most recent assessments of Medicaid residents with an assessment date of June 15.)

For each facility, the Bureau will multiply the number of Medicaid residents in each case mix classification group including those in the unclassified group by the case mix weight for the relevant classification group. The sum of these products divided by the total number of Medicaid residents equals the facility's case mix index. The roster sent to the nursing facility for confirmation of residents in the nursing facility is relied upon by the Department in determining the residents in the nursing facility. It is the nursing facilities responsibility to check the roster and make corrections within one week of receiving the roster and submit such corrections to the Department or it's designee.

For purposes of this section, resident assessments that are incomplete due to the death, discharge, or hospital admission of the resident during the time frame in which the assessment must be completed will not be included in the unclassified group or used to compute the case mix index. (Note: For Medicaid residents, the facility would be paid the facility rate for the number of days the resident is at the facility.)

80.3.4.2 Direct resident care rate per day

The direct resident care rate per day shall be computed by multiplying the allowable base year case mix adjusted cost per day by the applicable case mix index.

80.3.4.3 The direct cost, as defined in Section 41, shall be determined by adjusting the allowable necessary and reasonable direct patient care costs (subject to the limitations cited in Section 41) from the base year by the inflationary factor defined in Section 91.

80.3.5 Direct Patient Care Cost Savings. Managers of facilities who operate in an efficient and economical manner and thereby limit their direct patient care costs during their fiscal year to less than the amounts paid through the direct patient care cost component of the final prospective rate will share with the Department in the resulting savings the resulting savings.

For fiscal years beginning on or after July 1, 1995 direct patient care cost savings will result in the facility retaining 25% of this savings as long as residents needs are determined to be met and the facilities comply with all relevant state and federal requirements.

Facilities which incur direct patient care costs during their fiscal year in excess of the direct patient care cost component of the prospective rate will receive no more than the amount allowed by the prospective rate.

80.4 INDIRECT PATIENT CARE COST COMPONENT

Indirect Care Patient Care Cost component base year rates shall be computed as follows:

80.4.1 Using each facility's base year (fiscal year beginning on or after 10/1/92) cost report, the provider's base year total allowable Indirect Patient Care costs shall be determined in accordance with Section 42.

80.4.2 The base year per diem allowable Indirect Patient Care costs for each facility shall be calculated by dividing the base year total allowable indirect patient care costs by the total base year resident days.

80.4.3 The Bureau of Medical Services will array all nursing facility's base year per diem allowable Indirect Patient Care costs adjusted to a common fiscal year by the appropriate inflationary factor, from low to high and identify the median.

80.4.4 The per diem limit shall be the median plus 10 percent for facilities fiscal year beginning on or after July 1, 1995.

80.4.5 Each facility's Base Year Indirect Patient Care cost per diem rate shall be the lesser of the limit set in subsection 80.4.4 or the facility's base year per diem allowable indirect patient care costs.

80.5 ROUTINE CARE COST COMPONENT

Routine Care Cost component base year rates shall be computed as follows:

80.5.1 Using each facility's base year (fiscal year beginning on or after 10/1/92) cost report, the provider's base year total allowable routine care costs shall be determined in accordance with Section 43.

80.5.2 The base year per diem allowable routine care costs for each facility shall be calculated by dividing the base year total allowable routine care costs by the total Base Year resident days.

80.5.3 The Bureau of Medical Services will array all nursing facility's base year per diem allowable routine costs adjusted to a common fiscal year by the appropriate inflationary factor, from low to high and identify the median.

80.5.4 The per diem limit shall be the median plus 8 percent for fiscal year beginning on or after July 1, 1995.

80.5.5 Each facility's Base Year Routine Care cost per diem rate shall be the lesser of the limit set in Subsection 80.5.4 or the facility's base year per diem allowable routine care costs.

80.6 RATES FOR FACILITIES RECENTLY SOLD, RENOVATED OR NEW FACILITIES

80.6.1 A nursing home project that proposes renovation, replacement or other actions that will increase Medicaid costs and for which an application is filed after March 1, 1993 may be approved only if appropriations have been made by the Legislature expressly for the purpose of meeting those costs. The basis for establishing the facility's rate through the certificate of need review is the lesser of the rate supported by the costs submitted by the applicant or the statewide base year median for the direct, indirect and routine cost components inflated to the current period. The fixed costs determined through the Certificate of Need review process must be approved by the Bureau of Medical Services (also see Section 44.25.2).

80.6.1.1 For a facility sold after October 1, 1993, the direct, indirect and routine rate shall be the lessor of the rate of the seller or the rate supported by the costs submitted by the purchaser of the facility. The fixed cost component recognized by the Medicaid program will be determined through the Certificate of Need review process. Fixed costs determined through the certificate of need review process must be approved by the Bureau of Medical Services.

80.6.2 Nursing facility's not required to file a certificate of need application, currently participating in the Medicaid program, that undergo replacement and/or renovation will have their appropriate cost components adjusted to reflect any change in allocated costs. However, the rates established for the affected cost components will not exceed the state median rates for facility's in its peer group. In those instances that the data supplied by the nursing facility to the Department indicates that any one component rate should be less than the current rate the Department will assign the lower rate for that component to the nursing facility.

80.6.3 The reimbursement rates set, as stated in Sections 80.6.1 and 80.6.2, will remain in effect for the period of three (3) years from the date that they are set under these Principles.

80.6.4 At the conclusion of the three years, the reimbursement rate will be rebased to the fiscal year stated in Sections 41.3.1, 42.1, and 43 or the most recent audited fiscal year occurring after the opening of the new facility, the completion of the new renovation, or the sale of the facility, whichever is the most current.

80.7 NURSING HOME CONVERSIONS

80.71 In reference to Public Law 1981, c. 705, Pt. V, § 304, the following guidelines have been established in relation to how nursing facilities that convert nursing facility beds to residential care beds will be reimbursed:

80.71.1 A pro forma step down cost report for the year in which the bed conversion will take place or the first full fiscal year in which the facility will operate with both nursing facility and residential care facility levels of care will be submitted to the Bureau of Elder and Adult Services and to the Division of Reimbursement and Financial Services of the Bureau of Medical Services.

80.71.2 Based on an analysis of the cost report by the Department, the allowable costs will be determined based on the Principles of Reimbursement for Nursing Facilities contained herein.

80.71.3 The occupancy level that will be used in the calculation of the rate will be set at the days included on the pro forma cost report submitted at the time of the conversion or at the 97% occupancy level, whichever is greater. For conversions with an effective date of July 1, 1998 or after, the occupancy level that will be used in the calculation of the rate will be set at the days included on the pro forma cost report submitted at the time of the conversion or at the 95% occupancy level, whichever is greater.

80.71.4 The case mix index will be determined as stated in Sections 41.2 , 80.3.1, 80.3.2, 80.3.3.2, and 80.3.4.1.

80.71.5 The upper limits for the direct, indirect, and routine care cost components will be inflated forward to the end of the fiscal year of the pro forma cost report submitted as required in Section 80.71.1.

80.71.6 The reimbursement rates set, as stated in Sections 80.71.1 -80.71.5, will remain in effect for the period of three (3) years from the date that they are set under these Principles. The direct, indirect, and routine components will be inflated to the current year, subject to the peer group cap.

80.71.7 At the conclusion of the three years, the reimbursement rate will be rebased to the fiscal year stated in Sections 41.3.1, 42.1, and 43 or the most recent audited full fiscal year occurring after the conversion of nursing facility beds to residential care beds, whichever is the most current.
80.71.8 Section 80.7 is effective for Nursing Facilities with the effective date of conversion of nursing facility beds to residential care facility beds occurring on or after January 1, 1996.

81 INTERIM AND SUBSEQUENT RATES
81.1 Interim Rate and Subsequent Year Rates. Fifteen days prior to the beginning of the facility's fiscal year, an interim rate will be established by using the fixed cost component of the previous fiscal year and adding to it the inflated indirect and routine cost components of the base year. The interim rate in subsequent fiscal years will be determined in the same manner as outlined above. The direct cost component is computed as specified in Section 80.3.4.

82 FINAL PROSPECTIVE RATE.
Upon final audit of all nursing facility's base year cost reports, the Department will determine a final prospective rate. The final prospective rate will be used as the basis for determining any adjustment that is required to adjust the computation of the median and upper limits for the indirect cost and routine cost components for subsequent fiscal years.
82.1 Adjustments to the Median Base Year and Upper Limit Computation for the Indirect and Routine Cost Components. The Department of Human Services in computing the base year median and upper limits for the routine and indirect cost components will rely on the most recent available data from cost report data files. To the extent that the data on this file is unaudited data, the computation will be recomputed when base year audits on all nursing facilities have been settled to determine the variance between the initial computations and the audited data computations. If the variance is material (+ or - 1%) the rates in a subsequent period following the recalculation of the median will be adjusted to reflect the audited data.
82.2 A cost report is settled if there is no request for reconsideration of the Division of Audits findings made within the required time frame or, if such request for reconsideration was made and the Division of Audit has issued a final revised audit report.

84 FINAL AUDIT OF FIRST AND SUBSEQUENT PROSPECTIVE YEARS.
84.1 Principle. All facilities will be required to submit a cost report in accordance with Section 32 at the end of their fiscal year on cost report forms approved by the Department. The Department will conduct a final audit of each facility's cost report, which may consist of a full scope examination by Department personnel and which will be conducted on an annual basis.
84.2 Upon final audit of a facility's cost report for the first and subsequent prospective years, the Department will:
84.2.1 determine the actual allowable fixed costs incurred by the facility in the prior fiscal year,
84.2.2 determine the occupancy levels of the nursing facility,
84.2.3 The Division of Audit can make determinations required to implement these Principles of Reimbursement. The following are examples of such determinations:
84.2.3.1 Savings for the direct patient care cost component, to be determined by computing the difference between the actual costs and the direct patient care cost component rates paid during the facilities year.
84.2.3.2 Nursing facilities that transfer a cost center from one cost component to another cost component resulting in increased Medicaid costs will have the affected cost components adjusted at time of audit.
84.2.3.3 calculate a final rate,
84.2.3.4 calculate any adjustments necessary to the current prospective rates for all nursing facility's based on the above determination, and
84.2.3.5 after adjusting for the base year audited cost reports specified in 82.1 above, subsequent fiscal years costs in the indirect and routine cost components will only be adjusted for inflation using the factors specified in Section 91 of these Principles.
Upon final audit of a facility's cost report, the Department will calculate a final prospective rate and determine the lump sum settlement amounts either due to or from the nursing facility.
84.2.4 The Division of Audit final audit adjustment to the nursing facilities annual cost report will consider the impact of days waiting placement as specified in the Principles of Reimbursement for Residential Care Facilities. Fixed cost reimbursement for the nursing facility will not be affected by days waiting placement reimbursement to the nursing facilities.

85 SETTLEMENT OF FIXED EXPENSES
85.1 The Department will reimburse facilities for the actual allowable fixed costs which are incurred during a fiscal year. Upon final audit of a facility's cost report, if the Department's share of the allowable fixed costs actually incurred by the facility is greater than the amount paid by the Department (the fixed cost component of the final prospective rate multiplied by the number of days of care provided to Medicaid beneficiaries), the difference will be paid to the facility by the Department. If, the Department's appropriate share of the allowable fixed costs actually incurred by a facility is less than the amount paid by the Department, the difference will be paid to the Department by the facility.
85.2 Federal regulations state that during the first year of implementing the nursing home reform requirements, the new costs which a facility must incur to comply with these requirements will be treated as a fixed cost. The facility must maintain the appropriate documentation in order for these costs to be identified at the time of the facility's final audit.
The cost associated with meeting the Nursing Home Reform Act of 1987 requirements will continue to be treated as a fixed cost through the facility's first full fiscal year after September 30, 1991 and will not be included in the determination of incentive payments which the facility might be entitled to receive as a result of its performance during that year. Thereafter, the cost associated with implementing the Nursing Home Reform Act of 1987 will be considered in the appropriate cost component and will be added to the facility's final prospective rate.

Upon final audit of a facility's cost report, if the Department's share of the allowable OBRA costs actually incurred by the facility is greater than the amount paid by the Department, the Department will pay the facility the difference. If on the other hand, the Department's appropriate share of the allowable OBRA costs actually incurred by a facility is less than the amount paid by the Department, the difference will be paid to the Department by the facility.

86 ESTABLISHMENT OF PEER GROUP AND INCENTIVE PAYMENTS

86.1 Establishment of Peer Group. All Nursing care facilities will be included in one of two peer groups. Hospital based nursing facilities (excluding governmental institutions) will comprise one peer group, all other nursing facilities will be included in the second peer group. Please refer to Appendix C for a description of a hospital based nursing facility. It should be noted that the establishment of these two peer groups in developing a payment model is not an accepted model in determining the upper limits as established by Federal Statute. The Federal Statute recognizes free standing nursing facilities in determining the upper limit. The upper limit for hospital based facilities is based on one-half the routine costs of freestanding facilities and one-half the costs of hospital based facilities. Therefore, the appropriate Medicare upper limit test will be applied to all nursing facilities.

86.2 The relationship between each facility's direct, indirect and routine allowable cost per day as determined in Section 80 of these Principles and those of its peers will be determined once a year. The peer groups will form the basis for determining the median indirect and routine costs. The peer groups will be subject to the same upper limits.

87 SECOND AND SUBSEQUENT YEAR FINAL PROSPECTIVE RATE.

Upon final audit of a facility's cost report, the Department will calculate a final prospective rate and determine the lump sum settlement amounts either due to or from the nursing facility.

"Second and Subsequent Year" for purpose of this section shall mean the second full twelve (12) month fiscal year of the facility's operation following implementation of the October 1,1992 Principles of Reimbursement.

88 CALCULATION OF OVERPAYMENTS OR UNDERPAYMENTS.

Upon determination of the final rate as outlined in section 84 above, the Department will calculate the net amount of any overpayments or underpayments made to the facility.

If the Department determines that it has underpaid a facility, the Department will estimate the amount due and forward the result to the facility within thirty days. If the Department determines that it has overpaid a facility, the Department will so notify the facility. Facilities will pay the total overpayment within sixty (60) days of the notice of overpayment or request the Department to reduce facility payments during the balance of its fiscal year by the amount of the overpayment. Facilities that do not notify the Department of the method by which they intend to repay the overpayment will, beginning 60 days after their receipt of the notice of overpayment, have their subsequent payments from the Department reduced by the amount of overpayment.

If a facility appeals a determination of overpayment, the facility must repay within sixty (60) days of the notice of overpayment all portions of the determined overpayment except those that are expressly disputed and for which specific dollar values are identified. Repayment of each such specifically disputed portion and identified amount shall be stayed pending resolution of the dispute with respect thereto. The amount of money in dispute must be identified in the manner outlined in Section 150.

The net amount of any over or underpayment made to the facility will be based on 1) the calculation of actual fixed expenses incurred in the prior year, 2) the amount of savings, if any, earned by a facility and 3) the estimated difference in amount due or paid based on the interim versus final prospective rate.

89 BEDBANKING OF NURSING FACILITY BEDS

89.1 Any bedbanking request must be submitted to the Department for review by the Bureau of Elder and Adult Services and the Bureau of Medical Services. Nursing facilities are permitted to bank nursing facility beds, according to the guidelines contained in Title 22, Section 304, providing the space left vacant in the facility is not used for the creation of private rooms. In addition to those guidelines, a floor plan must be submitted to the Bureau of Elder and Adult Services which describes the intended use of the banked bed spaces. This floor plan will be reviewed by the Department. Reimbursement of costs associated with the banked beds will be allowed to the extent that such costs have been approved by the Department. Reasons that the Department may deny the space as reimbursable under these Principles includes, but is not limited to, the following:

89.11 the use of the space is not reimbursable under the criteria contained in these Principles,

89.12 the proposed purpose of the use of the space has already been designated by other space within the facility and this would constitute duplication of use,

89.13 the proposed use of the space is not deemed to be in the best interest of the physical, emotional, and safety needs of the residents (In this case, a recommendation by the Department may be made for an alternative use of the space).

89.2 Pursuant to Title 22, Section 304, the following cost components shall be decreased by a percentage equal to the percentage of bed days decreased by the banking of the beds. Total bed days used to calculate this_percentage will be the audited days (as filed if audited days are not available) from the base year cost report. (e.g. If a facility decreased the number of beds by 25%, and the total bed days in the base year equals 40000 and the facility was at 90% occupancy = 36000 days, then the bed days used in the calculation of the rate after the bedbanking would equal 90% of 30000 days or 27000 days.) This percentage decrease would be used in the calculation of the new rate for the following cost components based on what the total audited costs (as filed, if audited costs are not available) in the base year:

89.21 Indirect Patient Care Cost Component

89.21.1 Food Costs

89.21.2 Medical Supplies

89.22 Routine Cost Component
89.22.1 Administrative and Management Ceiling.
89.22.2 Housekeeping Supplies
89.22.3 Laundry Supplies
89.22.4 Dietary Supplies
89.22.5 Patient Activity Supplies
89.22.6 Medicine and Drugs

89.3 Direct Patient Care Cost Component - The Direct Patient Care Cost Component will be decreased, subject to Licensing and Certification Regulations, by a percentage equal to 50% of the total percentage decrease based on the audited costs (as filed, if audited costs are not available) in the base year for the following areas:
89.31 RNs
89.32 LPNs
89.33 CNAs, CMAs
89.34 Contract Nursing
89.35 Payroll Benefits and taxes for 89.31 through 89.34

(e.g. Using the example in 89.2 of a 25% decrease, if the total audited costs (as filed, if audited costs are not available) of the RNs, LPNs, CNAs, CMAs, Contract Nursing, and benefits and taxes were $400,000 in the base year, the allowable costs for this component would be reduced by $50,000 or 12.5%. The ratio of labor costs to benefits and taxes as contained in the base year cost report would be used in the determination of the amounts decreased in each of those areas.)

90 DECERTIFICATION/DELICENSING OF NURSING FACILITY BEDS

90.1 Pursuant to Title 22, Section 304, any request for delicensing/decertification of nursing facility beds must be submitted to the Department for review by Bureau of Medical Services. In addition to those guidelines, a floor plan must be submitted to the Bureau of Medical Services which describes the intended use, if any, of the space that the beds previously occupied. This floor plan will be reviewed by the Department. Reasons that the Department may deny the space as reimbursable under these Principles includes, but is not limited to, the following:

90.11 the use of the space is not reimbursable under the criteria contained in these Principles,

90.12 the proposed purpose of the use of the space has already been designated by other space within the facility and this would constitute duplication of use,

90.13 the proposed use of the space is not deemed to be in the best interest of the physical, emotional, and safety needs of the residents (In this case, a recommendation by the Department may be made for an alternative use of the space).

90.2 The following cost components shall be decreased by a percentage equal to the percentage of bed days decreased by the delicensing/decertification of the beds. Total bed days used to calculate this percentage will be the audited days (as filed if audited days are not available) from the base year cost report. The example used in Section 89.2 to also applicable to this section. This percentage decrease would be used in the calculation of the new rate for the following cost components based on what the total audited costs (as filed, if audited costs are not available) in the base year:
90.21 Indirect Patient Care Cost Component
90.21.1 Food Costs
90.21.2 Medical Supplies and Drugs
90.22 Routine Cost Component
90.22.1 Administrative and Management Ceiling.
90.22.2 Housekeeping Supplies
90.22.3 Laundry Supplies
90.22.4 Dietary Supplies
89.22.5 Patient Activity Supplies
89.22.6 Medicine and Drugs

90.3 Direct Patient Care Cost Component - The Direct Patient Care Cost Component will be decreased, subject to Licensing and Certification Regulations, by a percentage equal to 50% of the total percentage decrease based on the audited costs (as filed, if audited costs are not available) in the base year for the following areas:
90.31 RNs
90.32 LPNs
90.33 CNAs, CMAs
90.34 Contract Nursing
90.35 Payroll Benefits and taxes for 90.31 through 90.34.

(e.g. Using the example in 89.2 of a 25% decrease, if the total audited costs (as filed, if audited costs are not available) of the RNs, LPNs, CNAs, CMAs, Contract Nursing, and benefits and taxes were $400,000 in the base year, the allowable costs for this component would be reduced by $50,000 or 12.5%. The ratio of labor costs to benefits and taxes as contained in the base year cost report would be used in the determination of the amounts decreased in each of those areas.)

91 INFLATION ADJUSTMENT

91.1 The Maine Health Care Facility Economic Trend Factor will be used to forecast the expected increases in the cost of the goods and services which must be purchased by nursing care facilities.

The cost components, weights, proxies and method by which the Maine Health Care Facility Economic Trend Factor will be calculated are as follows:

91.1.1 Cost components: 1) wages and salaries, 2) employee benefits, 3) food, 4) fuel and other utilities, and 5) other expenses.

91.1.2 Cost component weights: The Department will use the most recent Nursing Facility Weights as published by Data Resources, Inc., of Washington, D.C.

91.1.3 Cost compensation proxy: The Department will use the most recent Nursing Facility %MOVAVG, published by Data Resources, Inc., of Washington, D.C., for all cost components except for employee wages and salaries.

The proxy for wages and salaries to be used in the Maine Health Care Facility Economic Trend Factor which will be calculated by the Department. The proxy for wages and salaries will equal the sum of the Maine specific weights for professional and technical workers and service workers times the cost compensation proxies used by the Maine Health Care Finance Commission for the same category of workers. The relative weights will be calculated every three years by the Department based on a study of the relative total costs of these categories of workers in all Maine nursing homes for the most recent available year.

91.1.4 The Maine Health Care Facility Economic Trend Factor is equal to the sum of the product of a) the cost component weight, and b) the cost compensation proxy component.

The Division of Audit shall use the most recent available publications of the applicable compensation cost proxies as published by Data Resources, Inc., for the Maine Health Care Finance Commission.

92 REGIONS

The regions shall be the regions defined by the Maine Health Care Finance Commission for hospitals. The regions are:

Region I - Cumberland County, Knox County, Lincoln County, Sagadahoc County, and York County.

Region II - Androscoggin County, Franklin County, Kennebec County, Oxford County, and Somerset County.

Region III - Penobscot County, Piscataquis County, Waldo County, Hancock County, and Washington County.

Region IV - Aroostook County

93 DAYS WAITING PLACEMENT

Reimbursement to nursing facilities for days waiting placement are governed by the regulations specified in the Principles of Reimbursement for Residential Care Facilities.

120 EXTRAORDINARY CIRCUMSTANCE ALLOWANCE

Facilities which experience unforeseen and uncontrollable events during a year which result in unforeseen or uncontrollable increases in expenses may request an adjustment to a prospective rate in the form of an extraordinary circumstance allowance. Extraordinary circumstances include, but are not limited to:

* events of a catastrophic nature (fire, flood, etc.)
* unforeseen increase in minimum wage , Social Security, or employee retirement contribution expenses in lieu of social security expenses
* changes in the number of licensed beds
* changes in licensure or accreditation requirements

If the Department concludes that an extraordinary circumstance existed, an adjustment will be made by the Department in the form of a supplemental allowance.

The Department will determine from the nature of the extraordinary circumstance whether it would have a continuing impact and therefore whether the allowance should be included in the computation of the base rate for the succeeding year.

121 Certificate of Need Extraordinary Circumstance Allowance

121.1 Based on findings made by the Commissioner of the Department of Human Services (hereinafter, the Commissioner), the Department may approve extraordinary indirect, routine, and fixed costs in excess of the provider's approved Certificate of Need (CON) that are within the upper limits established by the Department for the indirect and routine components, when all of the following conditions are met:

121.1(a) Costs would ordinarily be allowable under Federal Regulations and these Principles of Reimbursement;

121.1(b) Costs would have been allowable under the CON had a CON amendment been filed within the time constraints as outlined in the CON statutes and approved by the Department;

121.1(c) Approval is necessary in order for the Provider to obtain favorable refinancing, as determined by the Department;

121.1(d) Failure to approve may adversely affect patient care; and

121.1(e) In the Department's judgment, approval will further the Department's goal of ensuring that public funds are only expended for services that are necessary for the well being of the citizens of Maine.

121.2 Department approved costs, as determined in Section 121.2, from the CON will be recognized
at the time the Department approves the Certificate of Need Extraordinary Circumstance Allowance for a nursing facility.

121.3 The Department may require that the Provider(s) or owner of the Provider(s) who have been granted a Certificate of Need Extraordinary Circumstance Allowance under these Principles, be subject to the following conditions:

121.3(a) Be managed through an unrelated management company;

121.3(b) Hire a licensed administrator, through an unrelated management company, who is approved by the DHS Division of Licensing and Certification; and

Sections 121.3(a) and 121.3(b) will be in effect for a period of time determined by the Department.

121.4 If the provider fails to obtain the acceptable refinancing described in Section 121 within 15 months of the date the Commissioner made the findings under Section 121.1, the Department may 1) recapture costs approved under Section 121 at time of audit; or 2) withdraw the Extraordinary Circumstance Allowance under Section 121.

130 ADJUSTMENTS

130.1 Adjustment for Unrestricted Grants or Gifts. Unrestricted Federal or State grants or gifts received by a facility and which have been deducted from operating costs for purposes of reimbursement will be added back to the direct patient care, indirect patient care and routine cost component for purposes of calculating a base rate.

130.2 Adjustment for Appeal Decisions. The Department will adjust any interim or final prospective rate to reflect appeal decisions made subsequent to the establishment of those rates.

130.3 Adjustments for Capital Costs. The Department will adjust the fixed cost component of an interim or final prospective rate to reflect increases or decreases in capital costs. For example costs which have been approved under the Maine Certificate of Need Act or refinancing.

140 APPEAL PROCEDURES - START UP COSTS - DEFICIENCY RATE - RATE LIMITATION

140.1 Appeal Procedures

140.1.1 A facility may administratively appeal any of the following types of Division of Audit determinations:

1. Audit Adjustment
2. Calculation of final prospective rate
3. Adjustment of final prospective rate or a refusal to make such an adjustment pursuant to these Principles.

140.1.2 An administrative appeal will proceed in the following manner:

1. Within 30 days of receipt of an audit or other appealable determination, the facility must request, in writing, an informal review before the Director of the Division of Audit or his/her designee. The facility must forward, with the request, any and all specific information it has relative to the issues in dispute, note the monetary amount each issue represents and identify the appropriate principle supporting the request. Only issues presented in this manner and timeframe will be considered at an informal review or at a subsequent administrative hearing.
2. The Director or his/her designee shall notify the facility in writing of the decision made as a result of the informal review. If the facility disagrees with the results of the informal review, the facility may request an administrative hearing before the Commissioner or a presiding officer designated by the Commissioner. Only issues presented in the informal review will be considered at the administrative hearing. A request for an administrative hearing must be made, in writing, within 30 days of receipt of the decision made as a result of the informal review.
3. To the extent the Department rules in favor of the facility, the audit report or prospective rate will be corrected.
4. To the extent the Department upholds the original determination of the Division of Audit, review of the results of the administrative hearing is available in conformity with the Administrative Procedures Act, 5 M.R.S.A. §11001 et seq.

150 START UP COSTS APPLICABILITY

Start-up costs are incurred from the time preparation begins on a newly constructed or purchased building, wing, floor, unit, or expansion thereof to the time the first patient is admitted for treatment, or where the start-up costs apply only to nonrevenue-producing patient care functions or nonallowable functions, to the time the areas are used for their intended purposes. Start-up costs are charged to operations. If a provider intends to prepare all portions of its entire facility at the same time, start-up costs for all portions of the facility will be accumulated in a single deferred charge account and will be amortized when the first patient is admitted for treatment. If a provider intends to prepare portions of its facility on a piecemeal basis (e.g., preparation of a floor or wing of a provider's facility is delayed), start-up costs would be capitalized and amortized separately for the portion(s) of the provider's facility prepared during different time periods. Moreover, if a provider expands its facility by constructing or purchasing additional buildings or wings, start-up costs should be capitalized and amortized separately for these areas.

Start-up costs that are incurred immediately before a provider enters the program and that are determined to be immaterial by the Department need not be capitalized, but rather will be charges to operations in the first cost reporting period. In the case where a provider incurs start-up costs while in the program and these costs are determined to be immaterial by the Department, these costs need not be capitalized, but will be charged to operations in the periods incurred.

For program reimbursement purposes, costs of the provider's facility and building equipment should be depreciated over the lives of these assets starting with the month the first patient is admitted for treatment, subject to the provider's method of determining depreciation in the year of acquisition or construction. Where portions of the provider's facility are prepared for patient care services after the initial start-up period, these asset costs applicable to each portion should be depreciated over the remaining lives of the applicable assets. If the portion of the facility is a patient care area, depreciation should start with the month the first patient is admitted for treatment. If the portion of the facility is a nonrevenue - producing patient care area or nonallowable area, depreciation should begin when the area is opened for its intended purpose. Costs of major movable equipment, however, should be depreciated over the useful life or each item starting with the month the item is placed into operation.

151 COST TREATMENT FOR REIMBURSEMENT

151.1 Where a provider prepares all portions of its facility for patient care services at the same time and has capitalized start-up costs, the start-up costs must be amortized ratable over a period of 60 consecutive months beginning with the month in which the first patient is admitted for treatment.

151.2 Where a provider prorates portions of its facility for patient care services on a piecemeal basis, start-up costs must be capitalized and amortized separately for the portions of the provider's facility that are prepared for patient care services during different periods of time.

152 DEFICIENCY PER DIEM RATE.
When a facility is found not to have provided the quality of service or level of care required, reimbursement will be made on 90% of the provider's per diem rate, unless otherwise specified. This "deficiency rate" will be applied following written notification to the facility of the effective date of the reduced rate for any of the following service deficiencies:
152.1 Staffing over a period of two weeks or more does not meet the Federal Certification and State Licensing requirements, except where there is written documentation of a good faith effort to employ licensed nurses to meet the licensed nurse requirements over and above the full time director of nursing;
152.2 Food service does not meet the Federal Certification and State Licensing requirements;
152.3 Specific, documented evidence that the care provided does not meet the Federal Certification and State Licensing requirements. Such penalty to be effective no sooner than 30 days from written notification that such deficiencies exist;
152.4 Failure to correct, within the time frames of an accepted Plan of Correction, deficiencies in meeting the Federal Certification and State Licensing requirements, which cause a threat to the health and safety of residents in a facility or the surrounding community;
152.5 Failure to submit a cost report, financial statements, and other schedules as requested by the Division of Audit and to maintain auditable records as required by these Principles and other relevant regulations may result in application of the deficiencies per diem rate. The deficiency per diem rate for these items will go into effect immediately upon receipt of written notification from the Department of Human Services.
152.6 Failure to correct MDS as requested in writing and submit within the specified time outlined in Section 41.21 of these Principles of Reimbursement.
A reduction in rate because of deficiencies shall remain in effect until the deficiencies have been corrected, as verified by representatives of the Department of Human Services, following written notification by the provider that the deficiencies no longer exist. No retroactive adjustments to the full rate shall be made for the period that the deficiency rate is in effect unless the provider demonstrates to the satisfaction of the Department that there was no just cause for the reduction in payment.

160 INTENSIVE REHABILITATION NF SERVICES FOR TRAUMATIC BRAIN INJURED INDIVIDUALS (TBI)
It has been determined that the reasonable cost of comprehensive rehabilitative services of traumatic brain injury is an allowable cost. This requires that the facility possess characteristics, both in terms of staffing and physical design, which create a unique unit providing comprehensive rehabilitative TBI services.
The Department will require that the facility obtain prior approval of its staffing pattern for the nursing and clinical staff associated with the TBI unit from the Bureau of Medical Services. In the event a facility believes that the needs of the residents it serves have increased or decreased, the facility must request prior approval from the Bureau of Medical Services authorizing such a change to its staffing pattern.
The Department will recognize a NF-TBI unit when it is a distinct part of a dual-licensed nursing facility. The facility will be reimbursed for the average annual per diem cost for TBI rehabilitative services provided to those individuals classified in need of intensive rehabilitative nursing services.
160.1 Principle. A nursing facility which has a recognized TBI unit will be reimbursed for services provided to recipients_covered under the Title XIX Program based upon the actual cost of services provided. The Department will establish the rate and determine that the cost is reasonable and adequate to be an efficiently and economically operated facility in order to provide care and services in conformity with applicable state and federal laws, regulations and quality and safety standards.
160.2 Cost. The Department's payments made for allowable TBI services provided will be based on the actual cost of services provided to The allowable per diem cost for TBI services will include a routine service component and a rehabilitative ancillary service component.

160.2.1 The direct, indirect and routine cost component rates, that is, (The direct, indirect and routine costs less fixed costs and ancillary service costs) will be increased annually by the rate of inflation, for cash flow purposes only, at the beginning of a facilities fiscal year. This per diem rate is subject to audit and will be adjusted to actual costs at year end.

160.2.2 Rehabilitative ancillary services included in the care of a traumatically brain injured individual residing in a recognized TBI unit shall be considered an allowable cost. Covered ancillary services must meet the requirements and definitions under Medicare regulations.

160.3 Rehabilitative ancillary services are not subject to the routine service cost limitations.

Rehabilitative ancillary services include:
- Physical Therapy Services
- Occupational Therapy Services
- Speech Pathology Services
- Respiratory Therapy Services
- Recreational Therapy Services
- Physiatry Evaluation and Consultation Services
- Neuropsychology Evaluation and Consultation Services
- Psychology Evaluation and Consultation Services

160.4 Cost Reporting. Costs will be reported on forms provided by the Department which will segregate NF-TBI routine costs and TBI ancillary costs from standard NF costs.
For the purpose of calculating a separate NF-TBI rate, whether interim or final, a facility that has been granted a special NF-TBI rate for a distinct part shall allocate its costs to the distinct part as if the distinct part were licensed as a separate level of care.
All other principles pertaining to that allowability, recording and reporting of costs shall apply.

171 COMMUNITY-BASED SPECIALTY NURSING FACILITY UNITS

COMMUNITY-BASED SPECIALTY NURSING FACILITY UNITS PROVIDING SERVICES UNDER CONTRACT WITH THE DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES (DMHMRSAS) TO FORMER PATIENTS OF THE AUGUSTA MENTAL HEALTH INSTITUTE (AMHI) AND THE BANGOR MENTAL HEALTH INSTITUTE (BMHI).

The Department may designate specialty nursing facility units that provide special services under contract with the Department of Mental Health and Mental Retardation and Substance Abuse Services to former residents of the Augusta Mental Health Institute (AMHI) and the Bangor Mental Health Institute. It has been determined that the reasonable cost of services for these residents, who have multiple medical needs that make them eligible for nursing facility level of care and have a primary diagnosis of mental illness that requires the ongoing_supervision of trained professionals, is an allowable cost. This requires the nursing facility unit to possess characteristics, both in terms of staffing and physical design, for providing services to these patients.

Such designated specialty units shall be subject to the provision of these rules, except for the rate limitations contained in Sections 80-87.

The Department will require that the facility obtain prior approval of its staffing pattern for the nursing and clinical staff associated with these facilities from the Bureau of Medical Services. In the event a facility believes that the needs of the residents it serves have increased or decreased, the facility must request prior approval from the Bureau of Medial Services authorizing such a change to its staffing pattern.

171.1 Principle. A nursing facility which is recognized as a specialty unit under this section will be reimbursed for services provided to residents covered under the Title XIX program based upon the actual cost of services provided. The Department will establish the rate and determine that the cost is reasonable and adequate to be an efficiently and economically operated facility in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards.

171.2 Cost. The Department's payments made for allowable services provided will be based on the actual allowable cost of services provided to such residents. The allowable per diem cost for the services will be increased annually by the rate of inflation at the beginning of each facility's fiscal year. This per diem rate is subject to audit and will be adjusted to the actual allowable costs of providing services to such residents in these units at year end.

171.3 Cost Reporting. Costs will be reported in a manner that will segregate the costs of such residents in the specialty unit from the costs of other residents in the unit and the standard nursing facility's costs as apply under these Principles.

For the purpose of calculating the reimbursement rate for such residents in the specialty unit, whether interim or final, a facility that has been designated as a specialty unit under this section of the Principles for a distinct part shall allocate the costs of such residents in the distinct part as if the distinct part were licensed as a separate level of care.

All other sections of theses Principles pertaining to the allowability, recording, and reporting of costs shall apply.

APPENDIX A: DEFINITIONS

The term Department as used throughout these principles is the State of Maine Department of Human Services.

The term State Licensing and Federal Certification as used throughout these principles are the "Regulations Governing the Licensing and Functioning of Nursing Facilities" and the Federal Certification requirements for nursing care facilities that are in effect at the time the cost is incurred.

Accrual method of accounting means that revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

AICPA: American Institute of Certified Public Accountants

Allowable costs are those costs which Medicaid will reimburse under these Principles of Reimbursement.

Ancillary Services: medical items or services identifiable to a specific resident furnished at the direction of a physician and for which charges are customarily made in addition to the per diem charge.

Base Year: A fiscal period for which the allowable costs are the basis for the case mix prospective rate.

Capital Asset: Capital Asset is defined as services, equipment, supplies or purchases which have a value of $500 or greater.

Case Mix Weight: A relative evaluation of the nursing resources used in the care of a given class of residents.

Cash method of accounting means the revenues are recognized only when cash is received and expenditures for expense and asset items are not recorded until cash is disbursed for them.

Common Ownership: Common ownership exists when an individual possesses significant ownership or equity in the provider and the institution or organization serving the provider.

Community Integrated Rehabilitation: Individuals in this category may be able to achieve sufficient function to live adaptively and manage his/her environment in a community-based setting of choice and is expected to tolerate 3 - 5 hours of rehabilitative services within the first 20 days of residence. The individual needs intensive rehabilitative services from one or more of the following disciplines: PT, OT, SPT, RT, Social Work, and Psychological Services. The individual has potential for a discharge destination which is a more community integrated setting.

Compensation: Compensation means total benefit provided for the administration and policy-planning services rendered to the provider. It includes:

(a) Fees, salaries, wages, payroll taxes, fringe benefits, contributions to deferred compensation plan, and other increments paid to or for the benefit of, those providing the administration and policy- planning services.

(b) The cost of services provided by the provider to, or for the benefit of, those providing the administration and policy-planning services, including, but not limited to food, lodging, and the use of the provider's vehicles.

Comprehensive Rehabilitation (Progressive Rehabilitation/Transitional Rehabilitation): Individuals in this category are able to achieve stability of function in physical health and self care to move to a more community integrated setting and is expected to tolerate 3 hours of rehabilitative services within the first 20 days of residence. The individual needs intensive rehabilitative services from one or more of the following disciplines: PT, OT,

SPT, Social Work, and Psychological Services and/or Recreational Therapy. The individual has potential for a discharge destination which is a more community integrated setting.
Control: Control exists where an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.
Cost finding: the processes of segregating costs by cost centers and allocating indirect cost to determine the cost of services provided.
Days of Care means total number of days of care provided whether or not payment is received and the number of any other days for which payment is made. (Note: Bed held days and discharge days are included only if payment is received for these days.)
Direct Costs: costs which are directly identifiable with a specific activity, service or product of the program.
Discrete Costing: The specific costing methodology that calculates the costs associated with new additions/renovations of nursing facilities. None of the historical basis of costs from the original building are allocated to the addition/renovation.
Donated Asset: an asset acquired without making any payment in the form of cash, property or services.
DRI: Data Resources Institute Incorporated national forecasts of hospital, nursing home, and home health agency market baskets as published by McGraw- Hill.
Experience Modifier: This is the rating number given to nursing facilities based on worker's compensation claims submitted for the previous three years. The lower the rating number, the better the worker's compensation claims ratio.
Fair Market Value: The fair market value is the price that the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition. Usually the fair market price will be the price at which bona fide sales have been communicated for assets of like type, quality, and quantity in a particular market at the time of acquisition.
Fixed Cost: The fixed cost component shall be determined based upon actual allowable costs incurred by an economically and efficiently operated facility.
Free Standing Facility: a facility that is not hospital-affiliated.
Fringe Benefits: shall include payroll taxes, qualified retirement plan contributions, group health, dental, and life insurance's, cafeteria plans and flexible spending plans.
Generally accepted accounting principles means accounting principles approved by the American Institute of Certified Public Accountants. (GAAP): those accounting principles with substantial authoritative support. In order of authority the following documents are considered GAAP: (1) FASB standards and Interpretations, (2) APB Opinions and Interpretations, (3) CAP Accounting Research Bulletins, (4) AICPA Statements of Position, (5) AICPA Industry Accounting and Auditing Guides, (6) FASB technical Bulletins, (7) FASB Concepts statements, (8) AICPA Issues Papers and Practice Bulletins, and other pronouncements of the AICPA or FASB.
Health Care Financing Administration (HCFA): Agency within the U.S. Department of Health and Human Services (HHS) responsible for developing and implementing policies governing the Medicare and Medicaid programs.
Historical cost: Historical cost is the cost incurred by the present owner in acquiring the asset. The historical cost shall not exceed the lower of:

* current reproduction cost adjusted for straight-line depreciation over the life of the asset to the time of the purchase;
* fair market value at the time of the purchase;
* the allowable historical cost of the first owner of record on or after July 18, 1984.

In computing the historical cost the four categories of assets will be evaluated, Land, Building, Equipment and Motor Vehicles. Each category will be evaluated based on the methods listed above.
Hospital-affiliated facility: a facility that is a distinct part of a hospital provider, located within the same building as the hospital unit or licensed as a hospital facility.
Land (non-depreciable): Land (non-depreciable) includes the land owned and used in provider operations. Included in the cost of the land are costs of such items as off-site sewer and water lines, public utility charges necessary to service the land, governmental assessments for street paving and sewers, the cost of permanent roadways and grading of a non-depreciable nature, the cost of curbs and sidewalks whose replacement is not the responsibility of the provider and other land expenditures of a non-depreciable nature.
Land Improvements (depreciable): Depreciable land improvements include paving, tunnels, underpasses, on-site sewer and water lines, parking lots, shrubbery, fences, walls, etc. (if replacement is the responsibility of the provider).
Leasehold improvements: Leasehold improvements include betterment's and additions made by the lessee to the leased property. Such improvements become the property of the lessor after the expiration of the lease.
MDS as used throughout these Principles means the Minimum Data Set that is currently specified by the Health Care Financing Administration for use by Nursing Facilities.
Necessary and proper costs are those which are for services and items that are essential to provide appropriate patient care and patient activities at an efficient and economically operated facility. They are costs for services and items which are commonly provided and are commonly accepted as essential for the type of facility in question.
Net Book Value: The net book value of the asset is defined as the depreciable basis used under the program by the asset's last participation owner less the depreciation recognized under the program.
Nursing Facility: a nursing home facility licensed and certified for participation in the Medicaid Program by the State of Maine.
Owners: Owners include any individual or organization with 10% equity interest in the provider's operation and any members of such individual's family or his or her spouse's family. Owners also include all partners and all stockholders in the provider's operation and all partners and stockholders or organizations which have an equity interest in the provider's operation.
Per Diem Rate means total allowable costs divided by days of care. The prospective per diem rate, as described by days of care for Medicaid recipients, will determine reimbursement.
Policy Planning Function: The policy-planning function includes the policy-making, planning and decision-making activities necessary for the general and long-term management of the affairs of the facility, including, but not limited to the following:

The financial management of the facility.
The establishment of personnel policies.
The planning of patient admission policies.
The planning of expansion and financing thereof.

Prospective Case-Mix Reimbursement System: A method of paying health care providers rates that are established in advance. These rates take into account the fact that some residents are more costly to care for than others.

Reasonable costs are those which a prudent and cost-conscious buyer would pay for services and items that are essential for patient care and patient activities at the facility. If any of a provider's costs are determined to exceed by a significant amount, those that a prudent and cost-conscious buyer would have paid, those costs of the provider will be considered unreasonable in the absence of a showing by the provider that those costs were unavoidable.

Related to Provider: Related to the provider means that the provider to a significant extent is associated or affiliated by common ownership with or has control of or is controlled by the organization furnishing the services, facilities, and supplies.

Stand Alone Nursing Facility: a facility that is not physically located within a hospital.

Straight-line method: Under the straight-line method of depreciation, the cost or other basis (e.g., fair market value in the case of donated assets) of the assets, less its estimated salvage value, if any, is determined first. Then this amount is distributed in equal amounts over the period of the estimated useful life of the asset.

Sustained Rehabilitation: Individuals in this category demonstrate that there is no further potential for ability to develop stability of function in specific domains. The discharge destination would be a long term care facility or 24 supervised living arrangements.

Total Patient Census: Total number of residents residing in a nursing facility during the facility's fiscal year.

APPENDIX B

Supplies and Equipment provided to a recipient by a NF as part of regular rate of reimbursement are listed in Maine Medical Assistance Manual, Section 67, Chapter II.

APPENDIX C:

CERTIFIED NURSES AIDE TRAINING PROGRAMS

Principle. The median plus 10% of costs per student paid by the Department for state fiscal year 1993 to qualify individuals as certified nurses aides is reimbursable under the Maine Medicaid Program. These programs must be conducted in accordance with the requirements of the Maine Board of Nursing for education programs for nurses aides. To be allowable these programs must be conducted within a licensed nursing facility within the State of Maine or under contract with an educational institute whereby the classroom instruction may be provided in the educational facility, but the supervised clinical experience must be within the licensed nursing facility receiving reimbursement under the Principles of Reimbursement for Long-Term Care Facilities".

Definitions

1. Allowable Programs. All CNA programs must be approved by the Department of Education in order for a nursing facility to be reimbursed for a CNA training program.

The Department will reimburse for the number of courses needed to meet the facility's needs, or the needs of a group of facilities on a prorated basis, which is expected to be no more than three CNA courses per year, unless it is found that three courses in not enough to meet the facility's needs. However, costs for classes of four or fewer students will be allowed no more than twice a year.

2. Allowable Costs.

a) qualified instructor for classroom instruction and clinical instruction, not to exceed 150 hours.
b) instructor preparation time, not to exceed 15 hours.
c) additional clinical instructor time when number of students in program exceeds 10.
d) one "Train the Trainer Program" per facility per year.
e) training materials, books and supplies necessary for providing the CNA program.
f) liability insurance
g) competency examinations, if Department of Education no longer provides the competency examinations.
h) administrative overhead expenses shall be limited to 10% of the total allowable CNA training budget.

The cost per student cannot exceed the cost of tuition in a program offered through the Department of Education that is reasonably accessible. If it is determined that any of the CNA training programs offered by a facility has not met or does not presently meet the requirements of the Maine Board of Nursing or is not an approved program through the Department of Education, the Department will initiate action to recoup all reimbursement.

All income received from these programs must be used to reduce the overall cost of the programs.

Reimbursement. In order for a nursing facility to be reimbursed for conducting an approved CNA training program, the facility must submit a formal request for reimbursement to the Director of the Bureau of Medical Services, 11 State House Station, Augusta, Maine, 04333-0011. All requests must be received by the Department before the end of the facility's current fiscal year in which the CNA program began. Any request that is not received before the end of the facility's current fiscal year in which the CNA program begins will not be considered as an allowable cost under the Maine Medicaid Program.

All requests must include:

1. A completed schedule "Request for Budget Approval" available from the Bureau of Medical Services.
2. Copies of the letters of intent to employ for non-employees participating in the training program.
3. Copy of the Department of Education "Notice of Status" letter.

The Department will reimburse a nursing facility the median plus 10% of costs per student paid by the Department for state fiscal year 1993 for CNA training. The allowable cost of approved CNA training programs conducted at a nursing facility will not be included in the calculation of the facility's prospective rate, but will be reimbursed in a lump sum payment upon approval by the Bureau of Medical Services.
The Division of Audit will audit all CNA training costs at the time of the facility's final audit. Therefore it is very important that the facility maintain accurate records of the CNA training programs conducted by the nursing facility.

APPENDIX D: Bedbanking - State Law: Title XX, Chapter 103.
§ 304-F. Procedures after voluntary nursing facility reductions.
1. Procedures. A nursing home that voluntarily reduces the number of its licensed beds for any reason except to create private rooms may convert the beds back and thereby increase the number of nursing facility beds to no more than the previously licensed number of nursing facility beds, after obtaining a certificate of need in accordance with this section. To convert beds back to nursing facility beds under this section, the nursing facility must:
A. Give notice of its intent to preserve conversion options to the department no later than 30 days after the effective date of the license reduction; and
B. Obtain a certificate of need to convert beds back under Section 309, except that if no construction is required for the conversion of beds back, the application must be processed in accordance with subsection 2.
2. Expedited Review. Except as provided in subsection 1, paragraph B, an application for a certificate of need to reopen beds reserved in accordance with this section must be processed on an expedited basis in accordance with rules adopted by the Department providing for shortened review time and for a public hearing if requested by a directly affected person.
A. Review of applications that meet the requirements of the section must be based on the requirements of section 309, subsection 1, except that the determinations required by section 309, subsection 1, paragraph B must be based on the historical costs of operating the beds and must consider whether the projected costs are consistent with the costs of the beds prior to closure, adjusted for inflation; and
B. Conversion of beds back under this section must be requested within 4 years of the effective date of the license reduction. For good cause shown, the Department may extend the 4-year period for conversion for one additional 4-year period.
3. Effect on other Review Proceedings. Nursing facility beds that have been voluntarily reduced under this section must be counted as available nursing facility beds for the purpose of evaluating need under section 309 so long as the facility retains the ability to convert them back to nursing facility use under the terms of this section, unless the facility indicates in response to an inquiry from the department in connection with an ongoing project, that it is unwilling to convert them to meet a need identified in that project review.
EFFECTIVE DATE: July 1, 1998

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APPENDIX K

Medicaid Nursing Facility Reimbursement, Department of Human Services, June 3, 1998

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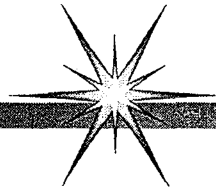
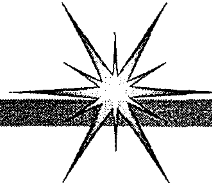
A Cost-Based Case-Mix Reimbursement System

Case Mix Reimbursement



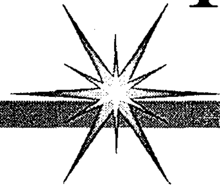
- Medicaid payments are based on the acuity and needs of the residents in the facility
- Residents are assessed by the facility at least quarterly using the Minimum Data Set (MDS) -- BMS verifies
- Assessments determine quarterly case-mix index -- index greater than one indicates acuity of patients greater than average - from the base year 1990
- Facilities average case-mix index is applied to the direct patient care component of the Medicaid rate - from the base year beginning on or after 10/1/92

Four Cost Components



- Direct Patient Care -- includes costs of direct patient care (e.g., RNs, LPNs, nurse aides)
  - Case-mix applied
  - Facility costs limited to median costs of all facilities + 12%
- Indirect Patient Care -- includes indirect costs of patient care (e.g., director of nursing, social services, food, vitamins, etc)
  - Facility costs are limited to the median +10%

Cost Components (con't)



- Routine Care -- includes facility routine costs (e.g., administrative services, operations, laundry, housekeeping, etc.)
  - Facility costs limited to the median of costs for all facilities + 8%
- Fixed Cost -- includes depreciation on building and land, property taxes, rental expenses, interest on debt, return on equity, etc.
  - A pass through without limits -- 90% or 85% occupancy adjustment applied here

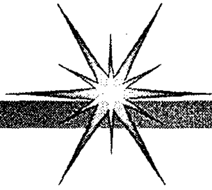
How Payments are Made to Facilities

- Prospective Payment
  - Starting point is base year audited cost data (1993) -- for direct care component case-mix is applied
  - Median cost for all facilities is calculated -- upper payment limits are calculated for each cost component.
  - Inflate to common payment year (6/30/95)
  - Facility rates determined (adjusted quarterly for case-mix) -- nursing facilities submit claims

How Payments are Made to Facilities (con't)

- Cost Settlement
  - After close of program year facility must file a cost report with DHS, Division of Audit
  - Department's audit determines allowable costs for the program year -- 90%/85% occupancy adjustment applied to allowable fixed costs here
  - Settlement with Facility -- State owes facility or facility owes State

Case-Mix Sanctions



- Purpose is to ensure accuracy of resident assessments -- and appropriate payments
- Since first implemented two years ago only 17 of 140 facilities have been sanctioned
- Total sanctions of $130,000 while Medicaid payments totaled $220 million per year
- During same period assessment error rate has dropped significantly saving the Medicaid program millions

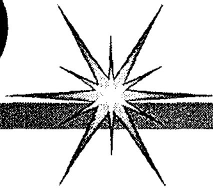
Case-Mix Sanctions -- Implementation

- BMS nurses review sample of facility assessment records on quarterly basis
- Quarterly sanctions not imposed unless more than 35% of assessments are incorrect
  - 35 - 40% error rate -- 2% direct care rate reduction
  - 40 - 45% error rate -- 5% direct care rate reduction
  - 45 - 50% error rate -- 7% direct care rate reduction
  - >50% error rate -- 10% direct care rate reduction
- direct care rate is reduced for one-quarter

90 Percent Occupancy Adjustment

- An adjustment to a facility's fixed costs -- adjustment is done at settlement
- If facility's occupancy for payment year is less than 90% then fixed costs are adjusted at settlement to assume a 90% occupancy rate (60 or fewer beds-85%)
- Without this adjustment, fixed costs can be allocated to an ever decreasing number of residents resulting in an increase in the fixed cost rate as resident population decreases.

90% Occupancy Adjustment (con't)

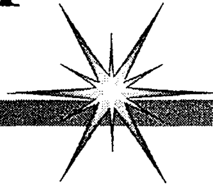


- This adjustment creates an incentive for facilities to address declining occupancy -- converting beds
- The adjustments are now being made as cost report audits for last year are completed
- Savings to the Medicaid program are expected to be almost $3 million this year

Principles of Reimbursement Proposed Eff: 7/1/98

- Rebasing Fixed Cost Component
- Depreciation Recapture
- Fixed costs related to acquisition costs of the rights to a nursing facility license
- Occupancy percentage for conversions changed from 97% to 95%

Principle Changes (con't.)



- TBI language changes
- Deletion of specialty facility rates
- New definitions for Bedbanking, acquisition cost, total patient census, experience modifier, discrete costing, community integrated rehab, comprehensive rehab, and sustained rehab.

APPENDIX L

Letter from Michael McNeil to Health and Human Services Committee regarding LD 991 and 1291, dated April 2, 1997

BERRY, DUNN, McNEIL & PARKER
CERTIFIED PUBLIC ACCOUNTANTS
MANAGEMENT CONSULTANTS

100 Middle Street / P.O. Box 1100, Portland, Maine 04104-1100 / (207) 775-2387 / FAX (207) 774-2375

April 2, 1997

Health and Human Services Committee
Maine Legislative
Augusta, ME 04333

Re: Public Hearing of April 1, 1997
Comments in Opposition to LDs 991 and 1291

Committee Members

We serve as consultants on financial and third-party payor payment matters to a significant portion of Maine long-term care providers and to the Maine Health Care Association. It is in this capacity we offer comment in opposition to LDs 991 and 1291.

LDs 991 and 1291 consist of one sentence each which, depending on the mechanics of implementation, will have devastating financial effects on either Maine's 140 nursing facilities, the State's Medicaid expenditures, or both. Each of these bills require all nursing home residents (or their payor program) to be charged the same rates for similar services. There is no direction contained in either bill indicating how this result is to be accomplished, which indicates an absence of analysis and evaluation of what the consequences of implementation might breed. One of the implications inherent in these bills is that the Medicaid payment methodology is currently (or would be changed to) one which provides a sufficient amount of revenues to meet nursing facilities' reasonable and necessary operating expenses, make debt service payments related to property mortgage loans, generate required working capital, and provide a reasonable return on investment sufficient to attract and retain the capital required to sustain the supply of services necessary to meet current and future demand. The Maine Medicaid rate-setting process does not currently produce such a payment.

Financial Impact

Medicaid beneficiaries constitute approximately 77% of the Maine resident days of care in nursing facility licensed beds. Medicare program beneficiaries are approximately 6% and self-pay residents are approximately 17% of the total resident days. The payment rates applicable to both the Medicare and Medicaid programs are not designed to recognize and pay for the proportionate share of the total cost of operations applicable to program beneficiaries' utilization. While each of these programs has different regulations governing the amount that will be paid for nursing care rendered to program beneficiaries, the rate for both programs covers only that portion of total operating costs defined in the respective regulations as being "allowable costs," and limitations in the form of maximum peer group caps are imposed on certain "allowable cost" categories to limit actual payment to less than "allowable costs." Medicaid "allowable costs" are 98% to 95% of total allowable costs, and peer group payment limits currently reduce the actual payments by an additional estimated 5%.

Bangor, Maine   Portland, Maine   Lebanon, New Hampshire   Manchester, New Hampshire   ...smouth, New Ham...

Based on the most recent information available to us from Medicaid cost reports for the twelve-month period ended August 31, 1996, the information in the enclosed Schedule A reflects the current financial status of Maine nursing facilities and the potential consequences of implementation of these proposed bills. As reflected in Schedule A, the Medicaid program currently pays only 72% of "allowable costs" while utilizing 77% of the resident days resulting in a $16.7 million cost shifting to self-pay residents. In addition, the Medicaid program recognizes no portion of costs incurred that are not defined as "allowable costs" (estimated to be between $6 and $16 million per year, but not included in the Schedule A analysis).

To accomplish the directive of the proposed legislation, the self-pay rate must be decreased to the amount of the Medicaid rate, the Medicaid rate must be increased to the self-pay rate, or both rates must be adjusted to meet somewhere in between the current amounts. As reflected in Schedule A, the first option would create an $18 million deficiency in nursing facility revenues compared to the defined "allowable costs" deemed by Medicaid to be essential for resident care and provide no contribution to the remaining $6 to $16 million of operating expenses not recognized by the Medicaid program. No nursing facility, or any other business for that matter, could continue operating in these circumstances. The second and third options, increase Medicaid rates to the current average self-pay charge, or increase Medicaid rates to a lessor amount to which the self-pay charge might be reduced, would cost the Medicaid program several million dollars, the specific amount being dependent on the amount of increase in the rate.

We all want more for less and prefer someone else pay for our usage. However, when one consumer group is able to procure services for less than its proportionate share of the cost of delivering the product or service, the remaining users must bear more than their proportionate share if the products or services are going to be available. The citizens of Maine have consciously or unconsciously structured a Medicaid payment system that demands a subsidization by self-pay consumers because the Medicaid payment structure is purposefully designed to pay less than its proportionate share of the cost of nursing facility services and health care services in general.

Administrative Cost

The process of rate-setting that would be required to execute the proposed legislation will not be as simple as portrayed in the language of LDs 991 and 1291 or in Schedule A, and it is not one that will operate without creation of a new bureaucracy to monitor and govern it. The best example of a similar process we have experienced was the Maine Health Care Finance Commission (MHCFC) established in the early 80s to set annual revenue limits for hospitals, a regulatory concept not substantially dissimilar to rate equalization contemplated in LDs 991 and 1291. The effectiveness and appropriateness of this process is evidenced by the fact the legislature dissolved MHCFC in 1996. MHCFC was initiated based on a projection of 5 to 6 staff required and an annual budget of $600,000. Within three years the operating expenditures increased threefold, and at its peak there were approximately 30 staff persons required to monitor revenue limits for 43 hospitals. In comparison, there are approximately 130 freestanding nursing facilities, plus another 10 hospital-based

nursing facility units, a much bigger opportunity to syphon off scarce dollars otherwise available for consumer health care.

Existing State Commitments and Statutes

The last issue we want to bring to the Committee's attention is the prior commitments of the State that would be compromised by the consequences that could germinate from this proposed legislation. The Maine Health and Higher Educational Facilities Authority (MHHEFA) was authorized by 1991 legislation to function as the agent for bond issues related to capital expenditures and refinancings for credit worthy proprietary and non-profit nursing and residential care facilities (a service historically provided to hospitals and municipalities). The program affords qualified nursing and residential care providers an opportunity to access capital from markets not previously available at attractive interest rates. More than 35 nursing facilities participate in the financing program with existing outstanding debt of approximately $142 million. We work with most of these borrowers. Use of the program has resulted in total interest expense savings to participants since inception estimated to be $30 million, which has correspondingly resulted in reduced Medicaid payments to nursing facilities of approximately $23 million. All capital expenditures and refinancing funded through MHHEFA received prior approval from the Maine Department of Human Services.

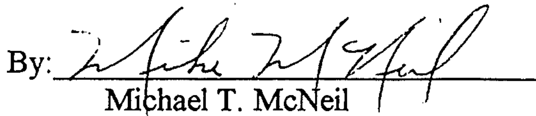
Two elements of this MHHEFA financing are particularly important. First, part of the collateral enhancement for these bonds is the moral obligation of the State of Maine to support bond payments due to bond holders if the borrowers are unable to repay borrowings and existing reserve funds are insufficient to do so. Should the Legislature decline to appropriate funds that might become necessary to meet this obligation, its credit rating would be severally jeopardized resulting in increased interest expense attached to future State borrowings for other purposes. The current financial condition of Maine nursing facilities is precarious due to the rapid occupancy decline from 98% to 85% since 1994. There are currently 15 to 20 facilities which are participants in the MHHEFA bond issues that are unable to meet the prescribed bond covenant requiring a debt service coverage ratio of 1.25. The State average debt service coverage ratio was only 1.2 in 1994, substantially below the national average of 2.1, and this ratio has deteriorated further in 1995 and 1996 as occupancy has declined. Any further deterioration of revenues will breed default.

Second, there is a section of the enabling Statutes for MHHEFA, Title 22, Section 2072, which appears to preclude the Legislature from taking any action that could impair the ability of any borrower under the MHHEFA program to meet their obligations under the bonds. A copy of that section of the Statutes is enclosed for your reference. A reduction in charges to self-pay residents pursuant to the proposed legislation would certainly impair the ability of the borrowers to make required payments and would, therefore, appear to violate the commitments and assurances the State has previously enumerated in existing State law.

We appreciate the Committee's consideration of the information offered herein during its deliberations, and we are available for further discussion of these issues.

Sincerely,

BERRY, DUNN, MCNEIL & PARKER

By: 
Michael T. McNeil

/ajb
Enclosures

cc: Senator Rochelle Pingree, Majority Leader

Maine Nursing Facilities
Illustrative Financial Data
Based on Information from Medicaid Cost Reports
Fiscal Years Ended During Twelve-Month Period
September 1, 1995 to August 31, 1996

	Resident Days	Daily Rate	Total	
Current				
Total "allowable operating costs" reflected on Medicaid cost reports (Note: estimated total operating costs are $6 to $16 million higher)	3,028,497	$110	$334,000,000	
Estimated Payments				
Medicaid program per cost reports	2,319,751	104	242,000,000	(72%)
Medicare and VA contract days based on estimated average daily rate equal to "Allowable operating cost"	204,726	110	22,500,000	(6%)
Self-pay at estimated average charge for semi-private room	504,020	140	70,500,000	(22%)
	3,028,497		335,000,000	
Resident payments in excess of "allowable operating costs" defined by Medicaid			1,000,000	
Proposed Rate Equalization				
Reduced revenue if self-pay rates reduced to Medicaid rates:				
Impact on self-pay payments $140 - $104 = $36 x 504,020			(18,140,000)	
Impact on Medicare payments by application of lower of cost or charges $110 - $104 = $6 x 204,726			(1,200,000)	
Total estimated reduced revenue			(19,340,000)	
Deficiency of revenues in relation to "allowable operating expenses"			$(18,340,000)	

Maine Non-Hospital Based Nursing Facilities
Summary Statistics
Fiscal Years Ending September 30, 1995 Through August 31, 1996

	Region 1	Region 2	Region 3	Region 4	Total
Number of Facilities	43	44	29	11	127
Total Beds	3,690	3,515	2,023	814	10,042
Average Beds	85	79	69	74	79
Minimum Beds	26	18	25	40	18
Maximum Beds	235	280	118	119	280
Resident Days	1,185,308	1,074,175	597,333	280,926	3,137,742
Average Resident Days	27,565	24,413	20,598	25,539	24,707
Minimum Resident Days	6,125	5,372	6,787	13,764	5,372
Maximum Resident Days	82,295	95,310	35,849	43,117	95,310
Resident Days by Type					
NF Days					
Medicare	83,091	65,621	44,412	3,641	196,765
VA	1,455	5,306	613	587	7,961
Medicaid	830,934	828,746	435,152	224,919	2,319,751
Self-Pay	219,679	152,408	104,835	27,098	504,020
Total NF Resident Days	1,135,159	1,052,081	585,012	256,245	3,028,497
Residential Care Days					
Medicaid	6,030	13,880	10,464	21,073	51,447
Self-Pay	27,781	8,214		3,608	39,603
TBI Days	9,826	-	814	-	10,640
Mental Health Days	6,512	-	1,043	-	7,555
Total Resident Days	1,185,308	1,074,175	597,333	280,926	3,137,742
Available Days	1,290,909	1,229,026	673,041	297,319	3,490,295
Occupancy Percentage	91.82%	87.40%	88.75%	94.49%	89.90%
Percent of NF Days to Total					
Medicare	7.32%	6.24%	7.59%	1.42%	6.50%
VA	0.13%	0.50%	0.10%	0.23%	0.26%
Medicaid	73.20%	78.77%	74.39%	87.77%	76.59%
Self-Pay	19.35%	14.49%	17.92%	10.58%	16.65%
	100.00%	100.00%	100.00%	100.00%	100.00%

interest on any unpaid installment of interest and all costs and expenses in connection with an action or proceeding by or on behalf of the bondholders, are fully met and discharged and such contracts are fully performed on the part of the authority. Nothing in this chapter precludes such limitation or alteration if and when adequate provision is made by law for the protection of the holders of such bonds, notes or other obligations of the authority or those entering into such contracts with the authority. The authority is authorized to include this pledge and undertaking for the State in such bonds, notes or other obligations or contracts.

1993, c. 390, § 28.

Historical and Statutory Notes

Amendments

1993 Amendment. Laws 1993, c. 390, § 28, in the 1st sentence, substituted "participating health care facilities" for "participating hospitals".

§ 2075. Maine Health Facilities' Reserve Fund

1. Maine Health Facilities' Reserve Fund. The authority shall establish and maintain a reserve fund called the "Maine Health Facilities' Reserve Fund" in which is deposited all money appropriated by the State for the purpose of that fund, all proceeds of bonds required to be deposited in the fund by terms of any contract between the authority and its bondholders or any resolution of the authority with respect to the proceeds of bonds and any other money or funds of the authority that the authority determines to deposit in the fund and any other money made available to the authority only for the purposes of the fund from any other source or sources.

[See main volume for A]

B. As used in this chapter, "required debt service reserve" means, as of any date of computation, the amount or amounts required to be on deposit in the reserve fund as provided by resolution of the authority. For purposes of this chapter, the amount of any letter of credit, insurance contract, surety bond or similar financial undertaking available to be drawn upon and applied to obligations to which money in the reserve fund may be applied is deemed to be and must be counted as money in the Maine Health Facilities' Reserve Fund, capital reserve funds or any other reserve fund as provided by resolution of the authority. The required debt service reserve is, as of any date of computation, an aggregate amount equal to at least the largest amount of money required by the terms of all contracts between the authority and holders of bonds secured by the reserve fund to be raised in the current or any succeeding calendar year for:

(1) The payment of interest on and maturing principal of that portion of outstanding bonds secured by the reserve fund; and

(2) Sinking fund payments required by the terms of any such contracts to sinking funds established for the payment or redemption of those bonds.

[See main volume for C; 2]

1995, c. 179, § 4.

Historical and Statutory Notes

Amendments

1995 Amendment. Laws 1995, c. 179, § 4, in subsec. 1, par. B, the first par., provided that if certain financial instruments were available to be drawn upon and the amount applied to obligations to which money in the reserve fund could be applied to, this amount must also be counted as money in the Maine Health Facilities' Reserve Fund, capital reserve funds or any other reserve fund as provided by the authority.

Maine, Minnesota, and North Dakota
Summary of Comparable Financial Ratios
Based on 1994 National Data (1)

	National Average	Maine	Minnesota	North Dakota
Average licensed beds per facility	100	66	92	92
State ranking		50th	37th	37th
Occupancy	93.99%	95.45%	97.57%	97.57%
Medicaid utilization	71.66%	80.61%	66.82%	58.78%
State ranking		10th	35th	48th
Average salary and benefits per FTE	$21,801	$28,104	$23,783	$20,087
Direct care expense per day	$29.38	$35.54	$35.51	$29.28
State ranking		12th	13th	30th
Administrative and general expense per day	$22.19	$16.18	$21.58	$21.13
State ranking		48th	27th	33rd
Profit margin	3.48%	1.6%	3.43%	2.22%
State ranking		39th	13th	30th
Current ratio	1.50	1.09	1.41	1.83
State ranking		50th	24th	10th
Debt service coverage ratio	2.12	1.22	N/A	2.48
State ranking		49th	N/A	21st

(1) All data abstracted from "The Guide to the Nursing Home Industry" 1994 Edition by HCIA, Inc., and Arthur Anderson, LLP.

Maine, Minnesota, and North Dakota
Summary of Relevant Medicaid Rate-Setting Methodology Issues

	Maine	Minnesota	North Dakota
Average reimbursement rate	$104.23 (1)	$95.61 (3)	$79.92 (3)
Less Gross Receipts Tax	7.59 (2)	---	---
	96.64	95.61	79.92
Average nursing hours per resident day	3.9 (2)	3.3 (3)	2.8 (3)
Average hourly wage rate and fringe benefits			
RN	15.53 (2)	16.39	Not available, but
LPN	11.91	11.69	but indicated
Aide	7.95	8.35	as being much lower
Fringe benefits	13.15	6.74	than Minnesota (3)
Acuity	Maine includes costs of Medicare SNF units	Report states Minnesota has larger percentage of residents requiring assistance with ADLs than North Dakota. No discussion about Medicare SNF care at all. (3)	
Average mark-up in self-pay charges	24% - 34% (2)	Report indicates average mark-up in other states range between 10% - 35%. (3)	
Major Medicaid rate calculation differences			
Resident or facility specific rate	Average daily rate per facility	Resident specific rate, 11 case mix rates (3)	Resident specific rate, 16 case mix rates (3)

(1) Net final average rate per day after retrospective annual settlement of direct care and fixed costs for 127 freestanding nursing facilities based on unaudited cost reports filed for fiscal years ending during twelve-month period ended August 31, 1996.

(2) State average based on BDM&P data base of Medicaid cost reports.

(3) Abstracted from summary of "Nursing Home Rates in the Upper Midwest," January 1997, Office of the Legislative Audits, State of Minnesota.

Maine, Minnesota, and North Dakota
Summary of Relevant Medicaid Rate-Setting Methodology Issues
(concluded)

	Maine	Minnesota	North Dakota
Property costs	Facility specific costs incurred, limited to 90% occupancy	Based on appraised value of property	Facility specific costs incurred, no limit
Base year for direct, indirect, and routine rate components	1993 inflated forward	Rebased annually	1992 inflated forward
Limits			
Direct	112% of median	Ceiling on different components based on July 1, 1995 costs, increased for inflation	99th percentile
Indirect	110% of median		85th percentile
Routine	108% of median		75th percentile
Retroactive settlement	75% of any savings in direct care repaid to DHS	None	None
Provider share of difference between actual cost and limit built into rate	None	Not stated	70% of routine component difference
Profit factor	None	Not stated	3% of direct and indirect components added to rate
State payment in excess of limit	None	Not stated	25% of excess
Average rate	$104.23	Case mix categories $46.90 - $234.70	Case mix categories $61.30 - $143.54

	Median Values		
	1994	1993	1992
ALL NURSING HOMES			
Beds	100	101	101
Occupancy Rate (%)	93.99	94.45	94.93
Medicaid Resident Days (%)	71.66	72.20	72.81
FTEs per Average Daily Census	0.84	0.83	0.80
Salaries and Benefits per FTE ($)	21,801	20,966	20,133
Per Resident Day ($)			
Net Patient Revenue	84.11	78.75	72.58
Expense			
Operating	82.68	77.86	71.99
Direct Care	29.38	27.54	25.66
Indirect Care	14.43	13.43	12.58
Administrative and General	22.19	21.56	20.50
Depreciation and Interest	6.96	6.67	6.50
Ancillary	2.34	2.28	2.16
Total Profit Margin (%)	3.48	3.26	3.15
Days in Accounts Receivable	35.86	35.44	35.37
Days in Accounts Payable	11.88	11.73	11.39
Current Ratio	1.50	1.49	1.45
Average Age of Plant (years)	8.96	8.64	8.28
Long-Term Debt to Total Assets	0.56	0.51	0.54
Debt Service Coverage Ratio	2.12	2.05	2.01
NURSING HOMES BY OWNERSHIP TYPE			
INVESTOR-OWNED			
Beds	101	102	102
Occupancy Rate (%)	94.01	94.43	94.91
Medicaid Resident Days (%)	73.01	73.64	74.19
FTEs per Average Daily Census	0.81	0.79	0.78
Salaries and Benefits per FTE ($)	21,517	20,664	19,877
Per Resident Day ($)			
Net Patient Revenue	84.50	77.44	70.22
Expense			
Operating	82.20	75.85	68.77
Direct Care	28.69	26.65	24.98
Indirect Care	14.03	13.14	12.29
Administrative and General	21.81	20.17	19.11
Depreciation and Interest	7.09	6.84	6.60
Ancillary	2.40	2.28	2.16
Total Profit Margin (%)	3.68	3.54	3.41
Days in Accounts Receivable	36.02	35.57	35.77
Days in Accounts Payable	12.09	11.93	11.61
Current Ratio	1.43	1.42	1.39
Average Age of Plant (years)	8.42	7.96	7.69
Long-Term Debt to Total Assets	0.57	0.53	0.57
Debt Service Coverage Ratio	2.03	1.92	1.88
GOVERNMENT			
Beds	87	88	88
Occupancy Rate (%)	95.90	96.64	96.71
Medicaid Resident Days (%)	70.14	71.27	71.54
FTEs per Average Daily Census	0.92	0.91	0.89
Salaries and Benefits per FTE ($)	22,162	21,445	20,615
Per Resident Day ($)			
Net Patient Revenue	80.15	74.65	68.33
Expense			
Operating	85.73	79.71	73.71
Direct Care	32.70	31.42	29.76
Indirect Care	17.63	16.40	15.60
Administrative and General	23.26	22.60	21.41
Depreciation and Interest	3.63	3.29	2.92
Ancillary	1.84	1.69	1.68
Total Profit Margin (%)	1.25	1.23	1.19
Days in Accounts Receivable	34.21	34.45	34.12
Days in Accounts Payable	9.96	8.94	9.42
Current Ratio	2.38	2.26	2.12
Average Age of Plant (years)	14.07	13.40	13.42
Long-Term Debt to Total Assets	0.26	0.32	0.31
Debt Service Coverage Ratio	3.05	2.82	2.66

Median values are not additive.

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DEFINITIONS OF PERFORMANCE INDICATORS

Administrative and General Expense per Resident Day

Calculated as the sum of those expenses associated with a nursing home's basic administrative and general office functions, divided by the number of resident days in a nursing home. Administrative and general expenses include non-patient telephone bills, cashiering, patient billing, maintenance and repairs, operation of plant, maintenance of personnel, employee benefits, and medical records.

Ancillary Costs per Resident Day

Calculated as total costs for all services incurred during a patient's stay except for room and board, nursing, dietary, physician services, and blood, divided by the number of resident days in the nursing home.

Average Age of Plant

Calculated as total accumulated depreciation on physical assets divided by total current depreciation expense. *Average age of plant* measures the average accounting age of a nursing home's assets, such as buildings, fixtures, and major movable equipment.

Beds

The total number of beds in service in a nursing home at the end of its fiscal year. *Beds* is a measure of the capacity or size of a nursing home.

Current Ratio

Calculated as total current assets, including the balance of the depreciation fund, divided by total current liabilities. *Current ratio* is an indicator of a nursing home's liquidity and ability to meet short-term obligations.

Days in Accounts Payable

Calculated as accounts payable times 365 divided by a facility's total operating expenses less depreciation. *Days in accounts payable* is a measure of the average amount of time that elapses before payables are met.

Days in Accounts Receivable

Calculated as net patient accounts receivable times 365 divided by net patient revenue. *Days in accounts receivable* is a measure of the number of days of operating revenue that a nursing home has due from its patient billings after deductibles for doubtful accounts.

Debt Service Coverage Ratio

Calculated as the sum of net income, depreciation, and interest expense divided by annual debt service. *Debt service coverage ratio* measures the ratio of available funds for the payment of debt service to a specific year's principal and interest payment. It is one measure of a nursing home's ability to repay debt or creditworthiness.

Depreciation and Interest Expense per Resident Day

Calculated as the sum of those expenses in a nursing home that are associated with the maintenance of long-term assets and liabilities, including capital lease payments, divided by the number of resident days in a nursing home.

Direct Care Expense per Resident Day

Calculated as the sum of those expenses directly associated with patient care, such as nursing costs, divided by the number of resident days in a nursing home. It is also referred to as *capital expense.*

Full-Time Equivalent Personnel (FTEs) per Average Daily Census

The total number of full-time equivalent personnel in a nursing home divided by the nursing home's average daily census. *Full-time equivalent personnel per average daily census* is a measure of the staffing level of a nursing home; alternatively, it can be seen as a measure of the labor inputs being used to provide a day of nursing home care.

Indirect Care Expense per Resident Day

Calculated as the sum of those expenses directly associated with indirect patient care, such as laundry and linen service, housekeeping, dietary, cafeteria, central services and supply, pharmacy, and social services divided by the number of resident days in a nursing home.

Long-Term Debt to Total Assets

Calculated as the ratio of long-term liabilities to total assets. *Long-term debt to total assets* measures the degree of financial leverage employed by a nursing home.

Net Patient Revenue per Resident Day

Calculated as total revenues collected for services rendered to patients, divided by the number of resident days in a nursing home. *Net patient revenue per resident day* is a measure of the patient care revenue per unit (per day) received by a nursing home.

Occupancy Rate

Calculated as the ratio of a nursing home's average daily census to its total number of nursing home beds, expressed as a percentage.

Operating Expense per Resident Day

Calculated as the total operating expenses of a nursing home divided by the number of resident days in the nursing home. Total operating expenses include salaries, supplies, depreciation, and interest expenses. Total operating expenses do not include "below the line" extraordinary items or charges against income. *Operating expense per resident day* is the best measure of the average cost per unit (per day) in a nursing home.

Percent Medicaid Resident Days

Calculated as the total number of Medicaid resident days in a nursing home divided by all resident days in the nursing home, expressed as a percentage.

Salary and Benefits per Full-Time Equivalent Personnel

Calculated as the sum of total salaries and employee benefits expense divided by the number of full-time equivalent personnel in a nursing home. *Salary and benefits expense per full-time equivalent personnel* measures the average direct labor expense per employee in a nursing home.

Total Profit Margin

Calculated as the difference between total net revenue and total expenses, divided by total net revenue, expressed as a percentage. *Total profit margin* is a measure of the overall profitability of a nursing home and reflects the inclusion of philanthropic contributions, endowment revenue, government grants, investment income, and other revenues and expenses not related to patient care operations.

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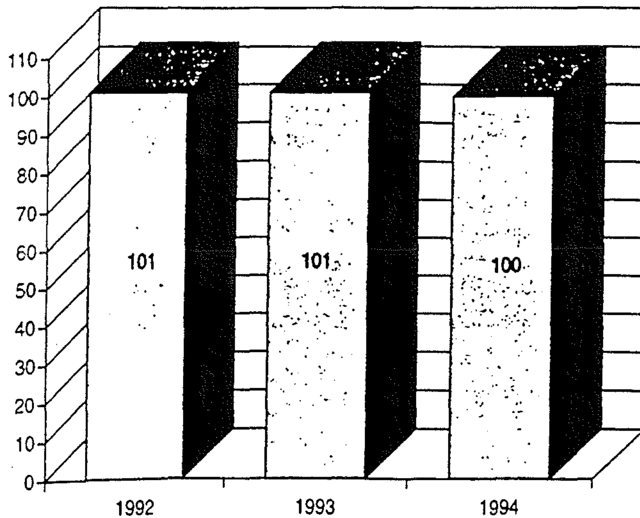
BEDS

The total number of beds in service in a nursing home at the end of its fiscal year. *Beds* is a measure of the capacit or size of a nursing home.



As the median bed size for all U.S. nursing homes indicates, the nursing home industry overall experienced little variation in size during the three-year period from 1992 through 1994. Several factors, including restrictive CON laws and restrictive Medicaid reimbursement policies, continue to limit growth within the industry. The typical nursing facility had 101 beds in service in 1992 and 1993, and 100 beds in service in 1994. Median bed size does continue to vary greatly among different types of facilities, however. The typical government nursing facility, with only 87 beds in service in 1994, remained significantly smaller than its typical investor-owned or not-for-profit counterparts, which had 101 and 102 beds in service, respectively, in 1994. Similarly, the typical freestanding nursing home, with 100 beds in service in 1994, remained significantly smaller than its system-affiliated counterpart, which had 109 beds in service.

	1994	1993	1992
All Nursing Homes	**100**	**101**	**101**
Investor-Owned	101	102	102
Government	87	88	88
Not-for-Profit	102	103	103
System-Affiliated	109	108	107
Freestanding	100	100	98
0–49 Beds	44	43	42
50–99 Beds	75	73	71
100–199 Beds	121	121	122
200+ Beds	240	240	240

	1994	1993	1992
Alabama	104	104	104
Alaska	76	73	75
Arizona	124	124	124
Arkansas	101	100	100
California	98	98	98
Colorado	96	92	92
Connecticut	120	120	120
Delaware	106	107	107
District of Columbia	204	203	203
Florida	120	120	120
Georgia	100	100	100
Hawaii	120	120	125
Idaho	76	75	75
Illinois	106	106	106
Indiana	105	105	100
Iowa	71	71	72
Kansas	60	60	60
Kentucky	101	104	101
Louisiana	120	120	120
Maine	66	66	65
Maryland	132	130	130
Massachusetts	95	95	93
Michigan	110	110	110
Minnesota	92	94	94
Mississippi	97	98	98
Missouri	106	106	108
Montana	73	72	71
Nebraska	68	67	67
Nevada	120	120	118
New Hampshire	108	107	107
New Jersey	127	126	126
New Mexico	75	75	70
New York	182	178	178
North Carolina	120	120	118
North Dakota	92	95	95
Ohio	100	102	100
Oklahoma	79	79	79
Oregon	91	92	92
Pennsylvania	128	128	128
Rhode Island	82	80	80
South Carolina	102	105	105
South Dakota	66	66	66
Tennessee	119	118	115
Texas	102	103	103
Utah	95	95	95
Vermont	120	120	120
Virginia	118	118	118
Washington	99	100	100
West Virginia	94	96	94
Wisconsin	102	103	102
Wyoming	80	80	80

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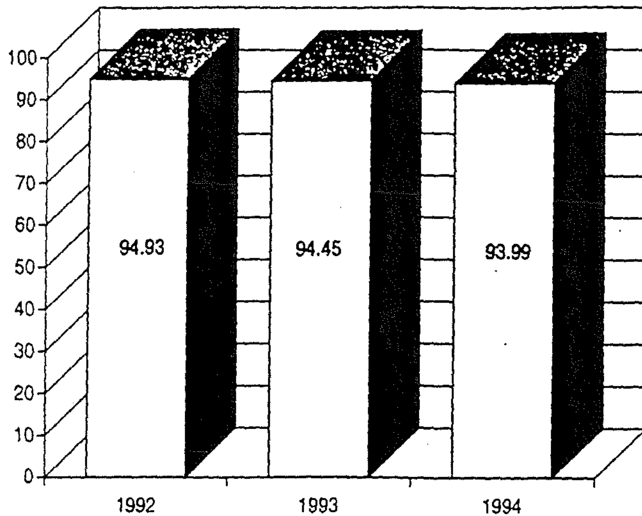
OCCUPANCY RATE

Calculated as the ratio of a nursing home's average daily census to its total number of nursing home beds, expressed as a percentage.



The nursing home industry's overall occupancy remained high in 1994, a reflection of both the shortage of lóng-term care beds available to an aging population and a recent increase in the number of elderly seeking subacute and rehabilitation care, as well as other types of specialized services, in long-term care facilities. In 1994, the industry experienced an overall median occupancy rate of 94 percent. Among different types of facilities, median occupancy rates varied only slightly from this figure. On a statewide basis, however, occupancy has varied greatly because of diverse supply and demand balances among the states. The majority of states that limit supply display high occupancy rates, whereas those that do not display lower rates. Although occupancy for the most part has remained stable across the country, some of the comparison groups experienced modest declines in each of the past two years. This slight drop in utilization is caused partly by increased support for utilization of less costly alternatives to nursing home care, such as assisted living and home- and community-based care, and partly by many facilities' attempt to retain vacant beds for privately paying patients who generate higher revenues.

	1994	1993	1992
All Nursing Homes	**93.99**	**94.45**	**94.93**
Investor-Owned	94.01	94.43	94.91
Government	95.90	96.64	96.71
Not-for-Profit	95.56	96.02	95.99
System-Affiliated	93.17	93.75	94.29
Freestanding	94.29	94.71	95.17
0–49 Beds	94.93	95.80	95.98
50–99 Beds	93.99	94.45	94.93
100–199 Beds	94.05	94.42	94.89
200+ Beds	93.76	94.46	94.62

	1994	1993	1992
Alabama	98.09	98.09	98.46
Alaska	90.06	88.76	86.86
Arizona	90.86	91.66	91.60
Arkansas	90.82	92.84	94.22
California	92.78	93.12	93.36
Colorado	90.08	90.49	88.09
Connecticut	96.62	96.39	97.62
Delaware	91.48	91.91	90.77
District of Columbia	97.77	98.10	98.15
Florida	95.18	95.36	95.47
Georgia	97.94	97.86	98.16
Hawaii	97.95	97.22	94.79
Idaho	91.73	92.72	93.34
Illinois	91.42	91.59	90.56
Indiana	86.79	86.89	86.67
Iowa	93.13	94.97	96.27
Kansas	91.64	93.09	94.43
Kentucky	97.12	98.19	98.56
Louisiana	91.84	92.63	91.23
Maine	95.45	97.25	96.54
Maryland	95.89	96.54	97.04
Massachusetts	96.80	97.09	97.74
Michigan	95.19	95.14	95.40
Minnesota	97.57	97.84	97.62
Mississippi	99.11	99.08	99.04
Missouri	88.55	89.78	90.72
Montana	93.54	91.43	92.31
Nebraska	93.56	92.97	93.41
Nevada	93.28	92.89	90.94
New Hampshire	95.70	95.91	96.57
New Jersey	94.85	94.09	94.81
New Mexico	94.10	96.90	96.37
New York	96.22	97.11	97.55
North Carolina	96.40	96.86	96.95
North Dakota	97.57	97.91	98.86
Ohio	94.58	94.50	95.65
Oklahoma	84.24	84.77	85.15
Oregon	88.81	89.41	90.51
Pennsylvania	94.19	94.34	94.77
Rhode Island	97.24	97.19	97.19
South Carolina	98.30	97.91	98.81
South Dakota	96.96	96.53	97.89
Tennessee	96.82	97.50	97.47
Texas	83.68	85.39	85.72
Utah	89.76	90.43	89.68
Vermont	97.26	96.71	96.94
Virginia	96.22	96.68	96.14
Washington	92.31	93.05	94.19
West Virginia	99.08	97.69	98.44
Wisconsin	94.04	95.14	96.02
Wyoming	90.18	90.07	88.33

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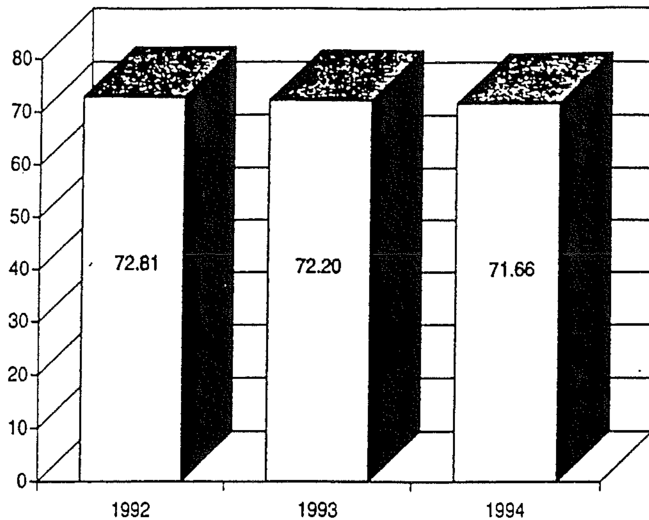
PERCENT MEDICAID RESIDENT DAYS

Calculated as the total number of Medicaid resident days in a nursing home divided by all resident days in the nu ing home, expressed as a percentage.



For nearly every major comparison group, the proportion of patient days accounted for by Medicaid beneficiaries declined slightly in 1994. This decline may be attributed in part to ongoing Medicaid budget cuts at the state and federal levels, facility attempts to retain vacant beds for privately paying patients, and growth in the role of private insurance in paying for long-term care. For all nursing homes nationwide, Medicaid days accounted for 71.7 percent of all patient days in 1994, down from 72.2 percent in 1993 and 72.8 percent in 1992. The smallest and largest facilities have continued to be the most dependent on Medicaid, with Medicaid days for the typical nursing homes with fewer than 50 beds and more than 200 beds accounting for 76.7 and 75.0 percent of all patient days, respectively, in 1994. Comparatively, Medicaid days accounted for only 71.7 percent of all patient days in nursing homes with 50 to 99 beds and 100 to 199 beds, in 1994. Among ownership types, not-for-profit facilities maintained a significantly smaller share of Medicaid days, 60.4 percent in 1994, than either investor-owned facilities (73.0 percent) or government facilities (70.1 percent).

	1994	1993	1992
All Nursing Homes	**71.66**	**72.20**	**72.81**
Investor-Owned	73.01	73.64	74.19
Government	70.14	71.27	71.54
Not-for-Profit	60.38	58.69	57.25
System-Affiliated	70.08	72.63	73.00
Freestanding	72.35	72.88	73.68
0–49 Beds	76.67	76.31	75.44
50–99 Beds	71.66	72.20	73.81
100–199 Beds	71.72	72.39	72.74
200+ Beds	75.00	76.63	77.22

	1994	1993	1992
Alabama	78.68	77.72	77.12
Alaska	85.03	87.51	87.36
Arizona	63.25	65.91	65.35
Arkansas	80.11	81.99	82.15
California	71.16	72.87	71.92
Colorado	69.67	68.56	68.80
Connecticut	73.36	71.03	71.26
Delaware	46.99	45.05	46.02
District of Columbia	88.53	90.02	89.65
Florida	70.09	70.80	69.62
Georgia	85.50	85.94	86.03
Hawaii	90.61	89.16	88.46
Idaho	66.90	67.47	67.37
Illinois	62.61	65.00	64.89
Indiana	68.39	69.30	68.79
Iowa	n/a	n/a	n/a
Kansas	55.30	54.52	55.11
Kentucky	72.26	74.21	75.18
Louisiana	88.80	88.27	88.12
Maine	80.61	80.30	78.43
Maryland	71.21	69.64	69.45
Massachusetts	76.44	77.36	78.29
Michigan	68.93	69.89	72.68
Minnesota	66.82	65.06	61.89
Mississippi	86.63	88.31	87.99
Missouri	66.63	65.55	65.04
Montana	63.50	65.01	63.06
Nebraska	51.75	52.18	51.93
Nevada	62.25	59.54	56.84
New Hampshire	n/a	n/a	n/a
New Jersey	61.47	60.08	58.91
New Mexico	78.31	80.44	80.55
New York	81.20	82.69	82.56
North Carolina	72.97	74.72	74.21
North Dakota	58.78	58.89	57.11
Ohio	74.58	74.64	74.30
Oklahoma	71.62	71.75	72.23
Oregon	60.85	60.24	59.51
Pennsylvania	57.43	59.69	59.29
Rhode Island	78.52	76.80	75.59
South Carolina	80.07	79.94	78.07
South Dakota	59.29	56.80	56.54
Tennessee	83.09	83.30	81.74
Texas	75.03	74.76	75.12
Utah	67.82	68.46	67.34
Vermont	71.79	71.87	70.58
Virginia	69.56	71.03	72.42
Washington	70.36	71.44	70.52
West Virginia	80.92	80.91	79.17
Wisconsin	69.16	68.41	69.63
Wyoming	66.49	65.04	65.84

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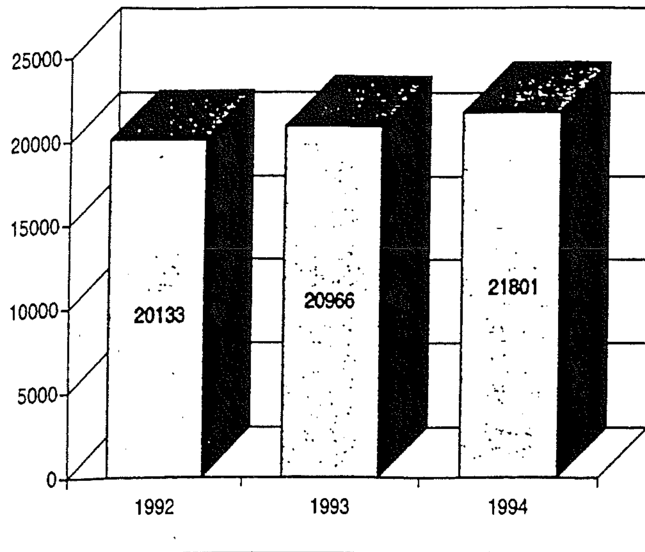
SALARY AND BENEFITS PER FTE

Calculated as the sum of total salaries and employee benefits expense divided by the number of full-time equivalent personnel in a nursing home. *Salary and benefits expense per full-time equivalent personnel* measures the average direct labor expense per employee in a nursing home.



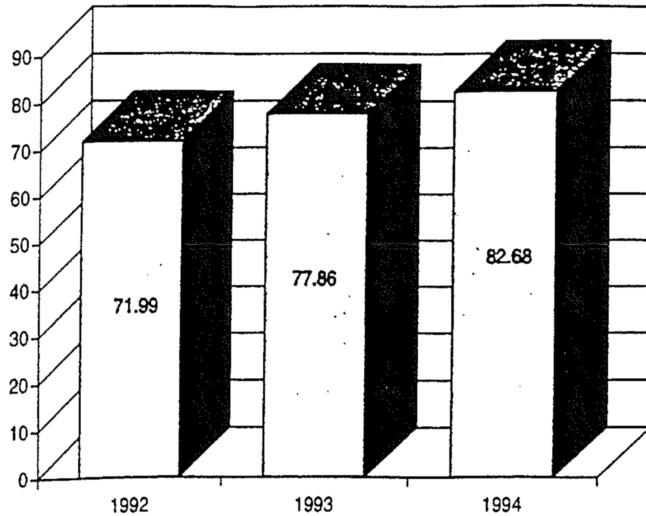
The average total compensation per FTE, which grew at a national rate of 4.0 percent in 1994, remains highest among the largest facilities, in part because of the more severe mix of patients typically treated at these facilities. The typical nursing facility with more than 200 beds paid a median compensation per FTE of $25,036 in 1994, as compared with a median value of only $21,441 for the typical nursing home with fewer than 50 beds. Among the different ownership categories, investor-owned facilities, with a median compensation per FTE of $21,517 in 1994, continued to pay the least. In comparison, the median compensation per FTE paid by the typical not-for-profit facility was $22,420 in 1994, and the median compensation paid by the typical government facility was $22.162.

	1994	1993	1992
All Nursing Homes	**21,801**	**20,966**	**20,133**
Investor-Owned	21,517	20,664	19,877
Government	22,162	21,445	20,615
Not-for-Profit	22,420	21,483	20,763
System-Affiliated	21,618	21,115	20,173
Freestanding	21,871	20,904	20,107
0–49 Beds	21,441	20,686	20,385
50–99 Beds	21,801	20,966	20,133
100–199 Beds	22,028	21,219	20,308
200+ Beds	25,036	24,025	23,110

	1994	1993	1992
Alabama	20,925	19,994	19,547
Alaska	34,561	34,229	33,512
Arizona	23,998	23,282	22,515
Arkansas	22,048	21,300	20,693
California	20,051	19,499	18,878
Colorado	19,185	18,131	17,601
Connecticut	32,933	31,983	31,099
Delaware	30,941	30,022	28,053
District of Columbia	33,485	31,631	29,195
Florida	23,125	22,296	20,973
Georgia	19,061	18,169	17,236
Hawaii	30,364	29,160	26,390
Idaho	21,177	20,430	19,994
Illinois	21,140	19,867	19,257
Indiana	22,186	21,066	21,641
Iowa	23,453	23,456	22,773
Kansas	20,011	19,361	18,784
Kentucky	22,267	21,376	20,250
Louisiana	15,558	15,594	15,381
Maine	28,104	27,924	27,593
Maryland	24,313	24,137	23,313
Massachusetts	29,578	29,240	28,096
Michigan	19,714	18,691	17,753
Minnesota	23,783	23,109	21,377
Mississippi	18,174	17,216	16,435
Missouri	17,071	16,114	15,290
Montana	20,492	19,169	19,002
Nebraska	21,587	20,633	19,359
Nevada	26,088	25,123	24,275
New Hampshire	29,053	28,191	27,764
New Jersey	32,101	31,798	29,095
New Mexico	21,131	20,171	19,214
New York	30,101	27,961	26,234
North Carolina	21,147	20,164	19,263
North Dakota	20,087	19,122	18,123
Ohio	22,178	21,694	20,235
Oklahoma	20,018	19,165	18,283
Oregon	22,424	22,654	22,823
Pennsylvania	25,092	23,850	22,901
Rhode Island	26,268	25,475	23,790
South Carolina	17,388	16,905	16,758
South Dakota	22,942	22,467	21,921
Tennessee	16,657	15,952	15,079
Texas	n/a	n/a	n/a
Utah	18,800	18,241	17,311
Vermont	20,886	19,936	19,294
Virginia	20,780	20,438	19,631
Washington	23,275	23,118	22,568
West Virginia	19,244	18,933	18,677
Wisconsin	23,991	22,992	22,114
Wyoming	23,028	22,128	20,275

OPERATING EXPENSE PER RESIDENT DAY

Calculated as the total operating expenses of a nursing home divided by the number of resident days in the nursing home. Total operating expenses include salaries, supplies, depreciation, and interest expenses. Total operating expenses do not include "below the line" extraordinary items or charges against income. *Operating expense per resident day* is the best measure of the average cost per unit (per day) in a nursing home.



The median total operating expense per resident day for all U.S. nursing homes increased 6.2 percent in 1994 to $82.68. Along with inflation, much of the increase can be attributed to additional costs associated with treating patients of higher acuity levels. Relative to earlier years, however, the rate of increase appears to be slowing, down from an increase of nearly 8.2 percent between 1992 and 1993. Aside from improved efficiency, slower growth in expenses on a per resident basis could also be the result of provider expansion into a number of less costly service offerings, such as home- and community-based care and assisted living. Like revenues, operating expense per resident day also varies with the size of the facility. The typical nursing facility with fewer than 50 beds had a median total operating expense per resident day of $80.71 in 1994, as compared with $100.85 for the typical nursing facility with more than 200 beds. Among the different ownership categories, not-for-profit nursing homes had a significantly higher median operating expense per resident day, $87.65 in 1994, than either investor-owned facilities, with a median of $82.20, or government-owned facilities, with a median of $85.73.

	1994	1993	1992
All Nursing Homes	**82.68**	**77.86**	**71.99**
Investor-Owned	82.20	75.85	68.77
Government	85.73	79.71	73.71
Not-for-Profit	87.65	83.35	78.06
System-Affiliated	87.50	81.29	74.82
Freestanding	81.57	76.40	70.72
0–49 Beds	80.71	75.06	69.14
50–99 Beds	80.28	74.86	67.99
100–199 Beds	86.67	80.48	73.92
200+ Beds	100.85	94.68	86.91

	1994	1993	1992
Alabama	78.59	73.76	67.10
Alaska	215.78	212.78	204.54
Arizona	104.39	98.75	93.59
Arkansas	57.85	52.88	49.27
California	98.56	88.07	77.43
Colorado	91.30	84.41	80.24
Connecticut	134.79	128.20	118.41
Delaware	107.38	104.34	101.03
District of Columbia	153.20	143.40	137.20
Florida	103.84	92.36	82.94
Georgia	70.80	64.71	59.40
Hawaii	133.42	129.45	124.35
Idaho	92.89	85.32	78.94
Illinois	72.28	70.58	67.48
Indiana	83.30	78.28	74.94
Iowa	58.62	56.42	53.58
Kansas	64.28	57.88	53.77
Kentucky	74.98	68.36	61.04
Louisiana	62.35	57.70	51.26
Maine	98.47	94.27	89.56
Maryland	94.32	89.82	84.10
Massachusetts	118.26	111.29	103.50
Michigan	87.10	79.62	72.42
Minnesota	80.07	74.79	69.38
Mississippi	67.01	61.96	57.03
Missouri	73.12	68.09	64.63
Montana	83.80	77.76	71.78
Nebraska	65.13	60.81	55.99
Nevada	104.47	97.02	90.62
New Hampshire	112.02	104.13	97.40
New Jersey	115.28	109.03	104.04
New Mexico	80.93	76.72	71.06
New York	137.18	132.82	128.00
North Carolina	82.61	78.46	72.37
North Dakota	80.18	76.73	72.95
Ohio	95.46	89.74	81.40
Oklahoma	51.00	48.57	45.85
Oregon	90.03	84.21	77.17
Pennsylvania	108.37	99.45	91.45
Rhode Island	110.78	103.38	95.03
South Carolina	85.69	76.68	71.95
South Dakota	68.08	64.50	59.54
Tennessee	74.68	69.20	61.58
Texas	58.59	54.72	51.80
Utah	80.58	73.21	65.27
Vermont	84.28	78.29	73.45
Virginia	96.01	90.70	85.28
Washington	111.28	101.82	90.81
West Virginia	86.29	79.18	71.70
Wisconsin	94.03	87.57	81.12
Wyoming	96.23	81.33	72.25

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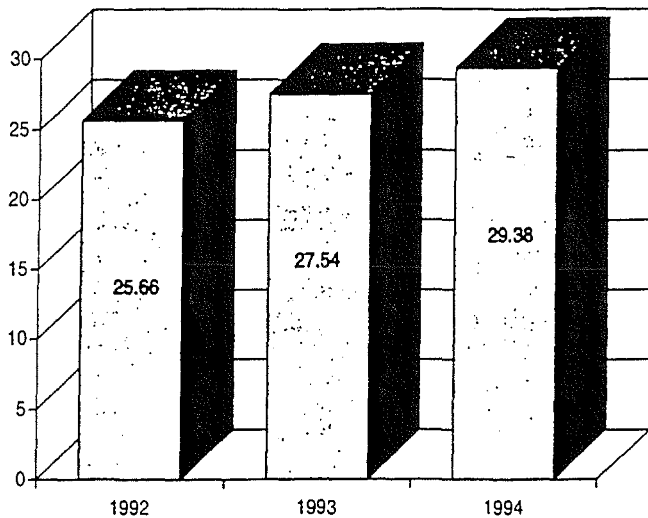
DIRECT CARE EXPENSE PER RESIDENT DAY

Calculated as the sum of those expenses directly associated with patient care, such as nursing costs, divided by the number of resident days in a nursing home.



Direct care costs, which at the typical U.S. nursing home increased 6.7 percent to $29.38 in 1994 from $27.54 in 1993, can vary greatly among facilities, as a result of differences in management decisions, the average debility level of the facility's residents, and plant size. The largest nursing homes spent a median of $36.20 per resident day on direct patient care, compared with a median of $30.00 per resident day for the smallest facilities, and a median of only $28.38 per resident day for facilities in the 50 to 99 bed size range. Among ownership types, the typical investor-owned facility spent the least on direct patient care, $28.69 in 1994, as compared with $32.70 for the typical governmental facility, and $32.51 for the typical not-for-profit facility.

	1994	1993	1992
All Nursing Homes	**29.38**	**27.54**	**25.66**
Investor-Owned	28.69	26.65	24.98
Government	32.70	31.42	29.76
Not-for-Profit	32.51	31.01	28.94
System-Affiliated	28.14	25.95	24.48
Freestanding	29.13	27.28	25.36
0–49 Beds	30.00	28.07	26.66
50–99 Beds	28.38	26.54	24.66
100–199 Beds	30.48	28.44	26.64
200+ Beds	36.20	34.07	31.95

	1994	1993	1992
Alabama	28.13	26.31	24.53
Alaska	65.14	64.44	63.18
Arizona	35.17	31.62	30.61
Arkansas	18.83	17.49	16.41
California	29.80	28.40	27.92
Colorado	37.27	34.22	32.28
Connecticut	45.61	41.66	41.40
Delaware	38.21	37.85	36.09
District of Columbia	56.09	55.62	53.73
Florida	32.91	30.38	29.33
Georgia	23.79	22.23	20.55
Hawaii	49.41	45.72	40.26
Idaho	30.71	32.16	29.94
Illinois	22.93	22.75	21.97
Indiana	27.92	27.32	25.53
Iowa	20.54	19.96	18.44
Kansas	22.32	20.44	18.85
Kentucky	26.72	23.85	21.66
Louisiana	19.28	18.04	16.90
Maine 12	35.54	35.95	36.17
Maryland	31.53	30.01	29.07
Massachusetts	43.44	41.81	38.91
Michigan	33.99	31.26	29.55
Minnesota 13	35.51	33.63	30.59
Mississippi	21.93	19.61	17.77
Missouri	24.55	23.52	22.04
Montana	30.76	27.71	25.58
Nebraska	27.34	26.25	22.88
Nevada	34.40	33.06	32.62
New Hampshire	40.12	38.58	35.33
New Jersey	37.91	35.73	34.86
New Mexico	21.35	22.40	20.53
New York	51.12	48.24	46.92
North Carolina	32.12	30.20	27.94
North Dakota 30	29.28	29.99	29.54
Ohio	34.46	34.56	31.37
Oklahoma	15.55	15.19	14.57
Oregon	32.91	32.53	30.00
Pennsylvania	34.49	31.86	29.41
Rhode Island	37.61	35.14	33.62
South Carolina	26.89	25.10	23.52
South Dakota	24.95	23.48	21.87
Tennessee	24.02	22.06	20.19
Texas	21.66	20.24	19.19
Utah	27.82	26.52	23.91
Vermont	28.53	25.10	24.61
Virginia	29.66	28.92	28.14
Washington	39.09	37.04	35.24
West Virginia	25.62	23.49	22.58
Wisconsin	34.36	32.23	29.77
Wyoming	37.64	33.77	29.71

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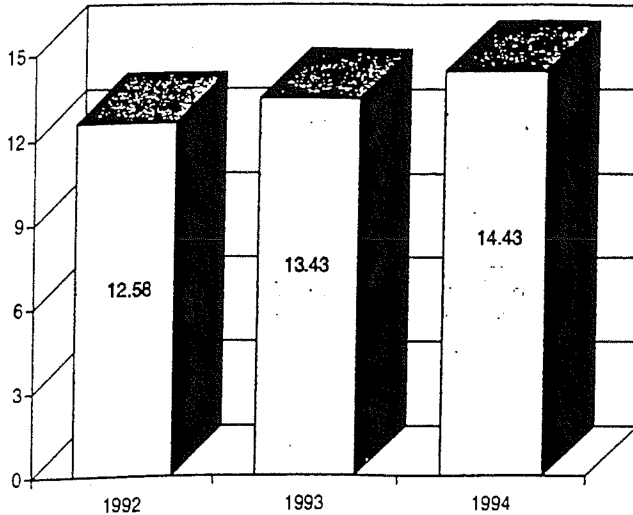
INDIRECT CARE EXPENSE PER RESIDENT DAY

Calculated as the sum of those expenses directly associated with indirect patient care, such as laundry and linen ser vice, housekeeping, dietary, cafeteria, central services and supply, pharmacy, and social services, divided by the number of resident days in a nursing home.



Indirect care costs, which at the typical U.S. nursing home increased 7.4 percent to $14.43 in 1994 from $13.43 in 1993, can vary greatly among facility types. Not surprisingly, system-affiliated nursing homes, with a median indirect care expense per resident day of $13.83 in 1994, spent considerably less on indirect care than their freestanding counterparts, which had a median indirect care expense of $14.69. Much of this difference is the result of economies of scale. Among the ownership types, investor-owned facilities, with a median indirect care expense of $14.03 in 1994, once again demonstrated their ability to constrain costs. The typical not-for-profit and governmental facilities, in comparison, both maintained significantly higher median indirect care expenses of $17.07 and $17.63, respectively, in 1994.

	1994	1993	1992
All Nursing Homes	**14.43**	**13.43**	**12.58**
Investor-Owned	14.03	13.14	12.29
Government	17.63	16.40	15.60
Not-for-Profit	17.07	16.24	15.22
System-Affiliated	13.83	12.94	12.06
Freestanding	14.69	13.67	12.82
0–49 Beds	15.41	14.32	13.60
50–99 Beds	14.43	13.43	12.58
100–199 Beds	14.22	13.05	12.16
200+ Beds	17.94	16.66	15.71

	1994	1993	1992
Alabama	13.01	12.42	11.33
Alaska	37.74	37.23	36.43
Arizona	15.40	14.04	13.38
Arkansas	11.39	10.50	10.15
California	15.93	15.48	15.30
Colorado	11.88	12.33	12.87
Connecticut	19.15	17.54	17.98
Delaware	21.85	21.85	20.88
District of Columbia	31.20	30.27	29.70
Florida	17.95	15.07	13.50
Georgia	11.54	10.90	10.46
Hawaii	18.29	20.55	20.58
Idaho	12.67	12.25	11.33
Illinois	13.40	12.52	11.38
Indiana	13.26	13.47	12.93
Iowa	10.77	11.33	10.71
Kansas	12.62	11.94	10.89
Kentucky	13.04	10.44	10.49
Louisiana	8.88	8.72	8.24
Maine	13.83	14.77	14.52
Maryland	16.16	15.60	14.80
Massachusetts	18.76	17.88	17.13
Michigan	15.35	14.01	13.13
Minnesota	17.21	16.54	15.73
Mississippi	9.94	10.12	9.11
Missouri	11.23	10.92	10.44
Montana	15.35	13.95	13.75
Nebraska	14.53	14.15	12.96
Nevada	17.25	14.36	12.57
New Hampshire	22.25	20.92	19.27
New Jersey	20.50	19.40	18.59
New Mexico	12.54	11.62	10.04
New York	27.46	25.92	25.12
North Carolina	14.50	13.59	13.09
North Dakota	13.22	13.81	15.80
Ohio	16.02	15.63	13.60
Oklahoma	10.49	10.15	9.81
Oregon	12.89	12.27	9.43
Pennsylvania	16.31	15.42	14.17
Rhode Island	15.95	15.77	15.12
South Carolina	13.85	14.07	12.74
South Dakota	13.18	12.74	11.88
Tennessee	13.08	12.46	11.60
Texas	10.87	10.52	9.95
Utah	11.30	10.91	10.77
Vermont	16.14	15.56	14.59
Virginia	12.46	12.73	12.44
Washington	14.43	13.00	12.18
West Virginia	13.08	11.91	11.13
Wisconsin	16.10	15.21	14.48
Wyoming	14.89	14.10	12.81

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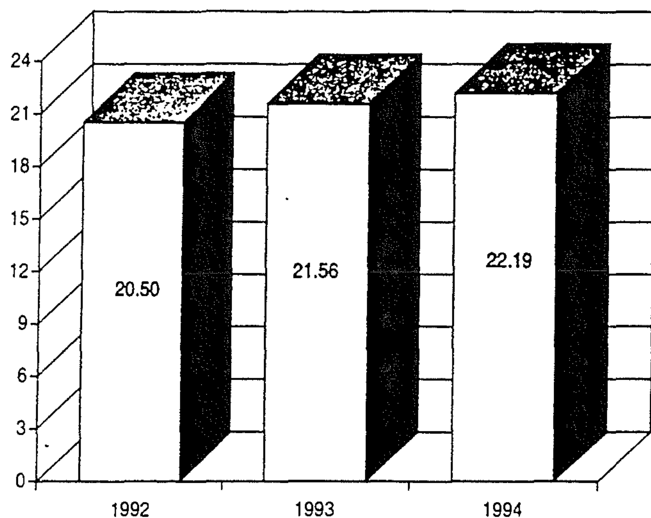
ADMINISTRATIVE AND GENERAL EXPENSE PER RESIDENT DAY

Calculated as the sum of those expenses associated with a nursing home's basic administrative and general office functions, divided by the number of resident days in a nursing home. Administrative and general expenses include non-patient telephone bills, cashiering, patient billing, maintenance and repairs, operation of plant, maintenance of personnel, employee benefits, and medical records.



Among all U.S. nursing homes, the median administrative and general expense per resident day, which consists of those costs associated with maintaining and running a facility, increased only 2.9 percent in 1994 to $22.19. Not surprisingly, investor-owned facilities, with a median administrative and general expense of only $21.81 in 1994, spent considerably less to maintain their facility than their not-for-profit and governmental facility counterparts, which had medians of $23.82 and $23.26, respectively, in 1994. Much of this difference is the result of economies of scale. Among the different bed size categories, the smallest facilities continued to maintain the lowest median administrative and general expense per resident day. To illustrate, the median administrative and general expense for facilities with fewer than 50 beds was only $21.88 in 1994, as compared with a median of $26.44 for facilities with more than 200 beds.

	1994	1993	1992
All Nursing Homes	**22.19**	**21.56**	**20.50**
Investor-Owned	21.81	20.17	19.11
Government	23.26	22.60	21.41
Not-for-Profit	23.82	23.76	22.66
System-Affiliated	22.64	21.30	19.14
Freestanding	23.03	22.29	20.22
0–49 Beds	21.88	21.41	20.79
50–99 Beds	22.19	20.56	19.50
100–199 Beds	22.42	22.57	20.51
200+ Beds	26.44	25.32	23.75

	1994	1993	1992
Alabama	21.00	19.48	18.08
Alaska	63.94	63.37	62.16
Arizona	27.06	25.63	23.88
Arkansas	18.16	16.81	15.31
California	33.18	30.62	28.05
Colorado	15.42	15.70	14.12
Connecticut	38.03	36.92	36.28
Delaware	26.15	25.94	25.04
District of Columbia	35.14	33.14	31.59
Florida	23.66	24.49	22.43
Georgia	20.78	19.31	17.21
Hawaii	39.80	35.81	33.36
Idaho	25.84	25.27	23.44
Illinois	20.04	19.62	18.30
Indiana	22.73	22.16	18.16
Iowa	15.39	14.86	13.95
Kansas	19.66	18.02	16.29
Kentucky	18.63	16.37	14.11
Louisiana	20.84	18.30	16.30
Maine 48	16.18	16.32	15.30
Maryland	27.52	26.65	24.14
Massachusetts	31.45	28.21	25.16
Michigan	18.39	16.49	15.91
Minnesota 27	21.58	20.53	19.09
Mississippi	18.51	19.03	17.46
Missouri	27.18	25.65	25.14
Montana	25.81	24.79	22.78
Nebraska	16.93	14.55	12.36
Nevada	27.48	26.86	25.55
New Hampshire	34.13	33.94	30.21
New Jersey	29.48	26.73	25.58
New Mexico	25.30	25.09	24.38
New York	38.35	36.40	34.92
North Carolina	19.74	19.63	18.21
North Dakota 33	21.13	19.64	18.76
Ohio	20.35	18.79	16.21
Oklahoma	14.16	15.66	14.21
Oregon	21.96	23.33	22.35
Pennsylvania	28.81	26.71	24.45
Rhode Island	25.12	26.82	26.16
South Carolina	19.08	18.20	17.69
South Dakota	18.56	16.68	15.26
Tennessee	19.79	18.93	16.77
Texas	16.75	15.65	14.46
Utah	24.69	23.81	21.28
Vermont	21.36	19.25	18.16
Virginia	20.05	19.71	17.70
Washington	29.45	27.17	25.29
West Virginia	20.94	18.26	17.67
Wisconsin	23.92	24.41	22.86
Wyoming	26.36	23.04	21.64

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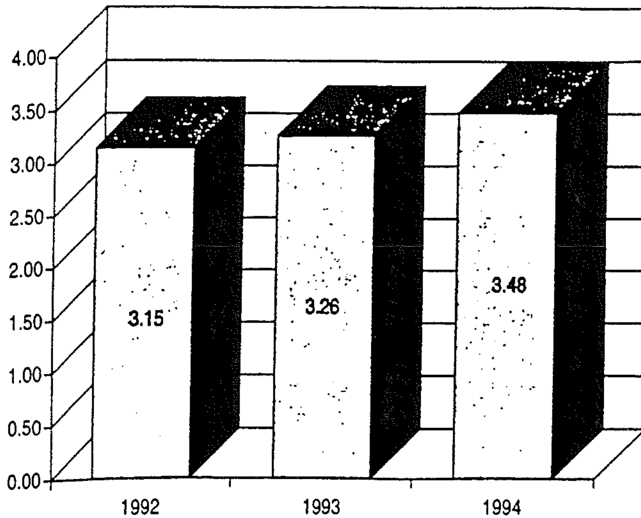
TOTAL PROFIT MARGIN

Calculated as the difference between total net revenue and total expenses, divided by total net revenue, expressed as a percentage. *Total profit margin* is a measure of the overall profitability of a nursing home and reflects the inclusion of philanthropic contributions, endowment revenue, government grants, investment income, and other revenues and expenses not related to patient care operations.



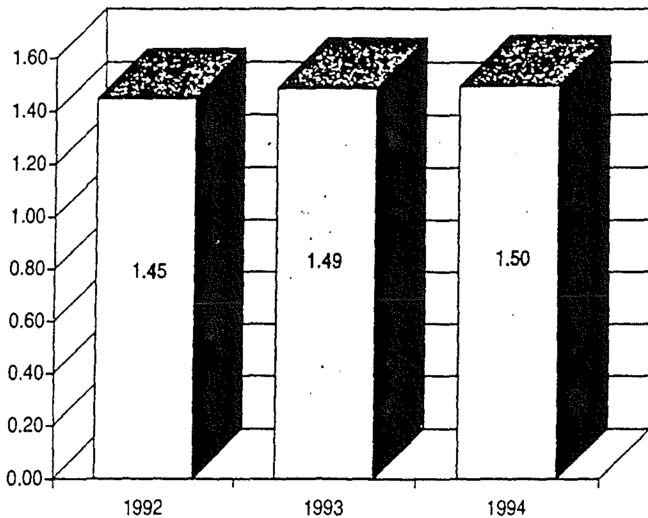
Nursing home profitability continued to improve across the board in 1994. The median total profit margin for all U.S. nursing homes rose to 3.48 percent in 1994, from 3.26 percent in 1993 and 3.15 percent in 1992. Among other things, improved profitability is likely the result of improved efficiency, greater expansion into higher-profit alternative service offerings, and a decline in the proportion of patient days accounted for by Medicaid beneficiaries. Investor-owned and system-affiliated facilities continued to be the most profitable types of facilities, earning net margins of 3.68 and 4.43 percent, respectively, in 1994. The higher profits of investor-owned and system-affiliated facilities is likely attributable to their greater ability to contain costs. Among the different size bed categories, moderately sized nursing homes with between 100 and 199 beds remained the most profitable in 1994, earning net margins of 4.18 percent. The smallest nursing facilities with fewer than 50 beds, in comparison, earned net margins of only 1.33 percent in 1994.

	1994	1993	1992
All Nursing Homes	**3.48**	**3.26**	**3.15**
Investor-Owned	3.68	3.54	3.41
Government	1.25	1.23	1.19
Not-for-Profit	2.26	1.94	1.77
System-Affiliated	4.43	4.34	4.20
Freestanding	3.03	2.93	2.77
0–49 Beds	1.33	1.48	1.28
50–99 Beds	3.28	3.26	3.15
100–199 Beds	4.18	4.09	4.02
200+ Beds	3.18	3.06	2.89

	1994	1993	1992
Alabama	5.98	5.43	6.55
Alaska	3.23	2.77	3.09
Arizona	2.43	2.96	3.09
Arkansas	5.87	5.71	5.41
California	1.66	2.06	1.93
Colorado	2.18	2.25	2.20
Connecticut	1.08	1.35	1.51
Delaware	0.52	0.88	0.48
District of Columbia	2.70	3.06	3.33
Florida	2.51	3.01	2.80
Georgia	2.39	2.43	2.69
Hawaii	1.49	2.63	1.86
Idaho	1.62	1.43	1.79
Illinois	2.47	2.27	2.53
Indiana	2.75	2.02	n/a
Iowa	2.92	3.70	3.10
Kansas	1.62	0.92	0.74
Kentucky	5.20	4.54	3.53
Louisiana	7.21	7.35	7.05
Maine	1.60	2.21	2.39
Maryland	3.93	3.45	2.30
Massachusetts	1.83	2.35	1.57
Michigan	2.12	1.14	1.72
Minnesota	3.43	2.55	2.52
Mississippi	5.09	3.93	5.12
Missouri	1.36	1.52	1.84
Montana	3.14	2.92	1.59
Nebraska	5.51	4.81	4.43
Nevada	2.84	2.42	1.08
New Hampshire	3.40	3.34	2.71
New Jersey	0.19	0.23	0.19
New Mexico	3.01	2.47	2.35
New York	3.28	2.89	3.58
North Carolina	2.87	3.18	1.51
North Dakota	2.22	1.83	1.14
Ohio	1.37	2.56	2.51
Oklahoma	n/a	n/a	n/a
Oregon	1.61	1.57	2.31
Pennsylvania	4.09	3.26	3.80
Rhode Island	1.06	(0.19)	(0.05)
South Carolina	1.04	0.95	0.60
South Dakota	5.23	4.23	3.63
Tennessee	2.41	2.04	1.12
Texas	n/a	n/a	n/a
Utah	3.26	3.17	2.93
Vermont	3.58	2.74	2.23
Virginia	3.55	2.93	2.24
Washington	2.15	2.22	2.44
West Virginia	3.77	3.08	1.64
Wisconsin	1.37	0.57	0.88
Wyoming	0.08	(0.30)	(0.26)

CURRENT RATIO

Calculated as total current assets, including the balance of the depreciation fund, divided by total current liabilities. *Current ratio* is an indicator of a nursing home's liquidity and ability to meet short-term obligations.



The nursing home industry overall experienced a slight increase in its median current ratio in 1994. However, the industry's 1994 median value of only 1.50 remains somewhat unfavorable. Investor-owned nursing facilities continued to demonstrate a lower median current ratio, 1.43 in 1994, than either not-for-profit facilities, with a median of 1.82, or governmental facilities, with a median of 2.38. This happens most likely because investor-owned nursing facilities typically transfer cash to their parent corporations in order to obtain more favorable investment returns. Among the different bed size groups, the largest nursing facilities maintained the highest, most favorable, median current ratio, 1.51 in 1994. The smallest nursing facilities maintained a median current ratio of only 1.39.

	1994	1993	1992
All Nursing Homes	**1.50**	**1.49**	**1.45**
Investor-Owned	1.43	1.42	1.39
Government	2.38	2.26	2.12
Not-for-Profit	1.82	1.94	1.89
System-Affiliated	1.51	1.50	1.47
Freestanding	1.47	1.47	1.42
0–49 Beds	1.39	1.45	1.39
50–99 Beds	1.48	1.49	1.45
100–199 Beds	1.52	1.51	1.47
200+ Beds	1.51	1.45	1.43

	1994	1993	1992
Alabama	1.80	1.58	1.91
Alaska	1.65	1.42	2.27
Arizona	1.19	1.41	1.31
Arkansas	2.42	2.56	2.46
California	1.20	1.38	1.45
Colorado	1.45	1.22	1.38
Connecticut	1.28	1.25	1.09
Delaware	1.28	0.97	0.94
District of Columbia	2.54	2.13	3.07
Florida	1.50	1.39	1.42
Georgia	1.30	1.39	1.17
Hawaii	1.61	1.41	1.94
Idaho	1.30	1.73	1.44
Illinois	2.38	2.38	1.86
Indiana	1.57	1.48	n/a
Iowa	1.45	1.75	1.83
Kansas	1.23	1.31	1.16
Kentucky	1.33	1.31	1.15
Louisiana	2.08	2.17	1.83
Maine	1.09	1.29	1.03
Maryland	1.33	1.38	1.53
Massachusetts	1.22	1.11	1.08
Michigan	1.52	1.44	1.40
Minnesota	1.41	1.06	1.16
Mississippi	2.41	2.52	2.78
Missouri	1.38	1.36	1.28
Montana	1.32	1.55	1.43
Nebraska	1.86	1.82	1.94
Nevada	1.56	1.56	1.39
New Hampshire	1.54	0.77	0.71
New Jersey	1.20	1.04	0.80
New Mexico	1.33	1.39	0.88
New York	1.36	1.42	1.29
North Carolina	1.21	1.27	1.26
North Dakota	1.83	1.43	1.51
Ohio	1.26	1.32	1.25
Oklahoma	n/a	n/a	n/a
Oregon	1.36	1.51	1.56
Pennsylvania	1.88	1.87	1.78
Rhode Island	1.14	1.23	1.10
South Carolina	1.24	1.00	0.95
South Dakota	2.45	1.52	1.63
Tennessee	1.61	1.47	1.20
Texas	n/a	1.84	1.93
Utah	n/a	n/a	n/a
Vermont	1.54	1.22	0.98
Virginia	1.88	1.94	1.68
Washington	n/a	n/a	n/a
West Virginia	2.33	1.71	1.95
Wisconsin	1.47	1.40	1.21
Wyoming	0.70	1.21	1.65

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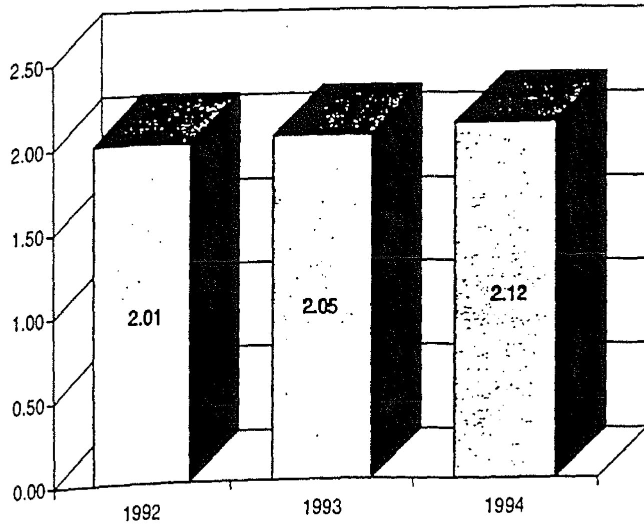
DEBT SERVICE COVERAGE RATIO

Calculated as the sum of net income, depreciation, and interest expense divided by annual debt service. *Debt service coverage ratio* measures the ratio of available funds for the payment of debt service to a specific year's principal and interest payment. It is one measure of a nursing home's ability to repay debt or creditworthiness.



As evidenced by a median debt service coverage ratio of more than 2.1 times, the nursing home industry's ability to service its debt continued to improve in 1994, a reflection of the industry's improved profitability. Government-owned facilities, with a median debt service coverage ratio of 3.1 times, maintained the best ability to service their debt among all ownership types in 1994. The median debt service coverage ratio for not-for-profit facilities, in comparison, was 2.5 times, and the median for investor-owned facilities was only 2.0 times. The sizable debt burden carried by investor-owned facilities is the primary reason for their weak debt service coverage. Among the different bed size categories, ability to service debt increased with the size of the facility. The smallest facilities demonstrated a median debt service coverage ratio of 1.6 times in 1994, compared with a median of 2.3 times for the largest facilities.

	1994	1993	1992
All Nursing Homes	**2.12**	**2.05**	**2.01**
Investor-Owned	2.03	1.92	1.88
Government	3.05	2.82	2.66
Not-for-Profit	2.48	2.31	2.20
System-Affiliated	2.42	2.24	2.17
Freestanding	1.99	1.98	1.95
0–49 Beds	1.58	1.77	1.53
50–99 Beds	2.12	2.09	2.01
100–199 Beds	2.31	2.21	2.19
200+ Beds	2.26	2.23	2.20

	1994	1993	1992
Alabama	3.42	2.85	3.52
Alaska	3.31	2.59	1.54
Arizona	1.50	1.44	1.50
Arkansas	4.00	4.15	3.57
California	1.29	1.39	1.36
Colorado	1.82	2.58	1.77
Connecticut	1.82	2.31	2.30
Delaware	1.68	1.78	1.52
District of Columbia	1.98	2.31	2.77
Florida	1.94	2.39	2.87
Georgia	1.86	1.77	1.75
Hawaii	1.72	1.92	1.87
Idaho	1.82	1.43	2.05
Illinois	2.83	1.94	2.51
Indiana	1.42	1.48	n/a
Iowa	3.07	3.21	3.11
Kansas	2.31	2.11	2.02
Kentucky	2.89	3.04	2.29
Louisiana	2.13	2.33	2.41
Maine	1.22	1.37	1.30
Maryland	2.23	1.94	1.95
Massachusetts	2.01	1.99	1.77
Michigan	2.41	1.99	1.99
Minnesota	n/a	n/a	n/a
Mississippi	3.45	1.96	2.22
Missouri	2.87	1.16	1.89
Montana	2.66	2.72	2.16
Nebraska	4.01	3.59	3.06
Nevada	2.57	2.40	2.53
New Hampshire	3.16	2.59	2.56
New Jersey	1.52	1.65	1.08
New Mexico	2.86	2.81	1.74
New York	2.50	2.46	2.24
North Carolina	1.85	2.10	1.63
North Dakota	2.48	2.43	1.60
Ohio	1.21	2.18	2.93
Oklahoma	n/a	n/a	n/a
Oregon	1.67	2.55	1.99
Pennsylvania	2.96	2.73	2.77
Rhode Island	0.72	1.00	1.12
South Carolina	1.65	1.53	1.55
South Dakota	4.73	4.49	4.38
Tennessee	3.23	2.25	1.46
Texas	3.23	2.82	2.70
Utah	2.53	2.39	1.83
Vermont	2.70	1.85	1.83
Virginia	1.97	1.66	1.60
Washington	2.16	1.81	2.23
West Virginia	2.01	2.00	1.53
Wisconsin	1.75	1.86	1.64
Wyoming	1.94	1.56	1.42

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Maine Non Hospital-Based Facilities
Comparative State Average Operating Cost Information
Fiscal Years Ended September 30 Through August 31, 1995 and 1996

	1995			1996		
	Total Cost	Medicaid Allow. Cost*		Total Cost	Medicaid Allow. Cost*	
Direct care costs	$ 44.27	$ 44.21	41.7%	$ 47.64	$ 47.58	42.2%
Indirect care costs	11.22	10.71	10.2%	12.46	11.82	10.4%
Fixed costs	23.64	23.08	21.7%	24.67	23.64	21.0%
Routine costs	51.78	27.94	26.4%	56.48	29.77	26.4%
Total	$130.91	$105.94	100%	$141.25	$112.81	100%
Salaries and fringe benefits percentage of total, excluding Administrator and owners			63.8%			62.3%
Average direct care hours per resident day			3.7 hours			3.9 hours

* Payment rates are facility-specific based on 1993 allowable costs (not current costs) increased for inflation, and limited to prescribed peer group caps for direct care, indirect care, and routine components of $47.54, $11.07, and $28.61, respectively, as of June 30, 1995. Direct care component of each facility's rate adjusted quarterly for change in average acuity of Medicaid residents in the facility.

Maine Non Hospital-Based Nursing Facilities
Occupancy and Resident Mix Information
Fiscal Years Ended September 30 Through August 31, 1995 and 1996

	1995		1996	
Facilities	129		127	
Resident Days				
Nursing facility				
Medicare	139,110	4.2%	196,765	6.5%
VA	9,786	.3%	7,961	.3%
Medicaid	2,580,379	78.4%	2,319,751	76.6%
Self-pay	563,946	17.1%	504,020	16.6%
	3,293,221	100%	3,028,497	100%
Residential care				
Medicaid/state	33,132	66.6%	51,447	56.5%
Self-pay	16,632	33.4%	39,603	43.5%
	49,764	100%	91,050	100%
TBI	11,930		10,640	
Mental health	6,356		7,555	
Total days	3,361,271		3,137,742	

Key Statistical and Financial Comparisons
Abstract from 1996 Edition of
"The Guide to the Nursing Home Industry"*

	National Average	Maine			
	1994	1994		1993	1992
		Data	Ranking**		
General Statistics					
Licensed beds	100	66	50	66	65
Occupancy	93.9%	95.4%	22	97.3%	96.5%
Medicaid utilization	71.66%	80.6%	10	80.3%	78.4%
Salary and benefits per FTE	$21,801	$28,104	10	$27,924	$27,593
Revenue/Expense Per Day					
Net patient revenue	$84.11	$97.24	18	$93.52	$89.86
Operating expense	82.68	98.47	17	94.27	89.56
Direct care expense	29.38	35.54	12	35.95	36.17
Indirect care expense	14.43	13.83	28	14.77	14.52
Administrative expense	22.19	16.18	48	16.32	15.30
Interest and deprec. expense	6.96	9.09	15	9.64	10.67
Ancillary	2.34	2.48	29	2.28	1.49
Financial Ratios					
Profit margin	3.5%	1.6%	39	2.2%	2.4%
Current ratio	1.5	1.09	50	1.29	1.03
Debt service coverage ratio	2.12	1.22	49	1.37	1.30

* A publication of HCIA, Inc. and Arthur Anderson, LLP
** Includes 50 states and District of Columbia

Maine Non Hospital-Based Nursing Facilities
Summary of Financial Position and Results of Operations

Maine DHS 1996 Summary of Cumulative Profit (Loss)	1993	1994	1995
Number of facilities for which information available	109	105	97
Cumulative profit (loss)	$703,444	$246,413	$(118,900)

Berry, Dunn, McNeil & Parker Data Base	Fiscal Years Ended September 30, 1994 Through August 31, 1995	Fiscal Years Ended September 30, 1995 Through March 31, 1996
Number of facilities	92	53
Cumulative equity (deficit)	$31,341,595	$(7,513,083)
Number with equity	65	27
Number with deficit	27	26
Cumulative return on equity	3.8%	negative
Cumulative profit margin	.5%	negative

MAINE MEDICAID PROGRAM NF RATE-SETTING

Most recent rate-setting regulations effective for fiscal years beginning on or after July 1, 1995. Semi-prospective rates (except TBI units that are paid allowable costs retrospectively) based on facility-specific base year (fiscal years beginning on or after October 1, 1992) allowable costs limited to peer group caps inflated to current fiscal year. Two peer groups, hospital-based and all others. No prescribed rebasing.

Rate Components

Direct Care

Lower of facility's case mix adjusted base year allowable CPD inflated to June 30, 1995 or peer group caps ($47.54 for non hospital-based facilities and $64.78 for hospital-based, 112% of median). Applicable CPD adjusted quarterly for facility's average case mix index of Medicaid residents in-house on 15th of last month of second preceding quarter.

MDS+ assessments required for all residents. Rate is reduced from 2% to 10% if unacceptable error rate identified by audit. RUGS III classification system used with Maine wage rates applied to 1990 national time study data to calculate relative weight for each of the 44 classifications.

If actual allowable CPD less than rate, facility repays 75% of difference to DHS.

- Nursing salaries and fringe benefits (excluding DON)
- Activities salaries and fringe benefits

Indirect Care

Lower of base year allowable CPD inflated to June 30, 1995 or peer group caps ($11.07 for non hospital-based facilities and $18.28 for hospital-based, 110% of median). Applicable June 30, 1995 CPD inflated to current fiscal year. No annual retrospective settlement.

- DON salaries and fringe benefits
- Social services salaries and fringe benefits
- Food
- Medical supplies
- Pharmacy, social service, and dietary consultants
- Medical Director - limited to $1,200 monthly

Fixed Cost

Facility-specific allowable CPD incurred calculated using higher of actual resident days for year or days equivalent to 90% occupancy.

Depreciation recapture applies to lower of accumulated depreciation or gain realized on sale of depreciable assets. Credits against recapture of building depreciation which eliminates recapture after 25 years of ownership.

- Interest on long-term debt
- Depreciation and amortization
- Property, liability, and malpractice insurance
- Workers' comp costs including insurance premiums and deductibles
- Gross Receipts Tax
- Water and sewer connection charges
- Return on equity (8%) for proprietary providers
- Rent
- Administrator in training salaries and fringe benefits with prior approval

Routine Cost

Lower of base year allowable CPD inflated to June 30, 1995 or peer group caps. ($28.61 for non hospital-based and $49.88 for hospital-based, 108% of median).

Administration and Policy Planning Ceiling sets maximum amount based on licensed beds that can be included in allowable cost for administrator's compensation and fringes, professional accounting costs, and other administrative functions.

- All other operating expenses except ancillaries and those not included in preceding components.

Ancillaries

Separately billable on fee-for-service basis

- PT, OT, ST, medication and drugs, and DMERC.

Other Considerations

All facilities required to have minimum of 20% of beds licensed for Medicare participation

Capital expenditures in excess of $500,000 and all transfers of ownership require CON. No CON can be issued if project increases annual Medicaid payments to facility. Basis of property for determination of allowable interest and depreciation expense limited to CON approved capital costs for new construction or seller's original approved historical cost fo a sale.

Medical eligibility requirements changed in '94. Reduced average occupancy from 98% to below 90%. Current regulatory policy focused on reducing NF beds.

Summary
Maine Medicaid Nursing Facility Rate-Setting Process

The "Principles of Reimbursement for Nursing Facilities" is the governing body of regulations which establishes procedures for determining Medicaid rates for Maine nursing facilities. These regulations have been extremely volatile with substantial changes occurring annually since 1988. The current regulations described herein are those effective for fiscal years beginning on or after July 1, 1995.

General Description

The payment system is a semi-prospective methodology based on facility-specific base year (fiscal year beginning on or after October 1, 1992) allowable costs with peer group caps. There are two peer groups, hospital-based facilities (licensed nursing facility beds located within a hospital building) and non hospital-based facilities. A portion of the rate (direct care) is adjusted quarterly for changes in each facility's average case mix index for Medicaid residents only, and all components except fixed costs are inflated annually. The regulations do not provide for any mandatory rebasing of the costs or the base year average case mix index (based on assessments of Medicaid residents in each facility on March 31, 1993). Although there are 44 different RUGS III clinical classifications based on differing resource needs and associated cost used for classifying residents based on MDS+ assessments, use of each facilities' average case mix index for Medicaid residents for rate-setting purposes results in an average rate per day paid to each facility for all Medicaid days of care rendered irrespective of the acuity and resource needs of individual residents.

Rate Components

A facility's Medicaid rate is the aggregate total of four components; direct care, indirect care, routine, and fixed costs. The operating expenses included in each component and the methodology for calculation of the rate are summarized below:

- Direct Care - includes salaries and fringe benefits for all nursing staff (except the DON), ward clerks, and activities personnel. The applicable rate for each facility is the lower of the facility's case mix adjusted base year allowable direct care cost per day (base year allowable cost per day divided by base year case mix index) inflated to June 30, 1995, or the peer group cap. The caps ($47.54 for non hospital-based facilities and $64.78 for hospital-based facilities) are 112% of the respective peer group base year case mix adjusted allowable direct care cost per day at June 30, 1995. The applicable June 30, 1995 amount for each facility is multiplied by the facility's average case mix index calculated on a quarterly basis using MDS+ assessments for Medicaid residents in-house on the 15th day of the last month of the second preceding quarter, plus inflation. The RUGS III classification system, used to classify residents and calculate the average case mix index, provides 44 potential resource utilization groups with differing relative resource weights applicable to each classification based on the estimated nursing minutes and average hourly rates applicable to each nursing position.

  If a facility's allowable direct care cost per day is less than the weighted average quarterly direct care rate paid during a fiscal year, the facility is required to repay 75% of the "savings" to DHS.

A facility's direct care component is reduced if an unacceptable error rate in MDS+ preparation is discovered by DHS through the assessment review process. Penalties range from 2% to 10% for error rates ranging from 35.8% to above 45% of the sample.

- Indirect Care- consists of the salary and fringe benefits of the DON and social service personnel, raw food costs, vitamins and food supplements, medical supplies, pharmacy consultants, dietary consultants, and medical director costs limited to $1,200 per year. The rate for each facility is the lower of the base year allowable cost per day inflated to June 30, 1995, or the peer group cap. The peer group caps ($11.07 for non hospital-based facilities and $18.28 for hospital-based facilities) are 110% of the respective peer group medians at June 30, 1995. The applicable June 30, 1995 amount for each facility is inflated to the appropriate fiscal year-end. This component of the rate is prospective.

- Fixed Cost - includes depreciation expense, amortization of leasehold improvements, real estate and personal property taxes, real estate insurance premiums, interest on long-term debt, return on capital for proprietary providers (8%), rent expense, amortization of finance start-up and organizational costs, insurance premiums for motor vehicles, liability and malpractice coverage, workers' compensation costs, salaries and fringe benefits associated with an administrator in training for an approved program, gross receipts tax, and water and sewer fees for initial connection to a community water and sewer system. Fixed costs are reimbursed retrospectively based on the actual allowable costs per day incurred for each fiscal year. An interim rate is based on the most recently audited cost report adjusted for any capital expenditures approved through the Certificate of Need (CON) process.

- Routine Cost - consists of all allowable operating expenses not included in the other three components. The rate for each facility is the lower of the allowable base year cost per day inflated to June 30, 1995, or the peer group cap. The caps ($28.61 for non hospital-based facilities and $49.88 for hospital-based facilities) are 108% of the respective peer group medians at June 30, 1995. The applicable June 30, 1995 amount for each facility is inflated to the appropriate fiscal year-end. This component of the rate is prospective.

Therapy services are paid on a fee-for-service basis independent of the rate-setting process described above. All nursing facilities are required to have a portion of their Medicaid licensed beds also licensed for Medicare.

Other Considerations

Notwithstanding elements of case mix and prospective payment methodology in the rate-setting system, the regulations are laced with archaic "cost reimbursement" restrictions on the allowability of specific operating costs. Administrative expenses, which include compensation and fringe benefits associated with the administrator and other defined administrative positions together with professional accounting fees are limited by an "Administrative and Policy Planning Ceiling" (Ceiling) which is a prescribed amount per licensed bed. The Ceiling is part of the routine cost component. Management fees, irrespective of to whom they are paid, are not allowed. Use of a facility average rate per day calculated based on a static base year and use of an average base year case mix index using only Medicaid residents in-house for one day, March 31, 1993, and subsequent adjustment by the use of a facility average case mix index based solely on Medicaid residents in a facility on one day each quarter, totally disassociates the payment from any reflection of the actual resource needs and related cost of providing the required services to specific residents.

All capital expenditures in excess of $500,000 and all changes in licensed capacity or ownership require CON approval. As a result of 1993 legislation, no CON will be granted for any project, including change of ownership, which results in higher annual Medicaid payments to a facility compared to those that would have been made absent implementation of the project. The basis of depreciable property and land for the purchaser for purposes of calculating allowable equity, depreciation and interest expense is limited to the seller's allowable Medicaid historical cost. Recapture of depreciation is applicable for any disposition of depreciable property generating a gain with the recapturable Medicaid portion of the gain, limited to accumulated depreciation, based on historical Medicaid utilization.

APPENDIX M

Letter from Michael McNeil to Paula Valente, Executive Vice President, Maine Health Care Association, dated July 24, 1998

BERRY, DUNN, McNEIL & PARKER
CERTIFIED PUBLIC ACCOUNTANTS
MANAGEMENT CONSULTANTS

July 24, 1998

Paula Valente, Executive Vice President
Maine Health Care Association
317 State Street
Augusta, ME 04330

Re: Financial Stability of Maine's Nursing Facilities

Dear Paula:

We understand MHCA intends to initiate an effort designed to raise the level of awareness of policy-makers regarding the financial jeopardy currently threatening the nursing facility (NF) segment of Maine's health care delivery system. You requested we provide you a foundation for your communication and discussions regarding this effort. The following financial information and commentary are provided in response to your request.

Overview of Current Environment

There has been an accelerated decline in the financial stability of Maine's nursing facilities during the last three years caused by three primary factors: 1) a decrease in average occupancy from 97% to 86%; 2) payments by the Medicaid program that are less than the cost of providing services to the respective program beneficiaries (documented by DHS Division of Audit presentation to Commission to Examine Rate Setting and Financing of Long Term Care Facilities as a minimum of $16 million less than defined "allowable" cost in 1996); and 3) an escalating pressure on wage rates caused by substantially full employment.

The current technical insolvency of many of Maine's nursing facilities brings us perilously close to the point where many will be forced to avail themselves of bankruptcy protection and/or terminate services, a situation that will have adverse consequences for not only those providers, but also Maine taxpayers and Maine's long term care consumers.

Statistics showing Maine is in the top ten nationally relative to per diem reimbursement rates and per capita expenditures often are cited as evidence of inefficient management, and the conclusion is drawn that this is the real cause of facilities financial distress. The conclusion is erroneous and ignores several critical realities. First, the table of state Medicaid expenditures (copy enclosed as Exhibit III) shows Maine decreased Medicaid expenditures for nursing facility care by 12% from 1992 to 1997 ($229 million to $202 million), while the remaining states and District of Columbia collectively increased Medicaid nursing facility payments by 34%! No state except Maine decreased its nursing facility expenditures in this period. Secondly, a discussion of per diem or per capita expenses does not provide any conclusive measure of effectiveness or efficiency without analysis of the factors that influence these cal-

culations, such as demographics, licensing standards, size of facilities, geographic wage differences, geographic construction cost differences, third party utilization, and relevant aspects of the regulatory environment.

Financial Analysis

The basis of all Maine and national information prior to 1997 referenced below and in the accompanying Exhibits is the 1997 edition of "The Guide to the Nursing Home Industry" publication of HCIA. The most recent data available is for 1995.

Exhibit I provides key financial ratios for 1993 – 1995 with Maine compared to similar national information. Exhibit I also reflects information abstracted from financial statements for 117 of the 129 Maine nursing facilities for 1997 (no financial statements available for remaining 12 facilities). The ratios most relevant to the evaluation of financial stability are the profit margin, the current ratio, and the debt service coverage ratio. We consider minimum acceptable ratios to be 3%, 1.2 and 1.2, respectively. Maine's cumulative averages are not only deficient when compared to minimum acceptable ratios, they are also substantially below the national medians for the period 1993 – 1995. The 1997 information reflects further deterioration from the 1995 data with a profit margin of less than 1% and a current ratio of less than 1.

Exhibit II reflects the 1997 financial ratios for nursing facilities segregated by region (the regions are county groupings which conform to those identified in the Maine "Principles of Reimbursement for Nursing Facilities" for the determination of inflation factors), and between not-for-profit and proprietary organizations. The ratios for the nursing facilities funded through the MHHEFA bond program are also separately identified. Exhibit II also provides the number of facilities in each grouping exhibiting specified adverse financial characteristics. Those facilities funded through MHHEFA are weaker than the total population with a negative profit margin approaching 3%, a current ratio of approximately 1, a debt service coverage ratio of less than 1, and cumulative negative equity.

As supporting material, we have included copies from the HCIA publication reflecting the source of the profit margin, current ratio, and debt service coverage ratio information reflected in Exhibit I. We have noted on those schedules the ranking of Maine, New Hampshire and Vermont in relation to other states for each of these ratios. The higher the ranking (number) the worse the relative standing. Based on the 1995 data, Maine is 37th in the country with regard to profit margin, 41st in the country with regard to current ratio, and 46th in the country with regard to debt service coverage. The ranking in each category portrays extreme relative financial weakness.

To address concerns regarding the relatively high cost per day and per capita cost of Maine's nursing facility care in relation to other states, we have included additional excerpts from the HCIA publication providing data on the State average number of beds per facility, the percentage of Medicaid utilization, the salary and fringe benefit costs per FTE, and the operating expense per resident day.

The operating expense per day information confirms that Maine does have one of the highest per diem costs for nursing care, ranking 10th based on 1995 information. Also of note, Maine's Northern New England sister states are comparable with New Hampshire ranking 8th and Vermont ranking 17th. This

information, however, is not meaningful without understanding the following key operating characteristics of Maine's facilities in relation to other states:

- One characteristic that substantially influences the cost per day is the size of the facility. The accompanying table reflecting the average bed size of nursing facilities shows Maine ranks 46th in facility size, i.e. it has relatively smaller facilities than most states. Accordingly, Maine's cost per day for nursing facility care is of necessity going to be higher than substantially every other state because economies of scale cannot be maximized and overhead expenses (costs that do not vary directly with utilization) are spread over fewer patient days.

- The table comparing state Medicaid utilization indicates Maine has the 12th highest Medicaid utilization in the country. A substantially higher proportion of Maine's total resident days are funded by a program that recognizes less than the programs' proportionate cost of operation, thereby diminishing financial stability relative to other states that have a higher proportion of non-Medicaid utilization.

- The table comparing average salary and benefits cost per FTE reflects Maine as having the 5th highest average compensation per FTE in the country. Since salary and fringe benefits approximate 65% of a nursing facility's total operating expenditures, Maine's ranking in this area, coupled with the small average size of the facilities, is the primary cause of the relatively high cost per day incurred by Maine facilities to deliver the care required, not inefficiency or ineffectiveness.

The last matter of importance is the financial condition of those facilities currently financed through the MHHEFA program. The creation of available financing for nursing facilities through MHHEFA has been characterized as a clandestine operation by nursing home providers to create a state subsidy for their private benefit. Those who have this view were not involved in the 1991 legislative process that created authorization for MHHEFA to facilitate such financing. The facts are that the catalyst for the crafting of this enabling legislation was supported by DHS to create less expensive alternatives to commercial bank financing for construction of nursing facility projects then being solicited by DHS, and to provide a mechanism to refinance existing nursing facility mortgage debt at a lower interest cost. Since interest expense is recognized for Medicaid reimbursement on a "pass through" basis, DHS desired to reduce interest expense for nursing facilities, thereby reducing Medicaid expenditures for reimbursement of same. Based on information provided to us during early 1997, it was estimated MHHEFA financing had saved $30 million in interest expense, and this converted to savings for the Maine Medicaid program of approximately $23 million. Enabling MHHEFA to facilitate nursing facility financing was a cooperative effort by DHS, the providers and the Maine legislature to reduce the cost of financing to the benefit of all parties. As the "rewards" are shared, so are the risks. The State's risk inherent in the MHHEFA program is one element of collateral offered to bondholders to attain the lower interest expense, the "moral obligation" of the State of Maine. The abrupt, unplanned change in long term care policy in Maine from the solicitation of construction of new nursing facilities through 1992, to a policy of dramatically reducing utilization, now jeopardizes the ability of borrowers to repay their debt. The State's "moral obligation", consciously granted in 1991 in exchange for the lower Medicaid interest expense which has benefited the Medicaid program, may now be called upon to fund the amount necessary

to repay the bondholders and/or preserve required reserves. Failure to provide this subsidy would jeopardize the State's credit rating and increase the borrowing cost of future financing for other purposes. Perhaps more importantly, however, a deterioration of the nursing facility segment of our delivery system will seriously jeopardize the availability of the service to those in need and create a damaging gap in Maine's healthcare continuum which will have to be rectified in a manner that has the likelihood of being more expensive than implementation of a plan to address the existing financial crisis facing current providers.

A resolution to the current financial crisis for Maine nursing facilities is not going to be forthcoming until policymakers are convinced that a problem actually exists and failure to resolve it will be detrimental to the State of Maine, its taxpayers, and the consumers of the healthcare services. We understand it is with this objective that MHCA will be communicating with the Commissioner of the Department of Human Services with the hope that dialogue can be directed toward the adoption of a meaningful resolution to the budding crises. We are sincerely hopeful your efforts will raise the level of awareness related to the seriousness of the current situation, and lead to dialogue that will result in adoption of one or more of the MHCA recommended actions for a resolution that is in the interest of all parties.

Sincerely,

Berry, Dunn, McNeil & Parker

By
Michael T. McNeil

Encs

Exhibit I

Maine Non-Hospital Based Nursing Facilities
Comparison of Financial Characteristics
to Historical National Data

	Maine				National		
	1997	1995	1994	1993	1995	1994	1993
All Free Standing Facilities (117 for which financial data available for 1997)							
Total Profit Margin (%)	(.54%)	1.80%	1.60%	2.21%	3.73%	3.21%	2.76%
Days in Accounts Receivable	35	22.83	21.97	21.85	38.18	36.44	35.48
Days in Accounts Payable*	15	12.39	9.31	7.96	12.79	11.99	11.67
Current Ratio	.9794	1.12	1.11	1.29	1.51	1.49	1.49
Average Age of Plant (Years)	8	9.84	7.15	7.83	9.76	8.81	8.23
Long-Term Debt to Total Assets		0.55	0.44	0.46	0.49	0.55	0.51
Debt Service Coverage Ratio	1.1559	1.06	1.22	1.35	3.22	2.02	1.95
Debt to Equity Ratio	6.0667	—	—	—	—	—	—
Proprietary							
Total Profit Margin (%)	(.75%)	1.86%	1.60%	1.99%	4.01%	3.37%	2.93%
Days in Accounts Receivable	32	21.39	19.94	21.65	38.39	36.65	35.60
Days in Accounts Payable*	17	12.39	9.24	8.04	13.06	12.13	11.86
Current Ratio	.9256	1.10	1.07	1.24	1.44	1.44	1.42
Average Age of Plant (years)	8	9.84	7.32	7.62	9.01	8.27	7.51
Long-Term Debt to Assets	—	0.61	0.43	0.45	0.50	0.56	0.53
Debt Service Coverage Ratio	1.0618	1.04	1.21	1.33	2.13	1.96	1.92
Debt to Equity Ratio	54.1874	—	—	—	—	—	—
Not-For-Profit							
Total Profit Margin (%)	.04%	.84%	1.18%	N/A	1.08%	.95%	.37%
Days in Accounts Receivable	42	4.97	30.49	33.39	39.64	32.17	34.26
Days in Accounts Payable*	9	13.07	9.49	7.27	9.82	9.93	8.73
Current Ratio	1.1655	1.26	0.71	2.76	2.24	2.43	2.36
Average Age of Plant (years)	7	N/A	N/A	N/A	15.36	14.06	13.39
Long-Term Debt to Total Assets	—	0.39	0.68	N/A	0.28	0.27	0.32
Debt Service Coverage Ratio	1.4348	1.18	1.33	N/A	2.89	2.26	2.99
Debt to Equity Ratio	2.7365	—	—	—	—	—	—

*The 1997 ratio includes only amounts classified as "accounts payable" in facility financial statement, and does not include accrued expenses. If accrued expenses were included, it is estimated this ratio would increase to in excess of 30 days for 1997.

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Maine Non Hospital Based Nursing Facilities
Summary of Financial Ratios

	Total	Region 1	Region 2	Region 3	Region 4	Not For Profit	Proprietary	MHHEFA Financed
Total Facility Population	117	40	40	26	11	21	96	28
Ratios								
Profit Margin	(.54%)	(.94%)	(1.09%)	(1.00%)	5.58%	.04%	(.75%)	(2.89%)
Days in Accounts Receivable	35	30	36	45	31	42	32	32
Days in Accounts Payable	15	15	14	20	5	9	17	20
Current Ratio	.9794	.8001	1.0181	1.2095	1.2884	1.1655	.9256	1.0429
Average Age of Plant	8	8	8	6	9	7	8	6
Debt service coverage ratio	1.1559	1.1066	1.0809	1.0718	1.4681	1.4348	1.0618	.9625
Debt to Equity ratio	6.0667	4.7701	26.8803	5.5335	2.3960	2.7365	54.1874	(Negative Equity $557,363 and approximately $140 million of total MHHEFA debt outstanding)
Number of Facilities								
With Losses From Operation	50	17	22	10	1	10	40	18
Current Ratio Less Than 1.0	49	20	17	8	4	4	45	19
Negative Cumulative Equity	42	14	20	7	1	3	39	18
Debt Service Coverage Ratio Less Than 1.2	44	12	19	12	1	4	40	13

TABLE A

NURSING HOME SERVICES

RANK	STATE	FY 1992 EXPENDITURES	FY 1993 EXPENDITURES	PERCENT CHANGE 92-93	FY 1994 EXPENDITURES	PERCENT CHANGE 93-94	FY 1995 EXPENDITURES	PERCENT CHANGE 94-95	FY 1996 EXPENDITURES	PERCENT CHANGE 95-96	FY 1997 EXPENDITURES	PERCENT CHANGE 96-97	FY 1997 EXPENDITURES CAPITA
1	WASHINGTON, DC	$138,808,474	$139,501,231	0.4	$156,480,881	12.2	$175,840,417	0.1	$120,000,216	-10.8	$169,895,886	28.5	$287.24
2	NEW YORK	$3,615,046,081	$4,085,322,034	12.3	$4,274,928,086	4.4	$4,598,398,332	7.4	$5,265,294,180	14.5	$5,344,818,820	1.5	$290.80
3	CONNECTICUT	$690,214,057	$727,091,826	5.3	$787,793,224	8.6	$813,879,382	0.0	$838,807,258	3.1	$831,341,811	2.3	$262.17
4	PENNSYLVANIA	$1,741,514,826	$1,524,818,890	-12.6	$1,872,898,773	22.8	$2,087,837,448	11.5	$2,102,185,573	0.4	$2,649,463,875	26.0	$224.01
5	RHODE ISLAND	$184,741,573	$203,283,795	10.1	$220,735,761	8.2	$215,701,575	3.8	$222,887,865	3.2	$218,521,517	-1.9	$220.74
6	MASSACHUSETTS	$1,206,517,785	$1,068,782,843	-11.3	$1,250,811,114	17.0	$1,437,500,108	14.2	$1,240,917,824	-13.7	$1,313,370,967	6.0	$215.65
7	MINNESOTA	$694,327,548	$740,185,367	6.6	$863,808,188	16.7	$1,003,731,488	16.2	$926,073,824	-7.7	$858,247,882	-7.3	$184.25
16	NEW HAMPSHIRE	$161,122,138	$167,526,613	4.5	$188,477,284	22.3	$195,887,026	0.4	$205,824,001	5.1	$204,920,984	-0.4	$176.25
8	NORTH DAKOTA	$88,741,811	$82,845,840	0.0	$84,828,717	2.1	$102,971,388	8.0	$107,473,823	4.4	$110,083,225	2.4	$170.84
9	OHIO	$1,390,339,307	$1,497,482,082	7.3	$1,601,860,090	7.0	$1,767,000,384	10.3	$1,891,873,852	-0.9	$1,817,671,758	14.2	$162.88
10	MAINE	$228,611,238	$224,830,613	-2.1	$230,140,345	3.3	$237,133,398	-0.4	$213,813,583	-0.8	$202,801,386	-5.4	$163.58
11	WISCONSIN	$682,811,787	[illegible]	7.6	$697,565,900	6.8	$723,880,779	14.9	$741,817,863	-3.2	$780,738,548	1.6	$147.43
12	NEW JERSEY	$840,658,354	$967,833,123	14.4	$1,051,543,830	8.4	$1,016,887,077	4.3	$1,104,041,825	0.0	$1,180,290,084	5.6	$146.01
13	SOUTH DAKOTA	$71,647,547	$78,072,236	9.0	$88,830,113	11.3	$92,000,761	5.2	$88,030,182	4.4	$90,374,081	1.4	$135.76
14	NEBRASKA	$161,707,806	$178,804,067	10.7	$188,158,770	5.1	$187,368,887	4.0	$210,426,896	4.6	$222,534,712	5.7	$134.70
15	WEST VIRGINIA	$188,778,325	$208,800,803	9.6	$231,298,802	10.7	$236,892,228	1.0	$232,876,148	-1.2	$240,664,787	3.3	$131.80
17	TENNESSEE	$428,342,316	$524,310,421	22.1	$551,800,582	5.5	$587,837,185	6.3	$627,818,782	0.0	$680,888,110	6.2	$124.67
18	ALABAMA	$308,724,003	$331,482,810	7.0	$382,180,858	15.5	$437,045,785	11.8	$444,192,837	4.3	$523,972,127	17.3	$122.53
19	ARKANSAS	$234,622,661	$251,801,174	7.4	$272,140,273	8.3	$284,794,021	4.6	$295,430,722	3.0	$300,964,229	2.0	$121.00
20	VERMONT	$68,368,930	$65,087,640	10.3	$70,250,157	7.3	$72,122,601	2.7	$78,112,863	0.1	$76,518,887	-8.7	$118.73
21	KENTUCKY	$288,507,780	$332,151,630	10.9	$370,180,813	11.5	$380,432,298	5.1	$404,987,618	4.0	$400,128,111	-12.0	$118.47
22	MISSOURI	$546,286,043	$418,097,831	-24.7	$428,308,246	2.0	$490,181,348	18.8	$554,807,867	11.2	$627,389,680	13.2	$117.87
23	HAWAII	$97,157,082	$101,757,886	4.8	$123,822,310	21.7	$128,643,899	2.5	$134,841,738	5.2	$136,480,000	1.2	$115.20
24	INDIANA	$667,877,547	$712,865,365	6.6	$735,183,634	3.2	$680,517,877	-7.9	$710,822,903	4.0	$672,183,670	-5.4	$115.07
25	MISSISSIPPI	$248,891,827	$215,824,827	-12.2	$244,348,217	15.8	$270,002,820	13.0	$301,640,980	5.6	$308,215,005	8.0	$113.83
26	MONTANA	$67,812,100	$91,508,291	35.0	$94,141,545	3.7	$105,400,977	11.1	$101,043,517	-4.2	$99,601,933	-1.4	$113.31
27	ILLINOIS	$1,048,641,080	$1,103,280,876	5.1	$1,145,843,097	3.9	$1,280,620,741	4.9	$1,288,159,538	-0.1	$1,328,103,191	19.6	$111.94
28	DELAWARE	$54,170,180	$58,155,065	7.3	$60,253,905	3.8	$64,283,249	6.5	$73,103,517	13.4	$77,340,239	5.7	$106.80
29	NORTH CAROLINA	$418,140,330	$503,804,180	20.0	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
30	MARYLAND	$344,272,070	$481,320,545	4.6	$480,283,304	4.0	$460,122,618	5.1	$389,627,932	-15.3	$522,720,000	34.0	$102.06
31	IOWA	$208,578,230	$222,870,631	6.0	$249,481,419	7.9	$267,402,213	7.1	$271,414,082	5.4	$289,121,126	6.5	$101.27
32	WYOMING	$32,660,102	$33,568,141	-21.1	$48,072,167	40.7	$44,048,341	9.5	$47,000,720	6.7	$47,270,548	0.8	$98.25
33	WASHINGTON	$398,803,731	$452,088,017	13.6	$498,713,128	8.4	$518,033,703	5.6	$622,173,112	0.0	$521,593,887	-0.0	$94.27
34	LOUISIANA	$419,735,934	$526,030,044	25.3	$514,202,679	-2.3	$569,871,831	9.1	$515,836,648	-0.1	$380,039,207	-34.0	$88.41
35	KANSAS	$164,200,272	$176,787,733	7.6	$201,701,283	14.2	$223,460,824	10.7	$225,060,237	1.0	$217,224,349	-0.7	$88.35
36	OKLAHOMA	$228,360,260	$237,496,122	4.0	$253,007,047	6.6	$270,508,430	8.0	$278,381,335	2.9	$288,890,782	4.2	$87.85
37	FLORIDA	$884,805,700	$1,011,048,103	14.3	$1,044,403,208	5.2	$1,210,574,000	15.7	$1,138,300,003	-6.0	$1,264,372,020	11.1	$87.83
38	MICHIGAN	$811,468,117	$823,297,381	10.5	$844,139,880	2.5	$868,490,211	3.3	$1,053,416,741	6.0	$612,817,020	-22.8	$84.71
39	COLORADO	$224,827,216	$220,142,937	-1.3	$238,848,901	8.5	$217,814,174	16.1	$304,818,730	9.9	$322,000,800	5.9	$84.48
40	GEORGIA	$481,641,940	$531,128,102	8.1	$572,400,638	2.0	$619,907,278	8.1	$648,137,138	4.2	$615,804,824	-4.7	$83.88
41	NEW MEXICO	$84,171,440	$89,617,310	6.6	$107,300,307	7.0	$113,811,820	5.2	$120,100,514	5.6	$132,801,882	10.7	$77.84
42	IDAHO	$62,828,342	$68,960,075	9.8	$71,966,848	4.4	$70,874,228	10.7	$80,664,488	12.6	$82,860,711	2.7	$77.42
43	SOUTH CAROLINA	$207,155,906	$208,758,157	9.3	$233,223,872	11.7	$245,177,178	5.1	$272,130,329	11.4	$280,648,516	3.5	$76.66
44	ALASKA	$38,830,453	$42,255,080	8.9	$50,837,088	19.8	$40,253,290	-8.6	$48,465,260	-3.7	$46,880,882	-5.9	$75.12
45	TEXAS	$980,284,806	$1,058,298,638	7.1	$1,144,800,803	8.6	$3,236,811,077	4.0	$1,272,700,981	8.4	$1,345,877,190	5.8	$70.37
46	CALIFORNIA	$1,722,808,047	$1,878,470,976	9.0	$1,948,491,283	7.2	$2,083,902,731	5.9	$2,069,896,843	-0.2	$2,000,868,536	1.5	$65.88
47	VIRGINIA	$344,884,938	$372,818,152	8.1	$379,372,830	1.8	$380,208,945	7.4	$383,114,221	1.2	$310,826,080	1.7	$58.80
48	OREGON	$152,886,122	$153,040,683	3.4	$167,338,882	-1.1	$109,683,845	1.6	$118,000,886	3.5	$200,138,141	2.0	$52.60
49	UTAH	$63,179,157	$72,080,863	14.9	$82,802,882	15.1	$84,878,126	2.3	$85,000,240	0.2	$86,878,973	2.2	$43.64
50	NEVADA	$60,641,464	$73,867,833	21.7	$72,801,480	-1.1	$69,148,590	-10.0	$62,800,402	-3.4	$67,887,200	7.0	$43.83
51	ARIZONA	$14,153,860	$10,913,280	-22.3	$12,681,580	16.3	$13,782,344	8.6	$15,835,944	-15.8	$16,470,836	40.0	$3.72
	UNITED STATES	$24,350,385,850	$26,117,180,360	7.3	$28,128,804,925	7.7	$30,354,130,234	7.8	$31,035,400,305	2.3	$32,532,606,785	4.0	$122.83

(229,641,238)
24,128,757,321

(202,071,391)
32,330,571,395

122 decrease
347 increase

Exh. 4 T

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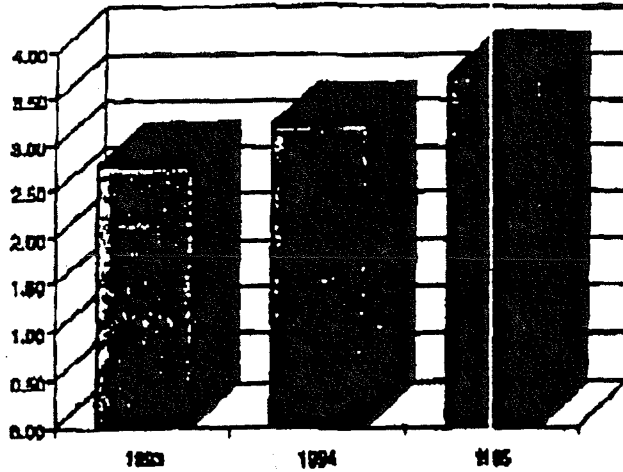
TOTAL PROFIT MARGIN

Calculated as the difference between total net revenue and total expenses, divided by total net revenue, expressed as a percentage. Total profit margin is a measure of the overall profitability of a nursing home and reflects the inclusion of philanthropic contributions, endowment revenue, government grants, investment income, and other revenues and expenses not related to patient care operations. Favorable values are above the median.



Nursing home profitability continued to improve in 1995. The median total profit margin for all U.S. nursing homes rose to 3.73 percent in 1995, from 3.21 percent in 1994 and 2.78 percent in 1993. Among other things, improved profitability is likely the result of improved efficiency and greater expansion into higher-profit alternative service offerings, and a decline in the proportion of patient days accounted for by Medicaid beneficiaries. Investor-owned and system-affiliated facilities continued to be the most profitable types of facilities, earning net margins of 4.01 and 5.30 percent, respectively, in 1995. The higher profits of investor-owned and system-affiliated facilities is likely attributable to their greater ability to contain costs. Among the different size bed categories, moderately sized nursing homes with between 100 and 199 beds remained the most profitable in 1995, earning net margins of 4.37 percent. The smallest nursing facilities with fewer than 50 beds, in comparison, earned net margins of only 2.04 percent in 1995.

	Median Values		
	1995	1994	1993
All Nursing Homes	3.73	3.21	2.78
Investor-Owned	4.01	3.37	2.93
Government	1.08	0.95	0.37
Not-for-Profit	3.40	2.10	1.45
System-Affiliated	5.30	4.74	3.87
Freestanding	3.15	2.73	2.34
0–49 Beds	2.04	1.39	1.55
50–99 Beds	3.54	3.28	2.74
100–199 Beds	4.37	4.08	3.42
200+ Beds	3.71	2.78	1.72

	Median Values		
	1995	1994	1993
Alabama	7.24	8.07	4.01
Alaska	3.04	10.23	1.77
Arizona	(1.98)	2.70	1.96
Arkansas	6.68	5.56	5.50
California	1.54	2.97	2.68
Colorado	5.94	3.18	8.05
Connecticut	0.92	0.07	1.03
Delaware	2.25	(0.28)	1.38
District of Columbia ...	0.69	2.70	1.08
Florida	7.44	2.62	6.61
Georgia	1.87	2.97	2.48
Hawaii	3.67	3.44	2.63
Idaho	8.18	11.62	1.43
Illinois	3.34	5.71	0.27
Indiana	1.87	3.75	3.02
Iowa	3.86	3.12	3.70
Kansas	8.40	1.63	0.95
Kentucky	5.00	5.20	4.54
Louisiana	7.04	7.18	8.35
Maine	1.80	1.80	2.21
Maryland	3.86	4.89	3.45
Massachusetts	n/a	1.84	2.35
Michigan	2.73	2.12	1.14
Minnesota	10.56	3.85	2.55
Mississippi	4.05	6.11	3.93
Missouri	4.04	1.16	1.52
Montana	2.22	3.14	2.92
Nebraska	1.91	5.50	4.85
Nevada	3.32	2.84	6.12
New Hampshire	4.46	4.00	(0.34)
New Jersey	3.38	1.93	3.22
New Mexico	6.18	6.31	6.17
New York	3.67	4.03	2.89
North Carolina	5.08	2.87	3.12
North Dakota	3.14	2.14	1.88
Ohio	8.77	0.37	3.56
Oklahoma	n/a	n/a	n/a
Oregon	0.44	1.61	1.57
Pennsylvania	6.31	4.30	3.31
Rhode Island	(1.44)	(1.42)	(0.87)
South Carolina	0.16	0.70	0.96
South Dakota	4.08	6.21	4.23
Tennessee	1.54	5.41	3.09
Texas	n/a	n/a	n/a
Utah	7.41	6.98	7.70
Vermont	2.62	4.35	2.74
Virginia	6.22	3.55	2.93
Washington	1.64	2.28	2.24
West Virginia	0.72	3.87	4.08
Wisconsin	1.61	1.35	0.57
Wyoming	4.47	0.06	(0.30)

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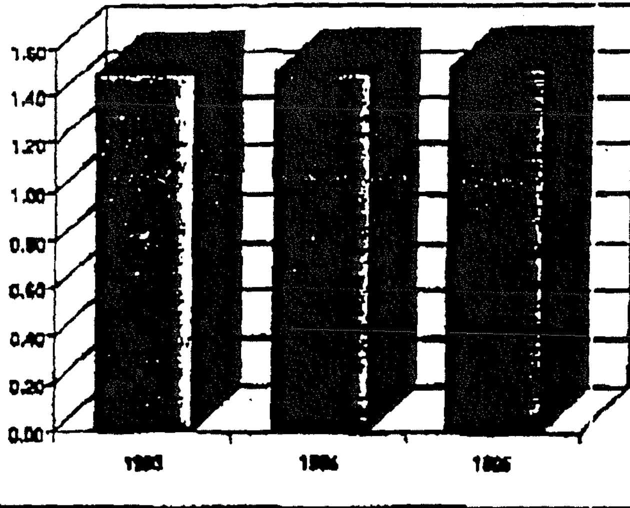
CURRENT RATIO

Calculated as total current assets, including the balance of the depreciation fund, divided by total current liabilities. Current ratio is an indicator of a nursing home's liquidity and ability to meet short-term obligations. Favorable values are above the median.



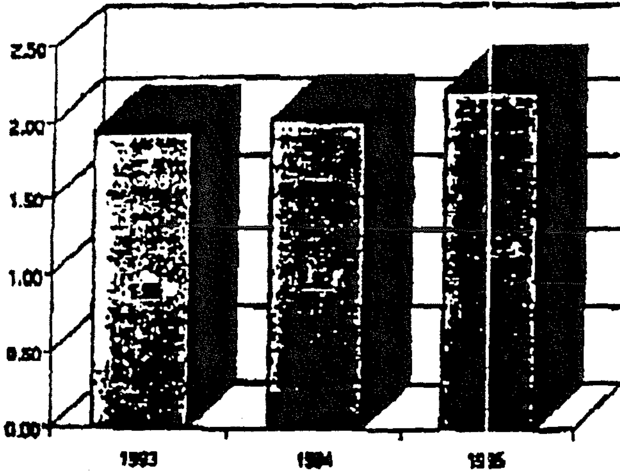
Another measure of liquidity, the current ratio (a ratio of total assets to total liabilities), increased slightly for the nursing home industry overall in 1995. However, this median value of only 1.51 remains somewhat unfavorable. Investor-owned nursing facilities continued to demonstrate a lower median current ratio, 1.44 in 1995, than either not-for-profit facilities, with a median of 1.75, or governmental facilities, with a median of 2.24. This happens most likely because investor-owned nursing facilities typically transfer cash to their parent corporations in order to obtain more favorable investment returns. System-affiliated nursing homes continued to display more favorable current ratios, with a 1995 median of 1.59, than their freestanding peers, with a 1995 median of 1.48.

	Median Values		
	1995	1994	1993
All Nursing Homes	1.51	1.49	1.45
Investor-Owned	1.44	1.44	1.42
Government	2.24	2.43	2.36
Not-for-Profit	1.75	1.84	1.88
System-Affiliated	1.59	1.52	1.54
Freestanding	1.48	1.47	1.47
0–49 Beds	1.54	1.44	1.42
50–99 Beds	1.61	1.57	1.55
100–199 Beds	1.53	1.51	1.51
200+ Beds	1.42	1.52	1.45

	Median Values		
	1995	1994	1993
Alabama	2.13	1.83	1.58
Alaska	2.39	1.65	1.42
Arizona	1.23	1.19	1.41
Arkansas	2.77	2.45	2.54
California	1.52	1.48	1.38
Colorado	0.97	1.45	1.22
Connecticut	1.27	1.37	1.25
Delaware	1.14	1.29	0.97
District of Columbia	0.89	2.54	1.19
Florida	1.36	1.50	1.39
Georgia	1.08	1.30	1.40
Hawaii	2.61	1.85	1.41
Idaho	1.36	1.30	1.73
Illinois	2.04	2.32	2.40
Indiana	1.64	1.57	1.48
Iowa	1.64	1.57	1.75
Kansas	1.31	1.21	1.32
Kentucky	1.64	1.34	1.31
Louisiana	2.08	2.08	2.15
Maine .... 41..	1.12	1.11	1.28
Maryland	1.61	1.34	1.38
Massachusetts	1.11	1.19	1.11
Michigan	1.70	1.52	1.44
Minnesota	1.78	1.43	1.08
Mississippi	2.43	2.41	2.52
Missouri	1.38	1.35	1.38
Montana	1.38	1.32	1.55
Nebraska	1.89	1.85	1.79
Nevada	1.69	1.55	1.38
New Hampshire ... 23	1.59	1.54	0.77
New Jersey	1.03	1.27	1.04
New Mexico	1.88	1.20	1.39
New York	1.34	1.35	1.42
North Carolina	1.17	1.21	1.25
North Dakota	1.68	4.43	1.43
Ohio	1.32	1.28	1.32
Oklahoma	n/a	n/a	n/a
Oregon	1.42	1.36	1.51
Pennsylvania	2.03	1.90	1.87
Rhode Island	1.14	1.14	1.23
South Carolina	1.23	1.23	1.00
South Dakota	1.02	2.63	1.62
Tennessee	1.72	1.61	1.46
Texas	1.47	n/a	1.84
Utah	n/a	n/a	n/a
Vermont .... 14.	1.60	1.57	1.21
Virginia	1.93	1.88	1.94
Washington	n/a	n/a	n/a
West Virginia	2.18	2.28	1.71
Wisconsin	1.63	1.46	1.40
Wyoming	0.83	0.70	1.21

DEBT SERVICE COVERAGE RATIO

Calculated as the sum of net income, depreciation, and interest expense divided by annual debt service. Debt service coverage ratio measures the ratio of available funds for the payment of debt service to a specific year's principal and interest payment. It is one measure of a nursing home's ability to repay debt or creditworthiness. Favorable values are above the median.



As evidenced by a median debt service coverage ratio of 2.22 times, the nursing home industry's ability to service its debt continued to improve in 1995, a reflection of improved profitability. Government-owned facilities, with a median debt service coverage ratio of 2.89 times, maintained the best ability to service their debt among all ownership types in 1995. The median debt service coverage ratio for not-for-profit facilities, in comparison, was 2.68 times, and the median for investor-owned facilities was only 2.13 times. The sizable debt burden carried by investor-owned facilities is the primary reason for their weak debt service coverage. Among the different bed size categories, ability to service debt increased with the size of the facility. The smallest facilities demonstrated a median debt service coverage ratio of 1.78 times in 1995, compared with a median of 2.69 times for the largest facilities.

	Median Values		
	1995	1994	1993
All Nursing Homes	2.22	2.12	1.96
Investor-Owned	2.13	1.96	1.92
Government	2.89	2.35	2.89
Not-for-Profit	2.68	2.30	2.16
System-Affiliated	2.65	2.11	2.13
Freestanding	2.09	1.19	1.80
0–49 Beds	1.78	1.88	1.74
50–99 Beds	2.11	2.16	1.91
100–199 Beds	2.35	2.13	2.08
200– Beds	2.69	2.12	1.99

	Median Values		
	1995	1994	1993
Alabama	3.91	3.44	2.85
Alaska	5.29	3.31	0.59
Arizona	0.98	1.49	1.44
Arkansas	5.77	5.52	7.17
California	1.25	1.45	1.30
Colorado	1.72	1.82	3.50
Connecticut	1.82	1.78	2.35
Delaware	1.42	1.27	1.78
District of Columbia	1.64	1.98	1.31
Florida	4.29	1.83	2.39
Georgia	1.52	1.85	1.77
Hawaii	2.83	3.23	1.92
Idaho	4.06	7.82	1.43
Illinois	2.94	4.05	1.95
Indiana	1.22	1.42	1.48
Iowa	3.22	3.15	3.21
Kansas	4.82	2.31	2.12
Kentucky	2.51	3.03	3.04
Louisiana	2.23	2.13	2.31
Maine	1.06	1.22	1.35
Maryland	2.14	2.20	1.94
Massachusetts	(0.96)	2.01	1.99
Michigan	2.28	2.48	1.99
Minnesota	n/a	n/a	n/a
Mississippi	8.11	3.81	1.98
Missouri	5.98	3.11	1.19
Montana	2.47	2.66	2.72
Nebraska	3.38	4.01	3.57
Nevada	2.51	2.57	1.34
New Hampshire	2.25	2.18	1.59
New Jersey	1.91	1.52	1.65
New Mexico	2.66	1.71	2.81
New York	2.54	2.39	2.46
North Carolina	2.93	1.85	2.15
North Dakota	4.14	3.03	2.82
Ohio	3.03	1.22	2.18
Oklahoma	n/a	n/a	n/a
Oregon	1.53	1.67	2.55
Pennsylvania	4.84	2.96	2.76
Rhode Island	1.14	1.23	1.00
South Carolina	1.59	1.63	1.53
South Dakota	2.70	7.73	4.40
Tennessee	1.87	3.23	2.86
Texas	2.56	3.23	2.82
Utah	2.78	2.53	2.39
Vermont	2.39	4.08	2.00
Virginia	2.11	1.97	1.66
Washington	1.82	2.17	1.82
West Virginia	1.61	2.01	2.00
Wisconsin	n/a	n/a	n/a
Wyoming	2.05	1.94	1.56

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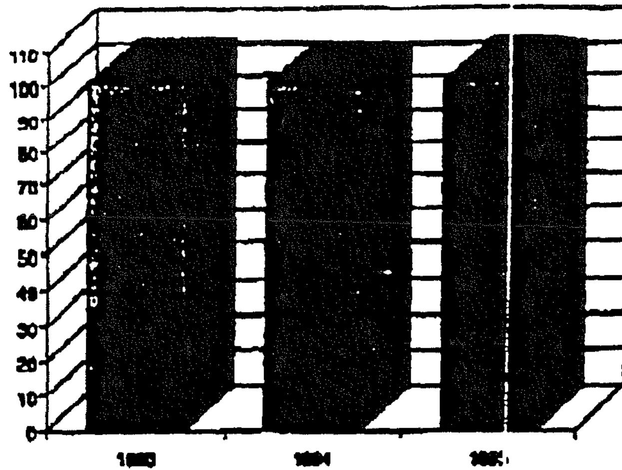
BEDS

The total number of beds in service in a nursing home at the end of its fiscal year. Beds is a measure of the capacity or size of a nursing home.



As the median bed size for all U.S. nursing homes indicates, the nursing home industry overall experienced little variation in size during the three-year period from 1993 through 1995. Several factors, including restrictive CON laws and Medicaid reimbursement, continue to limit growth. The typical nursing facility had 101 beds in service in 1995 and 1993, and 100 in 1994. Median bed size does continue to vary greatly among different types of facilities, however. The typical government nursing facility, with only 89 beds in service in 1995, remained significantly smaller than its typical investor-owned or not-for-profit peers, which had 100 and 108 beds in service, respectively, in 1995. Similarly, the typical freestanding nursing home, with 100 beds in service in 1995, remained significantly smaller than its system-affiliated counterpart, which had 108 beds in service.

	Median Values		
	1995	1994	1993
All Nursing Homes	101	100	101
Investor-Owned	100	100	100
Government	89	78	98
Not-for-Profit	108	108	106
System-Affiliated	108	108	109
Freestanding	100	100	100
0–49 Beds	39	39	40
50–99 Beds	72	72	73
100–199 Beds	122	122	122
200+ Beds	240	240	240

	Median Values		
	1995	1994	1993
Alabama	109	104	104
Alaska	56	n/a	63
Arizona	120	120	120
Arkansas	102	100	100
California	98	98	96
Colorado	104	96	110
Connecticut	120	120	120
Delaware	122	120	124
District of Columbia	140	174	n/a
Florida	120	120	120
Georgia	100	100	100
Hawaii	147	119	75
Idaho	73	89	88
Illinois	111	108	110
Indiana	119	119	123
Iowa	72	73	71
Kansas	60	80	80
Kentucky	100	101	106
Louisiana	120	120	120
Maine	70	70	68
Maryland	134	136	130
Massachusetts	101	101	101
Michigan	120	113	113
Minnesota	90	87	87
Mississippi	104	90	103
Missouri	100	100	100
Montana	79	83	72
Nebraska	67	68	67
Nevada	119	119	119
New Hampshire	108	108	107
New Jersey	178	174	180
New Mexico	90	101	98
New York	160	169	160
North Carolina	120	120	120
North Dakota	80	74	80
Ohio	100	100	104
Oklahoma	80	79	78
Oregon	92	87	92
Pennsylvania	133	123	130
Rhode Island	98	78	82
South Carolina	94	95	95
South Dakota	60	64	68
Tennessee	120	115	115
Texas	105	102	103
Utah	81	81	80
Vermont	90	90	96
Virginia	120	120	120
Washington	96	98	100
West Virginia	69	74	59
Wisconsin	99	102	103
Wyoming	90	90	90

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PERCENT MEDICAID RESIDENT DAYS

Calculated as the total number of Medicaid resident days in a nursing home divided by all resident days in the nursing home, expressed as a percentage. As a measure of payor mix, this element represents the nursing home's share of Medicaid days. As such, it is an approximation of the nursing home's share of Medicaid revenue.

For nearly every major comparison group, the proportion of patient days accounted for by Medicaid beneficiaries increased slightly in 1995. This growth bears out the expectation that Medicaid will continue to finance a greater portion of nursing home care in the coming years. For all nursing homes nationwide, Medicaid days accounted for 71.90 percent of all patient days in 1995, up from 71.51 percent in 1994. The smallest and largest facilities have continued to be the most dependent on Medicaid, with Medicaid days for the typical nursing home with fewer than 50 beds and more than 200 beds accounting for 75.38 and 76.07 percent of all patient days, respectively, in 1995. Comparatively, Medicaid days accounted for only 71.36 and 71.94 percent, respectively, in nursing homes with 50 to 99 beds and 100 to 199 beds. Among ownership types, not-for-profit facilities maintained a significantly smaller share of Medicaid days, 58.04 percent in 1995, than either investor-owned facilities (73.32 percent) or government facilities (71.14 percent).

	Median Values		
	1995	1994	1993
All Nursing Homes	71.90	71.51	72.00
Investor-Owned	73.32	72.81	73.42
Government	71.14	70.28	71.24
Not-for-Profit	58.04	56.57	55.07
System-Affiliated	70.25	69.32	70.45
Freestanding	72.54	72.21	72.98
0–49 Beds	75.38	78.01	74.72
50–99 Beds	71.36	71.93	71.73
100–199 Beds	71.94	71.54	72.22
200+ Beds	76.07	72.93	75.81

	Median Values		
	1995	1994	1993
Alabama	78.05	79.23	77.72
Alaska	87.72	85.03	87.51
Arizona	71.37	67.88	65.91
Arkansas	79.52	80.00	81.70
California	72.82	72.45	72.67
Colorado	69.36	69.67	68.56
Connecticut	72.79	73.10	70.85
Delaware	57.09	58.99	33.05
District of Columbia	64.52	78.53	n/a
Florida	68.26	70.09	70.80
Georgia	85.12	85.57	84.95
Hawaii	84.01	81.37	83.18
Idaho	66.86	65.90	67.47
Illinois	65.62	62.97	65.00
Indiana	66.19	66.77	64.50
Iowa	18.41	24.81	n/a
Kansas	54.69	55.00	54.18
Kentucky	71.94	72.57	74.21
Louisiana	89.64	88.82	88.20
Maine	78.81	80.81	80.30
Maryland	71.70	70.75	69.64
Massachusetts	74.30	74.59	75.36
Michigan	71.43	68.83	69.89
Minnesota	66.33	67.04	65.06
Mississippi	85.89	87.04	88.31
Missouri	67.42	67.55	69.55
Montana	62.72	63.50	65.01
Nebraska	52.00	51.34	52.18
Nevada	66.89	63.76	67.79
New Hampshire	45.02	46.51	45.29
New Jersey	65.54	n/a	59.24
New Mexico	78.27	74.52	76.44
New York	74.26	44.38	82.31
North Carolina	70.22	73.24	74.30
North Dakota	98.77	96.78	98.89
Ohio	74.22	74.80	67.84
Oklahoma	70.39	71.82	71.80
Oregon	64.23	65.15	65.24
Pennsylvania	58.38	56.62	59.69
Rhode Island	79.25	79.39	77.89
South Carolina	77.47	79.95	79.54
South Dakota	58.60	59.82	56.80
Tennessee	81.37	83.09	83.25
Texas	76.51	75.94	74.76
Utah	68.71	67.82	60.40
Vermont	68.93	70.83	72.33
Virginia	71.74	69.56	64.03
Washington	69.70	70.60	71.47
West Virginia	81.25	80.02	80.91
Wisconsin	68.67	69.12	68.83
Wyoming	55.25	56.49	54.04

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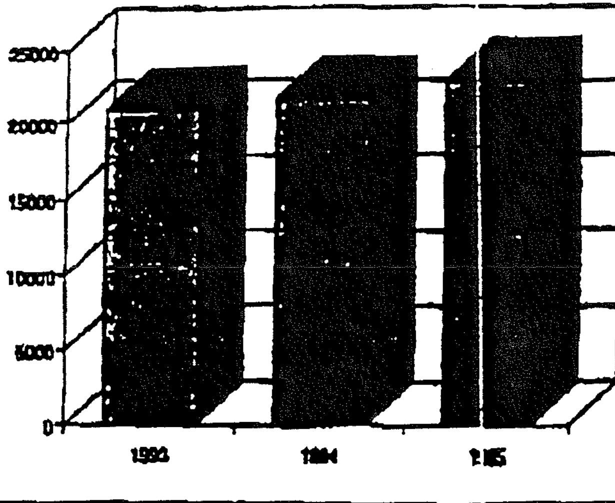
Average Compensation Per FTE

Calculated as the sum of total salaries and employee benefits expense divided by the number of full-time equivalent personnel in a nursing home. Salary and benefits expense per full-time equivalent personnel measures the average direct labor expense per employee in a nursing home. Favorable values are below the median.



The average total compensation (salary and benefits) per FTE, which increased more than 5 percent nationally between 1994 and 1995, remains highest among the largest facilities, in part because of the more severe mix of patients typically treated at those facilities. The typical nursing facility with more than 200 beds paid a median compensation per FTE of $26,497 in 1995, as compared with a median value of only $22,506 for the typical nursing home with fewer than 50 beds. Among the different ownership categories, investor-owned facilities, with a median compensation per FTE of $22,593 in 1995, continued to pay the least. In comparison, the median compensation per FTE paid by the typical not-for-profit facility was $23,922 in 1995, and the median compensation paid by the typical government facility was $23,193.

	Median Values		
	1995	1994	1993
All Nursing Homes	22,894	21,675	20,976
Investor-Owned	22,593	21,405	20,878
Government	23,193	22,021	21,424
Not-for-Profit	23,922	22,781	21,597
System-Affiliated	23,010	21,881	21,146
Freestanding	22,867	21,721	20,805
0–49 Beds	22,506	21,316	20,633
50–99 Beds	22,165	21,022	20,256
100–199 Beds	23,080	22,055	21,257
200+ Beds	26,487	24,908	23,898

	Median Values		
	1995	1994	1993
Alabama	21,909	20,953	19,984
Alaska	36,062	34,561	31,229
Arizona	24,376	23,898	23,282
Arkansas	22,479	22,039	21,248
California	19,003	18,954	19,459
Colorado	21,744	19,191	18,131
Connecticut	33,613	32,569	31,805
Delaware	25,004	23,521	22,030
District of Columbia	32,816	34,485	31,921
Florida	22,952	23,184	22,308
Georgia	18,781	19,058	18,168
Hawaii	29,774	31,017	29,190
Idaho	22,516	21,177	20,430
Illinois	22,344	21,203	19,861
Indiana	22,158	22,188	21,066
Iowa	24,029	23,449	23,456
Kansas	22,057	20,021	19,290
Kentucky	24,766	22,382	21,444
Louisiana 5th	9,048	11,543	11,807
Maine	28,964	27,986	27,977
Maryland	25,543	24,436	24,137
Massachusetts	28,658	29,584	29,240
Michigan	20,478	19,519	18,591
Minnesota	23,460	23,783	23,128
Mississippi	18,381	18,115	17,216
Missouri	17,013	16,677	16,117
Montana	21,077	20,647	19,189
Nebraska	22,353	21,582	20,633
Nevada 9th	24,747	25,151	25,101
New Hampshire	29,063	27,053	26,191
New Jersey	29,116	28,301	26,798
New Mexico	20,565	21,131	20,171
New York	30,251	34,800	27,981
North Carolina	22,380	21,150	20,151
North Dakota	20,358	20,087	19,152
Ohio	23,230	22,177	21,737
Oklahoma	19,726	20,025	19,159
Oregon	22,923	22,424	22,654
Pennsylvania	25,636	25,092	23,997
Rhode Island	26,819	25,835	25,573
South Carolina	18,467	17,388	16,889
South Dakota	23,280	22,835	22,457
Tennessee	17,642	16,657	15,965
Texas	n/a	n/a	n/a
Utah 35th	19,416	18,800	18,241
Vermont	21,538	20,718	19,989
Virginia	19,680	18,760	18,438
Washington	24,554	23,273	23,105
West Virginia	21,046	19,240	18,933
Wisconsin	25,432	24,040	22,892
Wyoming	22,475	23,028	22,128

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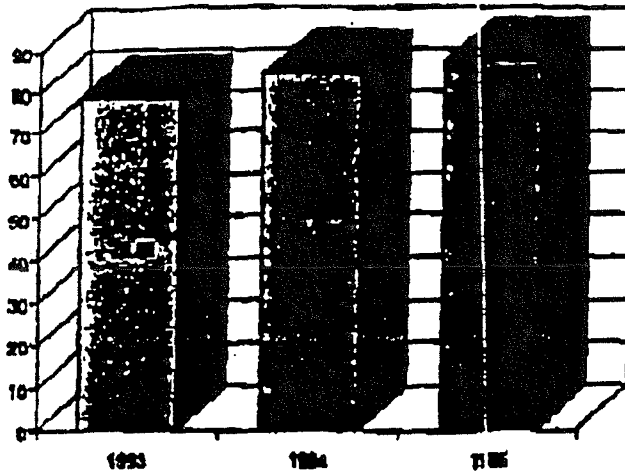
Operating Expense Per Resident Day

OPERATING EXPENSE PER RESIDENT DAY

Calculated as the total operating expenses of a nursing home divided by the number of resident days in the nursing home. Total operating expenses include salaries, supplies, depreciation, and interest expenses. Total operating expenses do not include "below the line" extraordinary items or charges against income. Operating expense per resident day is the best measure of the average cost per unit (per day) in a nursing home. Favorable values are below the median.



The median total operating expense per resident day for all U.S. nursing homes increased 3.38 percent in 1995 to $87.51. Much of the increase can be attributed to additional costs associated with treating patients of higher acuity levels. Relative to earlier years, however, the rate of increase appears to be slowing, down from an increase of 7.5 percent between 1993 and 1994 and nearly 8.2 percent between 1992 and 1993. This slower growth could be the result of improved efficiencies and provider expansion into a number of less costly service offerings, such as home care, community-based care, and assisted living. Like revenues, operating expense per resident day also varies with the size of the facility. The typical nursing facility with fewer than 50 beds had a median total operating expense per resident day of $83.70 in 1995, as compared with $104.40 for the typical nursing facility with more than 200 beds. Among the different ownership categories, not-for-profit nursing homes had a slightly higher median operating expense per resident day, $92.21 in 1995, than government facilities, with a median of $91.63, and a significantly higher median than investor-owned facilities, with a median of $86.22.

	Median Values		
	1995	1994	1993
All Nursing Homes	87.51	84.64	78.74
Investor-Owned	86.22	83.40	77.71
Government	91.63	85.11	78.34
Not-for-Profit	92.21	88.31	82.35
System-Affiliated	93.06	89.62	82.17
Freestanding	85.81	82.64	77.32
0–49 Beds	83.70	80.80	74.97
50–99 Beds	78.61	77.30	71.05
100–199 Beds	91.59	87.65	81.07
200+ Beds	104.40	100.75	95.48

	Median Values		
	1995	1994	1993
Alabama	86.85	78.64	73.76
Alaska	221.52	195.78	212.78
Arizona	110.33	106.21	98.75
Arkansas	61.07	57.69	52.86
California	101.61	98.65	88.07
Colorado	101.49	91.50	80.41
Connecticut	138.40	130.48	128.41
Delaware	107.43	100.40	101.34
District of Columbia	186.42	207.20	173.40
Florida	111.54	103.67	92.36
Georgia	74.53	70.93	64.70
Hawaii	143.16	134.92	118.75
Idaho	97.02	89.89	88.32
Illinois	77.65	72.33	74.58
Indiana	96.20	96.30	90.28
Iowa	63.61	58.69	56.42
Kansas	68.82	64.17	58.00
Kentucky	78.71	72.94	68.36
Louisiana	60.97	57.32	57.70
Maine	115.16	103.89	95.27
Maryland	102.04	94.56	88.89
Massachusetts	125.39	118.44	113.29
Michigan	96.94	87.10	79.62
Minnesota	84.90	82.94	84.78
Mississippi	73.72	67.67	59.96
Missouri	81.09	71.77	68.09
Montana	87.82	81.98	77.76
Nebraska	69.13	65.29	60.97
Nevada	104.56	94.47	87.99
New Hampshire	120.61	120.02	110.13
New Jersey	119.06	121.28	114.03
New Mexico	83.97	78.57	80.21
New York	137.48	144.86	131.78
North Carolina	90.80	81.61	78.45
North Dakota	78.77	72.18	67.04
Ohio	89.07	95.42	92.74
Oklahoma	53.04	50.00	48.64
Oregon	96.08	88.03	85.21
Pennsylvania	112.11	108.82	100.45
Rhode Island	110.01	102.81	100.38
South Carolina	84.35	78.51	72.68
South Dakota	76.85	67.36	63.50
Tennessee	86.49	74.41	70.11
Texas	62.65	58.48	54.72
Utah	75.49	74.58	79.21
Vermont	104.54	92.20	93.16
Virginia	81.78	70.01	76.70
Washington	121.86	111.71	101.91
West Virginia	92.07	86.01	79.18
Wisconsin	101.30	94.46	87.57
Wyoming	99.20	96.23	81.33

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Comparison of Reim... ...ble to Actual Costs

Facility	Fiscal Year Begin	Fiscal Year End	Total Reimb. Rate	Total Actual	Total Savings	Total State Days	Total Dollar Value of Savings
Amenity Manor	01/01/96	12/31/96	$95.05	$96.42	($1.37)	16,605	($22,749)
Aroostook Medical Center The - Health Center	01/01/96	12/31/96	$97.71	$109.67	($11.96)	15,695	($187,712)
Aroostook Medical Center The - Community General	01/01/96	12/31/96	$138.80	$164.02	($25.22)	4,673	($117,853)
Augusta Convalescent Center	01/01/96	12/31/96	$102.72	$111.99	($9.27)	17,815	($165,145)
Bangor City Nursing Facility	07/01/95	06/30/96	$119.36	$135.64	($16.28)	17,316	($281,904)
Bangor Convalescent Center	01/01/96	12/31/96	$108.46	$117.89	($9.43)	17,097	($161,225)
Barnard Nursing Home - Atlantic Rehab.	01/01/96	12/31/96	$81.94	$85.17	($3.23)	24,365	($78,699)
Barron Center	07/01/95	06/30/96	$110.69	$129.04	($18.35)	62,748	($1,151,426)
Bolster Heights Health Care	07/01/95	06/30/96	$95.06	$108.77	($13.71)	20,958	($287,334)
Borderview Manor	01/01/96	12/31/96	$115.25	$109.03	$6.22	21,989	$136,772
Brentwood Manor	01/01/96	12/31/96	$123.96	$158.64	($34.68)	13,340	($462,631)
Brewer Rehab & Living Center	01/01/96	12/31/96	$125.08	$136.92	($11.84)	22,815	($270,130)
Bridgton Hlth. Care Center	01/01/96	12/31/96	$107.82	$116.28	($8.46)	16,104	($136,240)
Camden Health Care Center	04/01/95	03/31/96	$103.61	$120.19	($16.58)	49,479	($820,362)
Caribou Nursing Home	10/01/95	09/30/96	$106.24	$103.16	$3.08	31,445	$96,851
Cedar Ridge Nursing Care Center	10/01/95	09/30/96	$128.54	$132.90	($4.36)	20,921	($91,216)
Cedars Nursing Care Center	05/01/95	04/30/96	$131.17	$144.69	($13.52)	24,645	($333,200)
Charles A. Dean Memorial Hospital	04/01/95	03/31/96	$104.54	$161.75	($57.21)	10,070	($576,105)
Clover Manor, Inc.	09/01/95	08/31/96	$109.10	$110.24	($1.14)	29,101	($33,175)
Collier's Health Care Center	01/01/96	12/31/96	$102.65	$105.91	($3.26)	10,706	($34,902)
Colonial Acres Nursing Home	01/01/96	12/31/96	$82.99	$85.55	($2.56)	18,975	($48,576)
Country Manor Nursing Home	01/01/96	12/31/96	$101.35	$94.90	$6.45	10,021	$64,635
Courtland Living Center	01/01/96	12/31/96	$107.63	$108.40	($0.77)	21,223	($16,342)
Cove's Edge	05/01/95	04/30/96	$145.93	$163.09	($17.16)	12,925	($221,793)
Dexter Nursing Home	01/01/96	12/31/96	$88.50	$97.80	($9.30)	15,839	($147,303)
Dionne Commons	01/01/96	12/31/96	$89.40	$92.06	($2.66)	21,747	($57,847)
Dixfield Health Care Center	01/01/96	12/31/96	$98.36	$114.94	($16.58)	9,889	($163,960)
Eastport Memorial Nursing Home	01/01/96	12/31/96	$97.02	$97.80	($0.78)	8,205	($6,400)
Edgewood Manor	01/01/96	12/31/96	$103.46	$110.33	($6.87)	14,461	($99,347)
Evergreen Manor	01/01/96	12/31/96	$97.77	$109.71	($11.94)	9,087	($108,499)
Falmouth By The Sea	01/01/96	12/31/96	$107.23	$127.04	($19.81)	11,247	($222,803)
Fieldcrest manor Nursing Home	01/01/96	12/31/96	$102.50	$111.28	($8.78)	15,666	($137,547)
Forest Hill Manor	10/01/95	09/30/96	$103.11	$102.63	$0.48	15,656	$7,515
Freeport Nursing Home	01/01/96	12/31/96	$110.34	$112.09	($1.75)	15,330	($26,827)
Gardiner Nursing Home	01/01/96	12/31/96	$87.96	$85.45	$2.51	17,794	$44,663
Gorham House	10/1/95	9/30/96	$140.76	$145.89	($5.13)	9,847	($50,515)
Gorham Manor	10/1/95	9/30/96	$129.16	$159.32	($30.16)	5,798	($174,868)
Greenwood Center	07/01/95	06/30/96	$120.50	$125.78	($5.28)	26,027	($137,423)
Harbor Home	01/01/96	12/31/96	$107.56	$111.00	($3.44)	13,882	($47,754)

from Mike McNeil

Comparison of Rein. [illegible]ble to Actual Costs

Facility	Fiscal Year Begin	Fiscal Year End	Total Reimb. Rate	Total Actual	Total Savings	Total State Days	Total Dollar Value of Savings
Hawthorne House	01/01/96	12/31/96	$93.41	$99.25	($5.84)	20,121	($117,507)
Heritage Manor	01/01/96	12/31/96	$95.79	$109.51	($13.72)	13,062	($179,211)
Hibbard Nursing Home	10/01/95	09/30/96	$88.74	$94.09	($5.35)	23,237	($124,318)
High View Manor	01/01/96	12/31/96	$87.54	$86.84	$0.70	22,783	$15,948
Hillcrest Manor Division	06/01/95	05/31/96	$97.53	$114.04	($16.51)	23,055	($380,638)
Homestead, Inc.	10/01/95	09/30/96	$104.72	$110.94	($6.22)	13,385	($83,255)
Houlton Regional Hospital	10/01/95	09/30/96	$187.71	$253.92	($66.21)	3,687	($244,116)
Island Nursing Home	07/01/95	06/30/96	$108.43	$130.10	($21.67)	11,757	($254,774)
Jackman Region Health Center	04/01/95	03/31/96	$105.37	$153.96	($48.59)	5,178	($251,599)
Katahdin Nursing Home	07/01/95	06/30/96	$99.75	$98.81	$0.94	16,120	$15,153
Ken. Long Term Care G.Birch	07/01/95	06/30/96	$99.59	$106.91	($7.32)	28,747	($210,428)
Kennebec Long Term Care	07/01/95	06/30/96	$94.61	$101.03	($6.42)	29,580	($189,904)
Kennebunk Nursing Home	01/01/96	12/31/96	$121.55	$133.13	($11.58)	9,014	($104,382)
Knox Center for Long Term Care	04/01/95	03/31/96	$100.92	$123.38	($22.46)	15,809	($355,070)
Ledgeview Nursing Home	07/01/95	06/30/96	$98.21	$98.44	($0.23)	33,491	($7,703)
Ledgewood Manor	01/01/96	12/31/96	$95.48	$102.75	($7.27)	17,060	($124,026)
Madigan Estates	07/01/95	06/30/96	$94.24	$88.53	$5.71	22,855	$130,502
Madigan Estates	07/01/96	12/31/96	$90.39	$90.23	$0.16	11,936	$1,910
Maine Stay Nursing Home	01/01/96	12/31/96	$110.23	$132.78	($22.55)	8,158	($183,963)
Maine Vet. Home - Bangor	10/03/95	06/30/96	$130.86	$170.66	($39.80)	4,803	($191,159)
Maine Vet. Home - So. Paris	07/26/95	06/30/96	$140.61	$217.97	($77.36)	5,351	($413,953)
Maine Veterans Home - Augusta	07/01/95	06/30/96	$108.55	$121.35	($12.80)	25,160	($322,048)
Maine Veterans Home-Caribou	07/01/95	06/30/96	$113.68	$128.40	($14.72)	12,388	($182,351)
Maine Veterans Home-Scar.	07/01/95	06/30/96	$115.52	$128.21	($12.69)	29,739	($377,388)
Maplecrest Living Center	01/01/96	12/31/96	$104.18	$107.61	($3.43)	13,753	($47,173)
Market Square Health Center	01/01/96	12/31/96	$111.70	$111.59	$0.11	29,597	$3,256
Marshall's Health Care Facility	10/01/95	09/30/96	$86.33	$88.41	($2.08)	18,930	($39,374)
Mercy Home	07/01/95	06/30/96	$103.76	$118.99	($15.23)	17,384	($264,758)
Mere Point Nursing Home	10/01/95	09/30/96	$107.54	$114.91	($7.37)	5,993	($44,168)
Merrill Memorial Manor	01/01/96	12/31/96	$107.31	$105.90	$1.41	12,641	$17,824
Montello Manor	01/01/96	12/31/96	$114.05	$112.81	$1.24	26,818	$33,254
Mountain Heights Health Care Facility	01/01/96	12/31/96	$102.30	$114.12	($11.82)	5,651	($66,795)
Narraguagus Bay Health Care Facility	01/01/96	12/31/96	$115.91	$126.96	($11.05)	17,598	($194,458)
Nicholson's Nursing Home	07/01/95	06/30/96	$82.60	$88.32	($5.72)	10,635	($60,832)
Norway Convalescent Center	01/01/96	12/31/96	$100.32	$120.53	($20.21)	11,430	($231,000)
Oceanview Nursing Home	01/01/96	12/31/96	$105.59	$106.24	($0.65)	12,730	($8,275)
Odd Fellow's Home of Maine	07/01/95	06/30/96	$113.79	$119.47	($5.68)	8,013	($45,514)
Orchard Park Living Center	01/01/96	12/31/96	$110.49	$118.32	($7.83)	10,239	($80,171)
[illegible] Nursing Home, Inc	01/01/96	12/31/96	$99.71	$103.05	($3.34)	23,101	($77,157)

Comparison of Reimbu[illegible] to Actual Costs

Facility	Fiscal Year Begin	Fiscal Year End	Total Reimb. Rate	Actual	Savings	State Days	Dollar Value of Savings
Penobscot Nursing Home	01/01/96	12/31/96	$95.29	$95.54	($0.25)	17,797	($4,449)
Pine Point Nursing Care Center	10/01/95	09/30/96	$121.21	$139.11	($17.90)	15,367	($275,069)
Presque Isle Nursing Home	10/01/95	09/30/96	$103.78	$104.07	($0.29)	26,887	($7,797)
Promenade Health Care Facility	07/01/95	06/17/96	$111.67	$120.58	($8.91)	7,817	($69,649)
Riverwood Health Care Center - Renaissance	01/01/96	12/31/96	$93.84	$99.04	($5.20)	19,063	($99,128)
Robinson's Hlth. Care Facility	01/01/96	12/31/96	$82.62	$83.66	($1.04)	15,271	($15,882)
Ross Manor	01/01/96	12/31/96	$122.20	$157.50	($35.30)	14,062	($496,389)
Rumford Community Home	07/01/95	06/30/96	$103.30	$105.49	($2.19)	24,965	($54,673)
Russell Park Manor	08/01/95	07/31/96	$100.29	$105.96	($5.67)	27,886	($158,114)
Sanfield Living Center	01/01/96	12/31/96	$103.15	$106.52	($3.37)	12,669	($42,695)
Sanford Health Care Facility	01/01/96	12/31/96	$121.32	$143.24	($21.92)	7,747	($169,814)
Seaside Nursing and Ret. Home	01/01/96	12/31/96	$116.31	$143.78	($27.47)	17,860	($490,614)
Sebasticook Valley Health Care facility	01/01/96	12/31/96	$89.82	$90.80	($0.98)	17,883	($17,525)
Schooner Retirement - Seville Park Plaza	01/01/96	12/31/96	$117.23	$124.64	($7.41)	5,390	($39,940)
Shore Village Nursing Center	01/01/96	12/31/96	$99.06	$107.97	($8.91)	9,309	($82,943)
So. Portland Nursing Home	01/01/96	12/31/96	$105.02	$115.28	($10.26)	17,007	($174,492)
Somerset Manor	01/01/96	12/31/96	$104.88	$112.08	($7.20)	8,637	($62,186)
Sonogee Estates	01/01/96	12/31/96	$114.59	$120.84	($6.25)	19,098	($119,363)
Southridge Living Center	01/01/96	12/31/96	$101.50	$104.32	($2.82)	30,489	($85,979)
St. Andre Health Care Facility	12/01/95	11/30/96	$105.42	$110.66	($5.24)	25,093	($131,487)
St. Joseph Nursing Home	01/01/96	12/31/96	$104.38	$103.29	$1.09	13,782	$15,022
St. Joseph's Manor	07/01/95	06/30/96	$114.37	$119.85	($5.48)	50,165	($274,904)
St. Marguerite D'Youville Pav.	01/01/96	12/31/96	$112.19	$129.33	($17.14)	70,207	($1,203,348)
Stillwater Health Care	01/01/96	12/31/96	$101.56	$100.53	$1.03	17,181	$17,696
Summit House Health Care Ctr.	01/01/96	12/31/96	$98.74	$97.29	$1.45	11,808	$17,122
Sunrise Residential Care Facility	01/01/96	12/31/96	$109.74	$107.54	$2.20	9,619	$21,162
Tallpines Health Care Facility	01/01/96	12/31/96	$114.47	$122.72	($8.25)	15,615	($128,824)
Trull Nursing Home	07/01/95	06/30/96	$85.35	$89.42	($4.07)	12,048	($49,035)
Varney Crossing Nursing Care Center	07/01/95	06/30/96	$111.40	$111.96	($0.56)	17,205	($9,635)
Victorian Villa Nursing Home	01/01/96	12/31/96	$98.51	$99.22	($0.71)	16,345	($11,605)
Viking ICF The	11/01/95	10/31/96	$101.37	$108.56	($7.19)	11,017	($79,212)
Westgate Manor	01/01/96	12/31/96	$106.89	$102.20	$4.69	23,169	$108,663
Winship Green Nursing Center	01/01/96	12/31/96	$122.67	$133.53	($10.86)	12,087	($131,265)
Woodlawn Nursing Home	01/01/96	12/31/96	$103.47	$111.78	($8.31)	11,332	($94,169)
Total							($16,169,517.00)

Direct Care Component Savings/Loss

Fiscal Year Begin	End	Upper Limit Pre CMI Not Inflated	Direct Reimb Rate	Actual	Savings	State Days	Dollar Value of Savings
01/01/96	12/31/96	$47.54	$43.63	$43.25	$0.38	16,605	$6,310
01/01/96	12/31/96	$47.54	$51.37	$51.29	$0.08	15,695	$1,256
01/01/96	12/31/96	$47.54	$45.96	$47.43	($1.52)	17,815	($27,079)
07/01/95	06/30/96	$47.54	$55.66	$61.05	($5.39)	17,316	($93,333)
01/01/96	12/31/96	$47.54	$48.98	$48.36	$0.62	17,097	$10,600
01/01/96	12/31/96	$47.54	$37.21	$38.70	($1.49)	24,365	($36,304)
07/01/95	06/30/96	$47.54	$53.05	$65.98	($12.93)	62,748	($811,332)
07/01/95	06/30/96	$47.54	$40.54	$47.80	($7.26)	20,958	($152,155)
01/01/96	12/31/96	$47.54	$58.02	$56.92	$1.10	21,989	$24,188
01/01/96	12/31/96	$47.54	$50.10	$65.66	($15.56)	13,340	($207,570)
01/01/96	12/31/96	$47.54	$55.40	$65.75	($10.35)	22,815	($236,135)
01/01/96	12/31/96	$47.54	$41.81	$44.27	($2.46)	16,104	($39,616)
04/01/95	03/31/96	$47.54	$48.79	$53.79	($5.00)	49,479	($247,395)
10/01/95	09/30/96	$47.54	$46.64	$44.91	$1.73	31,445	$54,400
10/01/95	09/30/96	$47.54	$54.73	$54.61	$0.12	20,921	$2,511
05/01/95	04/30/96	$47.54	$53.84	$54.44	($0.60)	24,645	($14,787)
09/01/95	08/31/96	$47.54	$52.29	$59.37	($7.08)	29,101	($206,035)
01/01/96	12/31/96	$47.54	$51.03	$51.42	($0.39)	10,706	($4,175)
01/01/96	12/31/96	$47.54	$38.17	$38.02	$0.15	18,975	$2,846
01/01/96	12/31/96	$47.54	$36.92	$36.77	$0.15	10,021	$1,503
01/01/96	12/31/96	$47.54	$49.36	$48.27	$1.09	21,223	$23,133
05/01/95	04/30/96	$47.54	$59.44	$68.20	($8.76)	12,925	($113,223)
01/01/96	12/31/96	$47.54	$39.42	$43.30	($3.88)	15,839	($61,455)
01/01/96	12/31/96	$47.54	$40.71	$42.28	($1.57)	21,747	($34,143)
01/01/96	12/31/96	$47.54	$47.24	$52.03	($4.79)	9,889	($47,368)
01/01/96	12/31/96	$47.54	$40.59	$39.82	$0.77	8,205	$6,318
01/01/96	12/31/96	$47.54	$42.12	$45.70	($3.58)	14,461	($51,770)
01/01/96	12/31/96	$47.54	$39.70	$45.13	($5.43)	9,087	($49,342)
01/01/96	12/31/96	$47.54	$46.78	$48.66	($1.88)	11,247	($21,144)
01/01/96	12/31/96	$47.54	$49.63	$49.58	$0.05	15,666	$783
10/01/95	09/30/96	$47.54	$43.66	$42.64	$1.02	15,656	$15,969
01/01/96	12/31/96	$47.54	$49.58	$48.72	$0.86	15,330	$13,184
01/01/96	12/31/96	$47.54	$40.42	$39.62	$0.80	17,794	$14,235
10/01/95	09/30/96	$47.54	$55.76	$57.99	($2.23)	9,847	($21,959)
10/01/95	09/30/96	$47.54	$47.85	$66.42	($18.57)	5,798	($107,669)
07/01/95	06/30/96	$47.54	$50.21	$51.84	($1.63)	26,027	($42,424)
01/01/96	12/31/96	$47.54	$50.27	$48.63	$1.64	13,882	$22,766
01/01/96	12/31/96	$47.54	$43.17	$45.50	($2.33)	20,121	($46,882)
01/01/96	12/31/96	$47.54	$40.09	$43.46	($3.37)	13,062	($44,019)
10/01/95	09/30/96	$47.54	$43.66	$43.84	($0.18)	23,237	($4,183)
01/01/96	12/31/96	$47.54	$38.74	$38.69	$0.05	22,783	$1,139
06/01/95	05/31/96	$50.57	$46.61	$57.20	($10.59)	23,055	($244,152)
10/01/95	09/30/96	$47.54	$46.30	$44.55	$1.75	13,385	$23,424
07/01/95	06/30/96	$47.54	$45.97	$54.68	($8.71)	11,757	($102,403)
04/01/95	03/31/96	$47.54	$50.81	$64.19	($13.38)	5,178	($69,282)
07/01/95	06/30/96	$47.54	$39.81	$39.39	$0.42	16,120	$6,770
07/01/95	06/30/96	$47.54	$46.55	$50.61	($4.06)	28,747	($116,713)
07/01/95	06/30/96	$47.54	$43.25	$47.72	($4.47)	29,580	($132,223)
01/01/96	12/31/96	$47.54	$55.86	$59.36	($3.50)	9,014	($31,549)
04/01/95	03/31/96	$47.54	$38.57	$48.47	($9.90)	15,809	($156,509)
07/01/95	06/30/96	$47.54	$42.67	$40.57	$2.10	33,491	$70,331
01/01/96	12/31/96	$47.54	$43.68	$46.27	($2.59)	17,060	($44,185)
07/01/95	06/30/96	$47.54	$41.68	$39.85	$1.83	22,855	$41,825
07/01/96	12/31/96	$47.54	$42.47	$41.53	$0.94	11,936	$11,220

Direct Care Component Savings/Loss

01/01/96	12/31/96	$47.54	$49.15	$57.95	($8.80)	8,158	($71,790)
10/03/95	06/30/96	$47.54	$50.32	$49.78	$0.54	4,803	$2,594
07/26/95	06/30/96	$47.54	$53.60	$53.43	$0.17	5,351	$910
07/01/95	06/30/96	$47.54	$53.03	$58.11	($5.08)	25,160	($127,813)
07/01/95	06/30/96	$47.54	$50.81	$56.89	($6.08)	12,388	($75,319)
07/01/95	06/30/96	$47.54	$52.91	$57.23	($4.37)	29,739	($129,959)
01/01/96	12/31/96	$47.54	$48.83	$48.20	$0.63	13,753	$8,664
01/01/96	12/31/96	$47.54	$51.04	$50.53	$0.51	29,597	$15,094
10/01/95	09/30/96	$47.54	$37.99	$40.33	($2.33)	18,930	($45,053)
07/01/95	06/30/96	$47.54	$44.43	$49.15	($4.72)	17,384	($82,052)
10/01/95	09/30/96	$47.54	$44.61	$45.30	($0.69)	5,993	($4,135)
01/01/96	12/31/96	$47.54	$46.61	$43.37	$3.24	12,641	$40,957
01/01/96	12/31/96	$47.54	$55.08	$54.40	$0.68	26,818	$18,236
01/01/96	12/31/96	$47.54	$49.47	$49.26	$0.21	5,651	$1,187
01/01/96	12/31/96	$47.54	$48.74	$57.91	($9.17)	17,598	($161,374)
07/01/95	06/30/96	$47.54	$32.07	$33.93	($1.86)	10,635	($19,781)
01/01/96	12/31/96	$47.54	$44.40	$49.96	($5.56)	11,430	($63,551)
01/01/96	12/31/96	$47.54	$47.60	$47.20	$0.40	12,730	$5,092
07/01/95	06/30/96	$47.54	$36.12	$35.93	$0.19	8,013	$1,522
01/01/96	12/31/96	$47.54	$41.54	$43.97	($2.43)	10,239	($24,881)
01/01/96	12/31/96	$47.54	$48.31	$48.12	$0.19	23,101	$4,389
01/01/96	12/31/96	$47.54	$44.30	$43.36	$0.94	17,797	$16,729
10/01/95	09/30/96	$47.54	$52.37	$52.37	$0.00	15,367	$0
10/01/95	09/30/96	$47.54	$45.66	$45.31	$0.35	26,887	$9,410
07/01/95	06/17/96	$47.54	$48.44	$49.70	($1.26)	7,817	($9,849)
01/01/96	12/31/96	$47.54	$43.44	$43.04	$0.40	19,063	$7,625
01/01/96	12/31/96	$47.54	$32.14	$31.90	$0.24	15,271	$3,665
01/01/96	12/31/96	$47.54	$54.89	$63.78	($8.89)	14,062	($125,011)
07/01/95	06/30/96	$47.54	$47.92	$49.05	($1.13)	24,965	($28,210)
08/01/95	07/31/96	$47.54	$46.36	$44.67	$1.69	27,886	$47,127
01/01/96	12/31/96	$47.54	$47.57	$47.75	($0.18)	12,669	($2,280)
01/01/96	12/31/96	$47.54	$54.10	$55.23	($1.13)	7,747	($8,754)
01/01/96	12/31/96	$47.54	$55.22	$64.71	($9.49)	17,860	($169,491)
01/01/96	12/31/96	$47.54	$38.37	$37.74	$0.63	17,883	$11,266
01/01/96	12/31/96	$47.54	$43.65	$43.93	($0.28)	5,390	($1,509)
01/01/96	12/31/96	$47.54	$40.58	$42.11	($1.53)	9,309	($14,243)
01/01/96	12/31/96	$47.54	$51.16	$54.39	($3.23)	17,007	($54,933)
01/01/96	12/31/96	$47.54	$41.30	$40.01	$1.29	8,637	$11,142
01/01/96	12/31/96	$47.54	$55.05	$58.12	($3.07)	19,098	($58,631)
01/01/96	12/31/96	$47.54	$48.06	$47.79	$0.27	30,489	$8,232
12/01/95	11/30/96	$47.54	$45.62	$47.73	($2.11)	25,093	($52,946)
01/01/96	12/31/96	$47.54	$46.14	$45.27	$0.87	13,782	$11,990
07/01/95	06/30/96	$47.54	$50.20	$54.45	($4.25)	50,165	($213,201)
01/01/96	12/31/96	$47.54	$52.09	$62.73	($10.64)	70,207	($747,002)
01/01/96	12/31/96	$47.54	$45.80	$44.85	$0.95	17,181	$16,322
01/01/96	12/31/96	$47.54	$43.95	$42.43	$1.52	11,808	$17,948
01/01/96	12/31/96	$47.54	$44.88	$42.69	$2.19	9,619	$21,066
01/01/96	12/31/96	$47.54	$46.38	$53.66	($7.28)	15,615	($113,677)
07/01/95	06/30/96	$47.54	$36.13	$37.12	($0.99)	12,048	($11,928)
07/01/95	06/30/96	$47.54	$47.53	$47.05	$0.48	17,205	$8,258
01/01/96	12/31/96	$47.54	$38.21	$39.18	($0.97)	16,345	($15,855)
11/01/95	10/31/96	$47.54	$45.88	$46.19	($0.31)	11,017	($3,415)
01/01/96	12/31/96	$47.54	$50.88	$49.53	$1.35	23,169	$31,278
01/01/96	12/31/96	$47.54	$55.00	$57.50	($2.50)	12,087	($30,218)
01/01/96	12/31/96	$47.54	$42.03	$42.80	($0.77)	11,332	($8,726)
								($5,712,390.00)

Indirect Care Component Savings/Loss

Fiscal Year Begin	End	Indirect Upper Limit Not Inflated	Indirect Reimb. Rate	Actual	Savings	State Days	Dollar Value of Savings
01/01/96	12/31/96	$11.07	$9.43	$10.13	($0.70)	16,605	($11,624)
01/01/96	12/31/96	$11.07	$10.84	$11.34	($0.50)	15,695	($7,848)
01/01/96	12/31/96	$11.07	$9.32	$11.10	($1.78)	17,815	($31,711)
07/01/95	06/30/96	$11.07	$11.44	$13.34	($1.90)	17,316	($32,900)
01/01/96	12/31/96	$11.07	$10.68	$12.59	($1.91)	17,097	($32,655)
01/01/96	12/31/96	$11.07	$10.59	$9.04	$1.55	24,365	$37,766
07/01/95	06/30/96	$11.07	$8.35	$10.68	($2.33)	62,748	($146,203)
07/01/95	06/30/96	$11.07	$9.65	$10.73	($1.08)	20,958	($22,635)
01/01/96	12/31/96	$11.07	$10.16	$9.23	$0.88	21,989	$19,350
01/01/96	12/31/96	$11.07	$11.62	$13.22	($1.60)	13,340	($21,344)
01/01/96	12/31/96	$11.07	$10.78	$11.82	($1.04)	22,815	($23,728)
01/01/96	12/31/96	$11.07	$11.58	$12.18	($0.60)	16,104	($9,662)
04/01/95	03/31/96	$11.07	$9.33	$10.59	($1.26)	49,479	($62,344)
10/01/95	09/30/96	$11.07	$11.56	$12.49	($0.93)	31,445	($29,244)
10/01/95	09/30/96	$11.07	$11.60	$13.69	($2.09)	20,921	($43,725)
05/01/95	04/30/96	$11.07	$12.27	$13.21	($0.94)	24,645	($23,166)
09/01/95	08/31/96	$11.07	$11.06	$9.91	$1.15	29,101	$33,466
01/01/96	12/31/96	$11.07	$11.64	$11.88	($0.24)	10,706	($2,569)
01/01/96	12/31/96	$11.07	$8.27	$7.66	$0.61	18,975	$11,575
01/01/96	12/31/96	$11.07	$11.32	$10.72	$0.60	10,021	$6,013
01/01/96	12/31/96	$11.07	$9.41	$12.36	($2.95)	21,223	($62,608)
05/01/95	04/30/96	$11.07	$11.82	$14.84	($3.02)	12,925	($39,034)
01/01/96	12/31/96	$11.07	$9.69	$9.75	($0.06)	15,839	($950)
01/01/96	12/31/96	$11.07	$8.85	$9.50	($0.65)	21,747	($14,136)
01/01/96	12/31/96	$11.07	$8.28	$7.43	$0.85	9,889	$8,406
01/01/96	12/31/96	$11.07	$11.65	$13.68	($2.03)	8,205	($16,656)
01/01/96	12/31/96	$11.07	$9.63	$9.76	($0.13)	14,461	($1,880)
01/01/96	12/31/96	$11.07	$10.30	$14.08	($3.78)	9,087	($34,349)
01/01/96	12/31/96	$11.07	$9.79	$12.44	($2.65)	11,247	($29,805)
01/01/96	12/31/96	$11.07	$6.72	$10.64	($3.92)	15,666	($61,411)
10/01/95	09/30/96	$11.07	$11.50	$11.40	$0.10	15,656	$1,566
01/01/96	12/31/96	$11.07	$7.29	$8.53	($1.24)	15,330	($19,009)
01/01/96	12/31/96	$11.07	$10.79	$10.04	$0.75	17,794	$13,346
10/01/95	09/30/96	$11.07	$11.58	$13.15	($1.57)	9,847	($15,460)
10/01/95	09/30/96	$11.07	$11.58	$13.63	($2.05)	5,798	($11,886)
07/01/95	06/30/96	$11.07	$10.81	$12.71	($1.90)	26,027	($49,451)
01/01/96	12/31/96	$11.07	$11.62	$12.81	($1.19)	13,882	($16,520)
01/01/96	12/31/96	$11.07	$8.07	$9.55	($1.48)	20,121	($29,779)
01/01/96	12/31/96	$11.07	$8.53	$10.33	($1.80)	13,062	($23,512)
10/01/95	09/30/96	$11.07	$8.27	$11.44	($3.17)	23,237	($73,661)
01/01/96	12/31/96	$11.07	$9.36	$9.55	($0.19)	22,783	($4,329)
06/01/95	05/31/96	$11.77	$12.18	$18.87	($6.69)	23,055	($154,238)
10/01/95	09/30/96	$11.07	$9.43	$12.42	($2.99)	13,385	($40,021)
07/01/95	06/30/96	$11.07	$11.05	$13.80	($2.75)	11,757	($32,332)
04/01/95	03/31/96	$11.07	$9.63	$10.44	($0.81)	5,178	($4,194)
07/01/95	06/30/96	$11.07	$10.90	$10.80	$0.10	16,120	$1,612
07/01/95	06/30/96	$11.07	$8.97	$10.32	($1.35)	28,747	($38,808)
07/01/95	06/30/96	$11.07	$8.76	$9.30	($0.54)	29,580	($15,973)
01/01/96	12/31/96	$11.07	$11.62	$11.65	($0.03)	9,014	($270)
04/01/95	03/31/96	$11.07	$9.50	$11.71	($2.21)	15,809	($34,938)
07/01/95	06/30/96	$11.07	$10.50	$11.51	($1.01)	33,491	($33,826)
01/01/96	12/31/96	$11.07	$10.55	$13.76	($3.21)	17,060	($54,763)
07/01/95	06/30/96	$11.07	$10.69	$10.17	$0.52	22,855	$11,885
07/01/96	12/31/96	$11.07	$10.61	$11.27	($0.66)	11,936	($7,878)

Indirect Care Component Savings/Loss

01/01/96	12/31/96	$11.07	$11.62	$16.96	($5.34)	8,150	($43,564)
10/03/95	06/30/96	$11.07	$11.44	$16.64	($5.20)	4,803	($24,976)
07/26/95	06/30/96	$11.07	$11.43	$24.24	($12.81)	5,351	($68,546)
07/01/95	06/30/96	$11.07	$11.43	$12.90	($1.47)	25,160	($36,985)
07/01/95	06/30/96	$11.07	$11.43	$17.10	($5.67)	12,388	($70,240)
07/01/95	06/30/96	$11.07	$11.44	$13.63	($2.19)	29,739	($65,128)
01/01/96	12/31/96	$11.07	$9.11	$11.23	($2.12)	13,753	($29,156)
01/01/96	12/31/96	$11.07	$11.48	$12.13	($0.65)	29,597	($19,238)
10/01/95	09/30/96	$11.07	$9.01	$9.59	($0.58)	18,930	($10,979)
07/01/95	06/30/96	$11.07	$9.67	$11.32	($1.65)	17,384	($28,684)
10/01/95	09/30/96	$11.07	$11.58	$13.88	($2.30)	5,993	($13,784)
01/01/96	12/31/96	$11.07	$10.24	$11.18	($0.94)	12,641	($11,883)
01/01/96	12/31/96	$11.07	$11.64	$11.51	$0.13	26,818	$3,486
01/01/96	12/31/96	$11.07	$11.65	$14.25	($2.60)	5,651	($14,693)
01/01/96	12/31/96	$11.07	$11.65	$10.37	$1.28	17,598	$22,525
07/01/95	06/30/96	$11.07	$9.66	$10.64	($0.98)	10,635	($10,422)
01/01/96	12/31/96	$11.07	$8.33	$9.96	($1.63)	11,430	($18,631)
01/01/96	12/31/96	$11.07	$11.18	$12.26	($1.08)	12,730	($13,748)
07/01/95	06/30/96	$11.07	$11.43	$11.37	$0.06	8,013	$481
01/01/96	12/31/96	$11.07	$10.69	$11.50	($0.81)	10,239	($8,294)
01/01/96	12/31/96	$11.07	$8.50	$10.59	($2.09)	23,101	($48,281)
01/01/96	12/31/96	$11.07	$10.11	$10.40	($0.29)	17,797	($5,161)
10/01/95	09/30/96	$11.07	$9.28	$15.20	($5.92)	15,367	($90,973)
10/01/95	09/30/96	$11.07	$9.99	$10.12	($0.13)	26,887	($3,495)
07/01/95	06/17/96	$11.07	$11.43	$13.89	($2.46)	7,817	($19,230)
01/01/96	12/31/96	$11.07	$8.55	$9.40	($0.85)	19,063	($16,204)
01/01/96	12/31/96	$11.07	$8.23	$8.72	($0.49)	15,271	($7,483)
01/01/96	12/31/96	$11.07	$11.60	$15.85	($4.25)	14,062	($59,764)
07/01/95	06/30/96	$11.07	$9.28	$9.24	$0.04	24,965	$999
08/01/95	07/31/96	$11.07	$9.58	$14.36	($4.78)	27,886	($133,295)
01/01/96	12/31/96	$11.07	$10.84	$11.06	($0.22)	12,669	($2,787)
01/01/96	12/31/96	$11.07	$11.46	$17.94	($6.48)	7,747	($50,207)
01/01/96	12/31/96	$11.07	$11.62	$16.02	($4.40)	17,860	($78,584)
01/01/96	12/31/96	$11.07	$9.23	$9.96	($0.73)	17,883	($13,055)
01/01/96	12/31/96	$11.07	$11.48	$13.07	($1.59)	5,390	($8,570)
01/01/96	12/31/96	$11.07	$10.35	$10.69	($0.34)	9,309	($3,165)
01/01/96	12/31/96	$11.07	$11.62	$14.46	($2.84)	17,007	($48,300)
01/01/96	12/31/96	$11.07	$11.55	$15.45	($3.90)	8,637	($33,684)
01/01/96	12/31/96	$11.07	$9.83	$9.53	$0.30	19,098	$5,729
01/01/96	12/31/96	$11.07	$9.70	$11.84	($2.14)	30,489	($65,246)
12/01/95	11/30/96	$11.07	$10.17	$12.40	($2.23)	25,093	($55,957)
01/01/96	12/31/96	$11.07	$11.43	$10.42	$1.01	13,782	$13,920
07/01/95	06/30/96	$11.07	$11.44	$12.63	($1.19)	50,165	($59,696)
01/01/96	12/31/96	$11.07	$10.18	$24.90	($14.72)	70,207	($1,033,447)
01/01/96	12/31/96	$11.07	$10.46	$10.28	$0.18	17,181	$3,093
01/01/96	12/31/96	$11.07	$11.11	$9.79	$1.32	11,808	$15,587
01/01/96	12/31/96	$11.07	$11.65	$11.58	$0.07	9,619	$673
01/01/96	12/31/96	$11.07	$10.71	$11.27	($0.56)	15,615	($8,744)
07/01/95	06/30/96	$11.07	$8.03	$9.54	($1.51)	12,048	($18,192)
07/01/95	06/30/96	$11.07	$11.44	$12.67	($1.23)	17,205	($21,162)
01/01/96	12/31/96	$11.07	$11.64	$11.30	$0.34	16,345	$5,557
11/01/95	10/31/96	$11.07	$11.56	$13.60	($2.04)	11,017	($22,475)
01/01/96	12/31/96	$11.07	$8.09	$8.50	($0.41)	23,169	($9,499)
01/01/96	12/31/96	$11.07	$11.13	$13.01	($1.88)	12,087	($22,724)
01/01/96	12/31/96	$11.07	$10.26	$11.20	($0.94)	11,332	($10,652)
							($3,771,068.00)

Routine Cost Component Savings/Loss

Fiscal Year Begin	End	Routine Upper Limit Not Inflated	Routine Reimb. Rate	Actual	Savings	State Days	Dollar Value of Savings
01/01/96	12/31/96	$28.61	$23.76	$24.46	($0.70)	16,605	($11,624)
01/01/96	12/31/96	$28.61	$24.12	$32.76	($8.64)	15,695	($135,605)
01/01/96	12/31/96	$28.61	$30.04	$33.85	($3.81)	17,815	($67,875)
07/01/95	06/30/96	$28.61	$29.57	$38.56	($8.99)	17,316	($155,671)
01/01/96	12/31/96	$28.61	$30.10	$35.42	($5.32)	17,097	($90,956)
01/01/96	12/31/96	$28.61	$23.34	$25.60	($2.26)	24,365	($55,065)
07/01/95	06/30/96	$28.61	$27.30	$30.39	($3.09)	62,748	($193,891)
07/01/95	06/30/96	$28.61	$26.68	$29.09	($2.41)	20,958	($50,509)
01/01/96	12/31/96	$28.61	$25.85	$21.61	$4.24	21,989	$93,233
01/01/96	12/31/96	$28.61	$30.04	$42.85	($12.81)	13,340	($170,885)
01/01/96	12/31/96	$28.61	$30.10	$30.55	($0.45)	22,815	($10,267)
01/01/96	12/31/96	$28.61	$27.54	$30.75	($3.21)	16,104	($51,694)
04/01/95	03/31/96	$28.61	$28.22	$37.92	($9.70)	49,479	($479,946)
10/01/95	09/30/96	$28.61	$26.84	$24.56	$2.28	31,445	$71,695
10/01/95	09/30/96	$28.61	$29.98	$32.37	($2.39)	20,921	($50,001)
05/01/95	04/30/96	$28.61	$29.44	$41.42	($11.98)	24,645	($295,247)
09/01/95	08/31/96	$28.61	$29.12	$24.33	$4.79	29,101	$139,394
01/01/96	12/31/96	$28.61	$24.87	$27.50	($2.63)	10,706	($28,157)
01/01/96	12/31/96	$28.61	$20.74	$24.06	($3.32)	18,975	($62,997)
01/01/96	12/31/96	$28.61	$29.47	$23.77	$5.70	10,021	$57,120
01/01/96	12/31/96	$28.61	$26.45	$25.36	$1.09	21,223	$23,133
05/01/95	04/30/96	$28.61	$28.88	$34.26	($5.38)	12,925	($69,537)
01/01/96	12/31/96	$28.61	$22.85	$27.93	($5.08)	15,839	($80,462)
01/01/96	12/31/96	$28.61	$22.19	$22.63	($0.44)	21,747	($9,569)
01/01/96	12/31/96	$28.61	$28.47	$37.09	($8.62)	9,889	($85,243)
01/01/96	12/31/96	$28.61	$30.09	$29.61	$0.48	8,205	$3,938
01/01/96	12/31/96	$28.61	$29.88	$31.23	($1.35)	14,461	($19,522)
01/01/96	12/31/96	$28.61	$30.04	$32.77	($2.73)	9,087	($24,808)
01/01/96	12/31/96	$28.61	$26.92	$34.07	($7.15)	11,247	($80,416)
01/01/96	12/31/96	$28.61	$30.04	$32.04	($2.00)	15,666	($31,332)
10/01/95	09/30/96	$28.61	$27.26	$27.90	($0.64)	15,656	($10,020)
01/01/96	12/31/96	$28.61	$30.04	$31.41	($1.37)	15,330	($21,002)
01/01/96	12/31/96	$28.61	$17.91	$16.95	$0.96	17,794	$17,082
10/01/95	09/30/96	$28.61	$29.92	$31.25	($1.33)	9,847	($13,097)
10/01/95	09/30/96	$28.61	$29.92	$39.46	($9.54)	5,798	($55,313)
07/01/95	06/30/96	$28.61	$29.52	$30.98	($1.46)	26,027	($37,999)
01/01/96	12/31/96	$28.61	$30.04	$33.93	($3.89)	13,882	($54,001)
01/01/96	12/31/96	$28.61	$22.28	$23.46	($1.18)	20,121	($23,743)
01/01/96	12/31/96	$28.61	$25.00	$30.65	($5.65)	13,062	($73,800)
10/01/95	09/30/96	$28.61	$23.66	$25.66	($2.00)	23,237	($46,474)
01/01/96	12/31/96	$28.61	$23.79	$22.95	$0.84	22,783	$19,138
06/01/95	05/31/96	$30.43	$29.05	$28.28	$0.77	23,055	$17,752
10/01/95	09/30/96	$28.61	$29.92	$34.90	($4.98)	13,385	($66,657)
07/01/95	06/30/96	$28.61	$27.85	$33.70	($5.85)	11,757	($68,778)
04/01/95	03/31/96	$28.61	$28.91	$59.83	($30.92)	5,178	($160,104)
07/01/95	06/30/96	$28.61	$26.33	$25.91	$0.42	16,120	$6,770
07/01/95	06/30/96	$28.61	$24.71	$26.62	($1.91)	28,747	($54,907)
07/01/95	06/30/96	$28.61	$23.33	$24.74	($1.41)	29,580	($41,708)
01/01/96	12/31/96	$28.61	$30.04	$37.36	($7.32)	9,014	($65,932)
04/01/95	03/31/96	$28.61	$28.27	$38.62	($10.35)	15,809	($163,623)
07/01/95	06/30/96	$28.61	$26.25	$26.94	($0.69)	33,491	($23,109)
01/01/96	12/31/96	$28.61	$23.58	$25.05	($1.47)	17,060	($25,078)
07/01/95	06/30/96	$28.61	$23.36	$20.00	$3.36	22,855	$76,793
07/01/96	12/31/96	$28.61	$20.59	$20.71	($0.12)	11,936	($1,432)

Routine Cost Component Savings/Loss

01/01/96	12/31/96	$28.61	$30.04	$38.45	($8.41)	8,158	($68,609)
10/03/95	06/30/96	$28.61	$28.77	$63.91	($35.14)	4,803	($168,777)
07/25/95	06/30/96	$28.61	$28.86	$93.58	($64.72)	5,351	($346,317)
07/01/95	06/30/96	$28.61	$28.86	$35.11	($6.25)	25,160	($157,250)
07/01/95	06/30/96	$28.61	$28.75	$31.72	($2.97)	12,388	($36,792)
07/01/95	06/30/96	$28.61	$28.89	$35.02	($6.13)	29,739	($182,300)
01/01/96	12/31/96	$28.61	$26.44	$28.38	($1.94)	13,753	($26,681)
01/01/96	12/31/96	$28.61	$29.08	$28.42	$0.66	29,597	$19,534
10/01/95	09/30/96	$28.61	$24.85	$23.97	$0.88	18,930	$16,658
07/01/95	06/30/96	$28.61	$26.69	$32.73	($6.04)	17,384	($104,999)
10/01/95	09/30/96	$28.61	$29.92	$34.30	($4.38)	5,993	($26,249)
01/01/96	12/31/96	$28.61	$28.34	$28.24	$0.10	12,641	$1,264
01/01/96	12/31/96	$28.61	$23.00	$22.57	$0.43	26,818	$11,532
01/01/96	12/31/96	$28.61	$30.10	$39.53	($9.43)	5,651	($53,289)
01/01/96	12/31/96	$28.61	$28.43	$31.59	($3.16)	17,598	($55,610)
07/01/95	06/30/96	$28.61	$29.12	$32.00	($2.88)	10,635	($30,629)
01/01/96	12/31/96	$28.61	$27.41	$36.58	($9.17)	11,430	($104,813)
01/01/96	12/31/96	$28.61	$28.75	$28.72	$0.03	12,730	$382
07/01/95	06/30/96	$28.61	$29.55	$35.48	($5.93)	8,013	($47,517)
01/01/96	12/31/96	$28.61	$30.08	$34.67	($4.59)	10,239	($46,997)
01/01/96	12/31/96	$28.61	$24.65	$26.09	($1.44)	23,101	($33,265)
01/01/96	12/31/96	$28.61	$27.03	$26.98	$0.05	17,797	$890
10/01/95	09/30/96	$28.61	$29.92	$38.62	($8.70)	15,367	($133,693)
10/01/95	09/30/96	$28.61	$23.56	$24.07	($0.51)	26,887	($13,712)
07/01/95	06/17/96	$28.61	$29.55	$33.41	($3.86)	7,817	($30,174)
01/01/96	12/31/96	$28.61	$26.06	$30.81	($4.75)	19,063	($90,549)
01/01/96	12/31/96	$28.61	$22.10	$22.89	($0.79)	15,271	($12,064)
01/01/96	12/31/96	$28.61	$27.54	$39.26	($11.72)	14,062	($164,807)
07/01/95	06/30/96	$28.61	$22.68	$23.78	($1.10)	24,965	($27,462)
08/01/95	07/31/96	$28.61	$22.88	$24.29	($1.41)	27,886	($39,319)
01/01/96	12/31/96	$28.61	$26.54	$28.65	($2.11)	12,669	($26,732)
01/01/96	12/31/96	$28.61	$11.63	$44.52	($32.89)	7,747	($254,799)
01/01/96	12/31/96	$28.61	$30.04	$39.26	($9.22)	17,860	($164,669)
01/01/96	12/31/96	$28.61	$23.51	$23.04	$0.47	17,883	$8,405
01/01/96	12/31/96	$28.61	$30.08	$35.62	($5.54)	5,390	($29,861)
01/01/96	12/31/96	$28.61	$30.04	$34.97	($4.93)	9,309	($45,893)
01/01/96	12/31/96	$28.61	$30.04	$33.38	($3.34)	17,007	($56,803)
01/01/96	12/31/96	$28.61	$28.47	$32.29	($3.82)	8,637	($32,993)
01/01/96	12/31/96	$28.61	$26.71	$29.69	($2.98)	19,098	($56,912)
01/01/96	12/31/96	$28.61	$24.20	$25.15	($0.95)	30,489	($28,965)
12/01/95	11/30/96	$28.61	$29.96	$30.86	($0.90)	25,093	($22,584)
01/01/96	12/31/96	$28.61	$27.69	$28.48	($0.79)	13,782	($10,888)
07/01/95	06/30/96	$28.61	$29.55	$29.59	($0.04)	50,165	($2,007)
01/01/96	12/31/96	$28.61	$27.20	$18.98	$8.22	70,207	$577,102
01/01/96	12/31/96	$28.61	$27.21	$27.31	($0.10)	17,181	($1,718)
01/01/96	12/31/96	$28.61	$28.09	$27.49	$0.60	11,808	$7,085
01/01/96	12/31/96	$28.61	$30.10	$30.16	($0.06)	9,619	($577)
01/01/96	12/31/96	$28.61	$29.30	$29.71	($0.41)	15,615	($6,402)
07/01/95	06/30/96	$28.61	$26.10	$27.67	($1.57)	12,048	($18,915)
07/01/95	06/30/96	$28.61	$27.64	$27.45	$0.19	17,205	$3,269
01/01/96	12/31/96	$28.61	$29.07	$28.72	$0.35	16,345	$5,721
11/01/95	10/31/96	$28.61	$25.28	$29.08	($3.80)	11,017	($41,865)
01/01/96	12/31/96	$28.61	$28.63	$24.88	$3.75	23,169	$86,884
01/01/96	12/31/96	$28.61	$30.04	$36.29	($6.25)	12,087	($75,544)
01/01/96	12/31/96	$28.61	$24.74	$28.53	($3.79)	11,332	($42,948)
							($5,441,574.00)

Maine Non-Hospital Based Nursing Facilities
Summary Statistics
Fiscal Years Ending January 1, 1996 Through December 31, 1996

	Region 1	Region 2	Region 3	Region 4	Total
Number of Facilities	43	44	29	11	127
Total Beds	3,619	3,477	2,030	802	9,928
Average Beds	84	79	70	73	78
Minimum Beds	17	18	25	40	17
Maximum Beds	235	280	118	119	280
Resident Days	1,165,994	1,104,315	643,060	275,321	3,188,690
Average Resident Days	27,116	25,098	22,174	25,029	25,108
Minimum Resident Days	5,805	5,372	5,941	13,764	5,372
Maximum Resident Days	82,295	93,157	39,693	42,975	93,157
Resident Days by Type					
NF Days					
Medicare	92,221	84,094	61,967	3,737	242,019
VA	654	5,303	576	508	7,041
Medicaid	803,939	811,103	457,793	218,658	2,291,493
Self-Pay	213,361	152,108	106,990	25,148	497,607
Total NF Resident Days	1,110,175	1,052,608	627,326	248,051	3,038,160
Residential Care Days					
Medicaid	10,214	34,893	13,430	22,843	81,380
Self-Pay	31,897	11,999	1,474	4,427	49,797
TBI Days	7,315	4,815	659	0	12,789
Mental Health Days	6,393	0	171	0	6,564
Total Resident Days	1,165,994	1,104,315	643,060	275,321	3,188,690
Available Days NF only	1,250,629	1,210,355	709,656	266,075	3,436,715
Occupancy Percentage NF	88.77%	86.97%	88.40%	93.23%	88.40%
Total Available Days	1,324,580	1,271,045	731,864	293,656	3,621,145
Occupancy Percentage All	88.03%	86.88%	87.87%	93.76%	88.06%
Percent of NF Days to Total					
Medicare	8.31%	7.99%	9.88%	1.51%	7.97%
VA	0.06%	0.50%	0.09%	0.20%	0.23%
Medicaid	72.42%	77.06%	72.98%	88.15%	75.42%
Self-Pay	19.21%	14.45%	17.05%	10.14%	16.38%
	100.00%	100.00%	100.00%	100.00%	100.00%

Actual Costs -- Regional Averages
For Fiscal Years Ending Between 01/01/1996 and 12/31/1996

	Region 1		Region 2		Region 3		Region 4		Combined	
	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD
ιECT CARE										
aries - R.N.	303,713	11.21	248,849	9.97	190,851	8.62	151,401	6.23	245,741	9.84
aries - L.P.N.	135,822	5.01	125,693	5.04	127,524	5.76	92,833	3.82	126,695	5.07
aries - C.N.A.	609,903	22.52	532,180	21.33	463,025	20.91	561,148	23.09	545,213	21.83
laries - C.M.T.	22,350	0.83	24,904	1.00	8,448	0.38	8,707	0.36	18,879	0.76
laries - Ward Clerks	8,122	0.30	5,267	0.21	6,113	0.28	542	0.02	6,018	0.24
ırsing Benefits & Taxes	292,772	10.81	257,097	10.30	224,929	10.16	239,607	9.86	260,316	10.42
ntract Nursing	14,809	0.55	20,242	0.81	5,516	0.25	0	0.00	13,287	0.53
tient Activities Salaries	36,982	1.37	29,693	1.19	28,353	1.28	29,058	1.20	31,800	1.27
t. Act. Benefits & Taxes	10,403	0.38	8,774	0.35	7,913	0.36	8,856	0.36	9,136	0.37
al DIRECT CARE	1,434,876	52.98	1,252,699	50.20	1,062,672	48.00	1,092,152	44.94	1,257,085	50.33
DIRECT CARE										
laries - Director of Nursing	44,681	1.65	37,017	1.48	37,951	1.71	37,383	1.54	39,857	1.60
.O.N. Benefits & Taxes	11,875	0.44	10,622	0.43	9,418	0.43	11,296	0.46	10,830	0.43
ocial Service Salaries	38,240	1.41	30,023	1.20	28,426	1.28	25,339	1.04	32,035	1.28
oc. Svc. Benefits & Taxes	10,997	0.41	9,097	0.36	7,533	0.34	8,186	0.34	9,304	0.37
ood	133,163	4.92	140,316	5.62	85,770	3.87	102,875	4.23	122,196	4.89
ledical Supplies	94,552	3.49	89,145	3.57	70,291	3.17	83,140	3.42	86,150	3.45
ledicine and Drugs	21,379	0.79	23,845	0.96	23,896	1.08	1,008	0.04	21,044	0.84
harmacy Consultant	2,184	0.08	2,324	0.09	2,202	0.10	2,292	0.09	2,246	0.09
ledical Director	4,167	0.15	4,270	0.17	3,663	0.17	2,926	0.12	3,980	0.16
ocial Service Consultant	140	0.01	55	0.00	19	0.00	76	0.00	77	0.00
ietary Consultant	2,958	0.11	3,500	0.14	2,893	0.13	1,215	0.05	2,980	0.12
tal INDIRECT CARE	364,336	13.46	350,214	14.02	272,062	12.28	275,736	11.33	330,699	13.23

Actual Costs -- Regional Averages

For Fiscal Years Ending Between 01/01/1996 and 12/31/1996

	Region 1		Region 2		Region 3		Region 4		Combined	
	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD
ED COSTS										
ıreciation of Building & Imp.	79,347	2.93	59,875	2.40	55,339	2.50	80,871	3.33	67,251	2.69
ıreciation - Land Improvements	2,027	0.07	1,029	0.04	371	0.02	2,145	0.09	1,313	0.05
ır. Furniture & Fixtures	30,318	1.12	31,182	1.25	25,160	1.14	18,233	0.75	28,393	1.14
ıreciation - Auto	2,071	0.08	1,285	0.05	878	0.04	2,956	0.12	1,603	0.06
rt-Up Cost Amortization	6,584	0.24	2,479	0.10	6,492	0.29	126	0.01	4,581	0.18
ıortization of Leasehold Imp.	1,265	0.05	469	0.02	403	0.02	0	0.00	683	0.03
ıortization of Finance Costs	3,270	0.12	3,924	0.16	6,044	0.27	1,954	0.08	4,016	0.16
ːrest on Long-Term Debt	137,969	5.09	123,508	4.95	113,221	5.11	77,262	3.18	122,050	4.89
ːility Rent (in lieu of above)	133,223	4.92	91,285	3.66	21,987	0.99	29,515	1.21	84,311	3.38
ıipment Rental	6,830	0.25	8,323	0.33	5,798	0.26	3,788	0.16	6,848	0.27
urn on Owner's Equity	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
ıl Estate & Personal Property Tax	23,648	0.87	20,659	0.83	25,876	1.17	20,513	0.84	22,850	0.91
urance (Fire, Liability, etc.)	15,083	0.56	14,172	0.57	10,261	0.46	23,253	0.96	14,374	0.58
ıtor Vehicle Insurance	733	0.03	269	0.01	562	0.03	901	0.04	548	0.02
ırkers' Compensation Ins.	78,906	2.91	66,147	2.65	59,346	2.68	94,327	3.88	71,355	2.86
ımin. in Training - Wages	573	0.02	418	0.02	1,348	0.06	0	0.00	647	0.03
lmin. in Training - Ben. and Taxes	52	0.00	101	0.00	201	0.01	0	0.00	99	0.00
oss Receipts Tax	223,040	8.23	181,275	7.26	174,745	7.89	155,133	6.38	191,661	7.67
her Capital Costs	573	0.02	4,425	0.18	1,553	0.07	1,823	0.08	2,240	0.09
her Capital Costs	4,888	0.18	274	0.01	-38	0.00	421	0.02	1,778	0.07
al FIXED COSTS	750,400	27.69	611,099	24.49	509,547	23.01	513,221	21.13	626,601	25.08
ıer Nursing Costs										
tient Activities Supplies	3,358	0.12	2,789	0.11	2,398	0.11	4,531	0.19	3,043	0.12
edical Records Salaries	6,624	0.24	3,075	0.12	4,520	0.20	1,871	0.08	4,502	0.18
edical Records Benefits	1,857	0.07	925	0.04	1,327	0.06	723	0.03	1,315	0.05
edical Records Supplies	506	0.02	294	0.01	903	0.04	9,274	0.38	1,283	0.05
ɔcial Service Supplies	377	0.01	134	0.01	158	0.01	328	0.01	239	0.01
ther Nursing Contracted Services	3,844	0.14	1,603	0.06	581	0.03	-43	0.00	1,986	0.08
ther Nursing Cost	54,682	2.02	21,644	0.87	5,166	0.23	1,473	0.06	27,321	1.09
ther Nursing Cost	33,922	1.25	12,163	0.49	4,457	0.20	1,280	0.05	16,828	0.67
ɔtal Other Nursing Costs	105,170	3.87	42,627	1.71	19,510	0.88	19,437	0.80	56,517	2.25

Actual Costs -- Regional Averages

For Fiscal Years Ending Between 01/01/1996 and 12/31/1996

	Region 1		Region 2		Region 3		Region 4		Combined	
	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD
t Oper. & Maint.										
ntenance Salaries and Wages	40,770	1.51	29,056	1.16	33,315	1.50	35,493	1.46	34,552	1.38
int. Employee Benefits & Taxes	12,323	0.45	8,276	0.33	10,327	0.47	9,785	0.40	10,246	0.41
intenance Equipment Rental	121	0.00	73	0.00	0	0.00	0	0.00	66	0.00
intenance Supplies	6,290	0.23	6,194	0.25	6,715	0.30	8,427	0.35	6,539	0.26
intenance Temporary Help	4,780	0.18	3,268	0.13	489	0.02	844	0.03	2,936	0.12
airs and Maintenance	21,314	0.79	16,373	0.66	13,044	0.59	8,887	0.37	16,637	0.67
ter & Sewer	13,900	0.51	11,658	0.47	11,669	0.53	8,243	0.34	12,124	0.49
ctricity	44,906	1.66	40,419	1.62	29,136	1.32	24,677	1.02	37,998	1.52
at	23,520	0.87	21,162	0.85	17,526	0.79	20,037	0.82	21,033	0.84
w & Rubbish Removal	3,734	0.14	3,950	0.16	3,786	0.17	1,640	0.07	3,639	0.15
er Oper. & Maint. Costs	4,926	0.18	5,129	0.21	2,713	0.12	4,148	0.17	4,423	0.18
er Oper. & Maint. Costs	1,294	0.05	1,223	0.05	319	0.01	5,059	0.21	1,373	0.05
al Plant Oper. & Maint.	177,878	6.57	146,781	5.89	129,039	5.82	127,240	5.24	151,566	6.07
usekeeping										
usekeeping Salaries and Wages	73,324	2.71	54,648	2.19	42,098	1.90	47,713	1.96	57,505	2.30
kpg Employee Benefits & Taxes	21,910	0.81	16,491	0.66	12,378	0.56	14,610	0.60	17,224	0.69
usekeeping Supplies	14,388	0.53	12,716	0.51	8,961	0.40	10,677	0.44	12,248	0.49
usekeeping Temporary Help	28	0.00	1,141	0.05	0	0.00	0	0.00	405	0.02
her Housekeeping Costs	9,688	0.36	10,308	0.41	16,031	0.72	11,342	0.47	11,494	0.46
her Housekeeping Costs	12	0.00	129	0.01	2	0.00	0	0.00	49	0.00
al Housekeeping	119,350	4.41	95,433	3.83	79,470	3.58	84,342	3.47	98,925	3.96

Actual Costs -- Regional Averages

For Fiscal Years Ending Between 01/01/1996 and 12/31/1996

	Region 1		Region 2		Region 3		Region 4		Combined	
	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD
ndry										
ındry Salaries and Wages	37,979	1.40	33,680	1.35	20,976	0.95	29,445	1.21	31,868	1.28
ındry Employee Benefits & Taxes	11,142	0.41	9,584	0.38	5,986	0.27	8,943	0.37	9,235	0.37
ıen and Bedding	4,571	0.17	3,844	0.15	2,656	0.12	3,176	0.13	3,761	0.15
ındry Supplies	6,309	0.23	4,902	0.20	3,157	0.14	3,605	0.15	4,867	0.19
ındry Temporary Help	1,084	0.04	0	0.00	0	0.00	0	0.00	367	0.01
tside Laundry Service	14,035	0.52	11,892	0.48	18,521	0.84	7,996	0.33	13,794	0.55
her Laundry Costs	565	0.02	1,697	0.07	104	0.00	-32	0.00	800	0.03
her Laundry Costs	14	0.00	1,688	0.07	0	0.00	211	0.01	608	0.02
al Laundry	75,699	2.79	67,287	2.70	51,400	2.32	53,344	2.20	65,300	2.60
tary										
etary Salaries and Wages	167,488	6.18	125,245	5.02	112,282	5.07	116,025	4.77	135,789	5.44
etary Employee Benefits & Taxes	45,878	1.69	34,758	1.39	33,202	1:50	35,537	1.46	38,235	1.53
etary Supplies	16,735	0.62	11,825	0.47	10,778	0.49	14,111	0.58	13,447	0.54
etary Temporary Help	104	0.00	76	0.00	0	0.00	0	0.00	61	0.00
her Dietary Costs	3,565	0.13	7,070	0.28	3,756	0.17	7,760	0.32	5,186	0.21
her Dietary Costs	2,894	0.11	1,057	0.04	238	0.01	354	0.01	1,431	0.06
tal Dietary	236,664	8.73	180,031	7.20	160,256	7.24	173,787	7.14	194,149	7.78
neral Office Costs										
ılary - Accountants / Bookkeeper	58,826	2.17	43,024	1.72	42,764	1.93	30,961	1.27	47,270	1.89
ılary - Secretary / Receptionist	17,709	0.65	12,319	0.49	9,575	0.43	9,483	0.39	13,272	0.53
ffice Employee Benefits & Taxes	22,610	0.83	16,420	0.66	14,666	0.66	12,258	0.50	17,755	0.71
dvertising (Personnel Only)	6,046	0.22	5,094	0.20	5,018	0.23	1,488	0.06	5,086	0.20
elephone and Telegraph	11,841	0.44	11,675	0.47	9,857	0.45	4,314	0.18	10,678	0.43
ıbscriptions	4,659	0.17	3,044	0.12	3,831	0.17	3,839	0.16	3,839	0.15
opier Expense	1,394	0.05	2,089	0.08	1,004	0.05	679	0.03	1,484	0.06
icense Fees	1,593	0.06	1,394	0.06	1,866	0.08	1,252	0.05	1,557	0.06
ıtomobile Operating Expenses	3,076	0.11	1,809	0.07	2,187	0.10	3,483	0.14	2,469	0.10
)ffice Supplies	10,096	0.37	7,518	0.30	5,755	0.26	4,709	0.19	7,745	0.31
rinting	1,942	0.07	784	0.03	463	0.02	742	0.03	1,099	0.04
ostage	2,675	0.10	2,502	0.10	1,847	0.08	1,496	0.06	2,324	0.09
egal	6,637	0.25	8,101		4,014	0.18	3,547	0.15	6,278	0.25

Actual Costs -- Regional Averages

For Fiscal Years Ending Between 01/01/1996 and 12/31/1996

	Region 1		Region 2		Region 3		Region 4		Combined	
	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD
ıer Taxes	1,869	0.07	1,043	0.04	179	0.01	797	0.03	1,104	0.04
ıvel and Seminar (In-State)	4,722	0.17	5,180	0.21	5,034	0.23	3,917	0.16	4,882	0.20
service Training	1,812	0.07	2,163	0.09	2,530	0.11	1,034	0.04	2,030	0.08
ta Processing	4,738	0.17	12,834	0.51	6,748	0.30	3,225	0.13	7,871	0.32
erest - Current Indebtedness	2,361	0.09	3,240	0.13	1,720	0.08	34	0.00	2,318	0.09
ntral Office Overhead	38,504	1.42	32,544	1.30	36,589	1.65	8,333	0.34	33,388	1.34
her General Office Costs	14,594	0.54	11,464	0.46	5,362	0.24	2,072	0.09	10,317	0.41
her General Office Costs	7,546	0.28	5,142	0.21	761	0.03	1,276	0.05	4,621	0.18
her General Office Costs	-10,383	-0.38	3,331	0.13	535	0.02	1,239	0.05	-2,132	-0.09
her General Office Costs	3,213	0.12	1,077	0.04	853	0.04	0	0.00	1,596	0.06
al General Office Costs	218,080	8.04	193,791	7.74	163,158	7.35	100,178	4.10	186,851	7.45
ministrative Costs										
lary - Administrator	55,504	2.05	46,254	1.85	45,537	2.06	49,272	2.03	49,484	1.98
dmin. Employee Benefits & Taxes	12,202	0.45	11,968	0.48	11,085	0.50	12,032	0.50	11,851	0.47
dmin. & Mgmt. Ceiling	0	0.00	5	0.00	0	0.00	0	0.00	2	0.00
ccounting	14,930	0.55	16,211	0.65	10,882	0.49	14,518	0.60	14,414	0.58
her Administrative Costs	-17,679	-0.65	916	0.04	3,044	0.14	1,492	0.06	-4,844	-0.19
her Administrative Costs	2,538	0.09	2,475	0.10	57	0.00	244	0.01	1,751	0.07
tal Administrative Costs	67,495	2.49	77,829	3.12	70,605	3.19	77,558	3.20	72,658	2.91
n-Reimbursable Expenses										
alary - Officers	4,508	0.17	591	0.02	0	0.00	6,844	0.28	2,324	0.09
alary - Assistant Administrator	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
hysical Therapy (Director & Staff)	29,363	1.08	26,029	1.04	34,957	1.58	9,883	0.41	27,798	1.11
ther Non-Reimbursable Wages	228,565	8.44	37,422	1.50	47,889	2.16	1,189,149	48.92	204,286	8.18
on-Reimb. Empl. Bene. & Taxes	76,816	2.84	10,451	0.42	16,878	0.76	397,988	16.37	67,955	2.72
eligious Services	124	0.00	1,582	0.06	0	0.00	12	0.00	591	0.02
eauty and Barber Shop	352	0.01	747	0.03	457	0.02	0	0.00	482	0.02
ift Shop	256	0.01	0	0.00	0	0.00	0	0.00	87	0.00
niform Purchases	-53	0.00	-114	0.00	61	0.00	0	0.00	-43	0.00
ersonal Purchases	137	0.01	35	0.00	249	0.01	0	0.00	115	0.00
dvisory Dentist	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
lanagement S[illegible]	19,901	0.73	26,476	1.06	31,404	1.42	0	0.00	23,082	0.92
irector Fees	291	0.01	0		78	0.00	0	0.00	5	0.00

2.45 / 2.45 (handwritten)

Actual Costs -- Regional Averages

For Fiscal Years Ending Between 01/01/1996 and 12/31/1996

	Region 1		Region 2		Region 3		Region 4		Combined	
	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD
lization Review	60	0.00	52	0.00	126	0.01	0	0.00	67	0.00
ome Taxes	1,792	0.07	-2,387	-0.10	469	0.02	12,927	0.53	1,006	0.04
:s	74	0.00	614	0.02	75	0.00	0	0.00	255	0.01
ployee Agency Fees	-86	0.00	328	0.01	0	0.00	0	0.00	84	0.00
ntributions	239	0.01	170	0.01	428	0.02	721	0.03	300	0.01
l Debts	37,788	1.39	28,179	1.13	31,462	1.42	2,496	0.10	29,958	1.20
t-of-State Travel	17	0.00	-105	0.00	121	0.01	52	0.00	1	0.00
vertising (Non Personnel)	4,476	0.17	4,058	0.16	1,371	0.06	320	0.01	3,262	0.13
:scription Drugs	9,959	0.37	6,092	0.24	8,397	0.38	233	0.01	7,420	0.30
te Fees and Penalties	2,838	0.10	3,237	0.13	1,078	0.05	0	0.00	2,329	0.09
n-Reimbursable Interest	199	0.01	5,385	0.22	84	0.00	6,242	0.26	2,493	0.10
n-Reimb Gross Receipts Tax	37,126	1.37	50,982	2.04	65,861	2.97	1,410,726	58.04	167,461	6.70
her Non-Reimbursable Costs	278,467	10.28	24,827	0.99	36,871	1.66	15,105	0.62	112,613	4.51
al Non-Reimbursable Expenses	733,209	27.07	224,651	8.98	278,316	12.55	3,052,698	125.58	654,042	26.15
Grand Total	4,283,157	158.10	3,242,442	129.88	2,796,035	126.22	5,569,693	229.13	3,694,393	147.81

	% Tot.	CPD
Salaries and Wages		66.78
Fringe Benefits		18.54
	57.7228%	85.32
Admin Comp.	1.6575%	2.45
Owners/Officers Comp.	.0609%	.09¢
Central Office Cost	.9066%	1.34
Mgt. Fees	.6224%	.92¢

Allowable Costs -- Regional Averages

For Fiscal Years Ending Between 01/01/1996 and 12/31/1996

	Region 1		Region 2		Region 3		Region 4		Combined	
	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD
ιECT CARE										
laries - R.N.	303,749	11.21	249,303	9.99	191,761	8.66	151,401	6.23	246,118	9.85
laries - L.P.N.	135,793	5.01	125,693	5.04	127,524	5.76	92,833	3.82	126,685	5.07
laries - C.N.A.	605,133	22.34	530,680	21.27	462,576	20.89	561,097	23.08	542,971	21.74
laries - C.M.T.	22,350	0.83	24,904	1.00	8,448	0.38	8,707	0.36	18,879	0.76
laries - Ward Clerks	8,122	0.30	5,267	0.21	6,113	0.28	253	0.01	5,993	0.24
ırsing Benefits & Taxes	295,221	10.90	257,458	10.32	225,094	10.16	240,199	9.88	261,359	10.46
ntract Nursing	12,711	0.47	20,190	0.81	5,516	0.25	0	0.00	12,558	0.50
tient Activities Salaries	36,264	1.34	29,693	1.19	28,264	1.28	29,058	1.20	31,537	1.26
t. Act. Benefits & Taxes	10,265	0.38	8,787	0.35	7,896	0.36	8,858	0.36	9,090	0.36
ıtal DIRECT CARE	1,429,608	52.78	1,251,975	50.18	1,063,192	48.02	1,092,406	44.94	1,255,190	50.24
DIRECT CARE										
laries - Director of Nursing	44,710	1.65	36,778	1.47	37,068	1.67	37,383	1.54	39,583	1.58
.O.N. Benefits & Taxes	12,092	0.45	10,617	0.43	9,274	0.42	11,425	0.47	10,880	0.44
ocial Service Salaries	38,240	1.41	30,009	1.20	28,426	1.28	25,339	1.04	32,030	1.28
oc. Svc. Benefits & Taxes	11,115	0.41	9,112	0.37	7,517	0.34	8,186	0.34	9,346	0.37
ood	127,225	4.70	136,148	5.46	84,471	3.81	98,667	4.06	118,080	4.73
ledical Supplies	88,804	3.28	79,984	3.21	68,916	3.11	82,652	3.40	80,674	3.23
ledicine and Drugs	8,189	0.30	8,252	0.33	1,628	0.07	1,008	0.04	6,091	0.24
harmacy Consultant	2,142	0.08	2,239	0.09	2,105	0.10	2,292	0.09	2,180	0.09
ledical Director	1,284	0.05	1,431	0.06	2,288	0.10	1,037	0.04	1,543	0.06
ocial Service Consultant	140	0.01	107	0.00	19	0.00	76	0.00	95	0.00
ietary Consultant	2,953	0.11	3,604	0.14	2,893	0.13	1,209	0.05	3,014	0.12
ıtal INDIRECT CARE	336,894	12.45	318,281	12.76	244,605	11.03	269,274	11.07	303,516	12.14

Allowable Costs -- Regional Averages

For Fiscal Years Ending Between 01/01/1996 and 12/31/1996

	Region 1		Region 2		Region 3		Region 4		Combined	
	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD
ED COSTS										
reciation of Building & Imp.	96,794	3.57	73,805	2.96	52,242	2.36	79,307	3.26	77,141	3.09
reciation - Land Improvements	2,253	0.08	1,028	0.04	537	0.02	2,547	0.10	1,462	0.06
r. Furniture & Fixtures	31,239	1.15	31,088	1.25	27,097	1.22	25,089	1.03	29,708	1.19
reciation - Auto	1,540	0.06	1,308	0.05	978	0.04	3,804	0.16	1,527	0.06
t-Up Cost Amortization	4,259	0.16	2,397	0.10	4,742	0.21	142	0.01	3,367	0.13
ortization of Leasehold Imp.	3,022	0.11	435	0.02	191	0.01	0	0.00	1,218	0.05
ortization of Finance Costs	7,640	0.28	4,732	0.19	1,926	0.09	1,745	0.07	4,817	0.19
rest on Long-Term Debt	158,956	5.87	122,177	4.90	86,637	3.91	80,844	3.33	122,934	4.92
ility Rent (in lieu of above)	17,696	0.65	15,484	0.62	350	0.02	378	0.02	11,469	0.46
ipment Rental	6,306	0.23	8,402	0.34	5,928	0.27	3,402	0.14	6,694	0.27
urn on Owner's Equity	17,453	0.64	7,959	0.32	29,791	1.35	28,790	1.18	17,963	0.72
l Estate & Personal Property Tax	31,189	1.15	26,817	1.07	26,703	1.21	22,881	0.94	27,930	1.12
urance (Fire, Liability, etc.)	16,488	0.61	13,758	0.55	10,644	0.48	12,431	0.51	13,856	0.55
tor Vehicle Insurance	624	0.02	327	0.01	505	0.02	818	0.03	511	0.02
rkers' Compensation Ins.	77,985	2.88	60,573	2.43	53,283	2.41	66,114	2.72	65,284	2.61
min. in Training - Wages	573	0.02	418	0.02	1,265	0.06	0	0.00	628	0.03
min. in Training - Ben. and Taxes	52	0.00	101	0.00	189	0.01	0	0.00	96	0.00
oss Receipts Tax	223,040	8.23	182,040	7.29	175,263	7.91	155,133	6.38	192,044	7.69
her Capital Costs	2,074	0.08	6,266	0.25	1,562	0.07	1,999	0.08	3,403	0.14
her Capital Costs	13,842	0.51	8,797	0.35	155	0.01	856	0.04	7,844	0.31
al FIXED COSTS	713,025	26.30	567,912	22.76	479,988	21.68	486,280	20.00	589,896	23.61
ner Nursing Costs										
tient Activities Supplies	3,319	0.12	2,925	0.12	2,379	0.11	4,366	0.18	3,058	0.12
edical Records Salaries	6,624	0.24	3,004	0.12	4,520	0.20	1,871	0.08	4,478	0.18
edical Records Benefits	1,857	0.07	899	0.04	1,327	0.06	723	0.03	1,306	0.05
edical Records Supplies	506	0.02	294	0.01	903	0.04	867	0.04	554	0.02
cial Service Supplies	377	0.01	134	0.01	158	0.01	328	0.01	239	0.01
her Nursing Contracted Services	906	0.03	1,257	0.05	396	0.02	0	0.00	833	0.03
her Nursing Cost	32,542	1.20	1,665	0.07	1,198	0.05	1,377	0.06	11,988	0.48
her Nursing Cost	13,415	0.50	962	0.04	960	0.04	1,280	0.05	5,205	0.21
tal Other Nursing Costs	59,546	2.19	11,140	0.46	11,841	0.53	10,812	0.45	27,661	1.10

Allowable Costs -- Regional Averages
For Fiscal Years Ending Between 01/01/1996 and 12/31/1996

	Region 1		Region 2		Region 3		Region 4		Combined	
	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD
ıt Oper. & Maint.										
intenance Salaries and Wages	41,036	1.51	29,017	1.16	32,694	1.48	35,377	1.46	34,477	1.38
int. Employee Benefits & Taxes	12,557	0.46	8,273	0.33	10,014	0.45	9,872	0.41	10,260	0.41
intenance Equipment Rental	-50	0.00	73	0.00	0	0.00	0	0.00	8	0.00
intenance Supplies	6,290	0.23	6,437	0.26	6,615	0.30	8,426	0.35	6,601	0.26
intenance Temporary Help	4,780	0.18	3,268	0.13	489	0.02	844	0.03	2,936	0.12
pairs and Maintenance	21,351	0.79	16,351	0.66	12,983	0.59	8,875	0.37	16,628	0.67
ıter & Sewer	13,894	0.51	11,649	0.47	11,663	0.53	9,530	0.39	12,229	0.49
:ctricity	44,816	1.65	41,565	1.67	28,848	1.30	23,112	0.95	38,164	1.53
at	22,712	0.84	21,146	0.85	17,292	0.78	20,255	0.83	20,719	0.83
ow & Rubbish Removal	4,347	0.16	3,949	0.16	3,723	0.17	1,640	0.07	3,832	0.15
her Oper. & Maint. Costs	4,666	0.17	4,901	0.20	2,713	0.12	3,875	0.16	4,233	0.17
her Oper. & Maint. Costs	1,294	0.05	1,105	0.04	238	0.01	5,059	0.21	1,314	0.05
ıal Plant Oper. & Maint.	177,693	6.55	147,734	5.93	127,272	5.75	126,865	5.23	151,401	6.06
usekeeping										
ousekeeping Salaries and Wages	73,324	2.71	54,575	2.19	42,098	1.90	47,713	1.96	57,479	2.30
skpg Employee Benefits & Taxes	22,255	0.82	16,442	0.66	12,371	0.56	14,760	0.61	17,335	0.69
ousekeeping Supplies	14,342	0.53	12,962	0.52	8,963	0.40	10,677	0.44	12,318	0.49
ousekeeping Temporary Help	28	0.00	1,141	0.05	0	0.00	0	0.00	405	0.02
ther Housekeeping Costs	9,688	0.36	10,308	0.41	16,031	0.72	11,342	0.47	11,494	0.46
ther Housekeeping Costs	11	0.00	129	0.01	2	0.00	0	0.00	49	0.00
ıal Housekeeping	119,648	4.42	95,557	3.84	79,465	3.58	84,492	3.48	99,080	3.96

(10)

Allowable Costs -- Regional Averages

For Fiscal Years Ending Between 01/01/1996 and 12/31/1996

	Region 1		Region 2		Region 3		Region 4		Combined	
	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD
ndry										
ındry Salaries and Wages	37,979	1.40	33,611	1.35	20,976	0.95	29,445	1.21	31,844	1.27
ındry Employee Benefits & Taxes	11,172	0.41	9,572	0.38	6,010	0.27	9,034	0.37	9,254	0.37
ıen and Bedding	4,664	0.17	3,783	0.15	2,656	0.12	3,176	0.13	3,771	0.15
ındry Supplies	6,308	0.23	5,214	0.21	3,160	0.14	3,507	0.14	4,968	0.20
ındry Temporary Help	1,084	0.04	0	0.00	0	0.00	0	0.00	367	0.01
ıtside Laundry Service	16,100	0.59	12,018	0.48	20,501	0.93	7,996	0.33	14,989	0.60
ıer Laundry Costs	565	0.02	1,697	0.07	104	0.00	-32	0.00	800	0.03
ıer Laundry Costs	14	0.00	1,688	0.07	0	0.00	211	0.01	608	0.02
al Laundry	77,886	2.86	67,583	2.71	53,407	2.41	53,337	2.19	66,601	2.65
tary										
etary Salaries and Wages	166,981	6.16	121,588	4.87	112,186	5.07	113,119	4.65	134,077	5.37
etary Employee Benefits & Taxes	46,491	1.72	33,988	1.36	33,331	1.51	34,702	1.43	38,133	1.53
etary Supplies	15,767	0.58	11,427	0.46	10,750	0.49	13,799	0.57	12,947	0.52
etary Temporary Help	102	0.00	71	0.00	0	0.00	0	0.00	59	0.00
her Dietary Costs	3,425	0.13	6,013	0.24	3,711	0.17	1,792	0.07	4,246	0.17
her Dietary Costs	4,336	0.16	985	0.04	238	0.01	354	0.01	1,894	0.08
tal Dietary	237,102	8.75	174,072	6.97	160,216	7.25	163,766	6.73	191,356	7.67
neral Office Costs										
lary - Accountants / Bookkeeper	54,845	2.02	42,167	1.69	42,880	1.94	30,061	1.24	45,574	1.82
lary - Secretary / Receptionist	16,251	0.60	11,117	0.45	7,993	0.36	9,483	0.39	12,000	0.48
ffice Employee Benefits & Taxes	20,953	0.77	15,966	0.64	14,338	0.65	12,143	0.50	16,952	0.68
dvertising (Personnel Only)	6,023	0.22	4,136	0.17	4,687	0.21	1,377	0.06	4,662	0.19
elephone and Telegraph	10,993	0.41	11,333	0.45	9,398	0.42	4,171	0.17	10,156	0.41
ubscriptions	4,194	0.15	2,853	0.11	3,436	0.16	3,290	0.14	3,478	0.14
opier Expense	1,281	0.05	1,799	0.07	1,004	0.05	679	0.03	1,345	0.05
icense Fees	1,484	0.05	1,299	0.05	1,836	0.08	1,218	0.05	1,477	0.06
utomobile Operating Expenses	2,171	0.08	1,605	0.06	1,831	0.08	2,976	0.12	1,967	0.08
ffice Supplies	9,773	0.36	7,617	0.31	5,729	0.26	4,522	0.19	7,648	0.31
rinting	1,935	0.07	784	0.03	463	0.02	742	0.03	1,097	0.04
ostage	1,943	0.07	2,460	0.10	1,847	0.08	1,476	0.06	2,060	0.08
egal	2,985	0.11	3,391	[illegible]	2,745	0.12	3,442	0.14	[illegible] 111	0.12

Allowable Costs -- Regional Averages

For Fiscal Years Ending Between 01/01/1996 and 12/31/1996

	Region 1		Region 2		Region 3		Region 4		Combined	
	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD
her Taxes	228	0.01	120	0.00	173	0.01	797	0.03	227	0.01
avel and Seminar (In-State)	4,595	0.17	5,142	0.21	5,008	0.23	2,712	0.11	4,716	0.19
-service Training	1,792	0.07	2,134	0.09	2,530	0.11	943	0.04	2,005	0.08
ita Processing	4,671	0.17	12,486	0.50	6,624	0.30	3,118	0.13	7,690	0.31
terest - Current Indebtedness	2,309	0.09	3,100	0.12	1,139	0.05	34	0.00	2,119	0.08
ntral Office Overhead	22,807	0.84	21,135	0.85	29,798	1.35	15,106	0.62	23,157	0.93
her General Office Costs	8,553	0.32	5,230	0.21	2,412	0.11	1,314	0.05	5,372	0.22
ther General Office Costs	5,601	0.21	2,002	0.08	524	0.02	1,109	0.05	2,806	0.11
ther General Office Costs	1,547	0.06	2,621	0.11	372	0.02	1,038	0.04	1,607	0.06
ther General Office Costs	3,114	0.11	127	0.01	54	0.00	0	0.00	1,042	0.04
tal General Office Costs	190,048	7.01	160,624	6.45	146,821	6.63	101,751	4.19	162,268	6.49
lministrative Costs										
alary - Administrator	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
dmin. Employee Benefits & Taxes	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
dmin. & Mgmt. Ceiling	72,627	2.68	68,777	2.76	69,913	3.16	66,709	2.74	70,161	2.81
ccounting	2,973	0.11	0	0.00	0	0.00	0	0.00	1,007	0.04
ther Administrative Costs	0	0.00	157	0.01	0	0.00	0	0.00	54	0.00
ther Administrative Costs	0	0.00	219	0.01	0	0.00	0	0.00	76	0.00
otal Administrative Costs	75,600	2.79	69,153	2.78	69,913	3.16	66,709	2.74	71,298	2.85
on-Reimbursable Expenses										
alary - Officers	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
alary - Assistant Administrator	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
hysical Therapy (Director & Staff)	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
ther Non-Reimbursable Wages	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
on-Reimb. Empl. Bene. & Taxes	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
eligious Services	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
eauty and Barber Shop	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
ift Shop	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
niform Purchases	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
ersonal Purchases	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Advisory Dentist	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Management S[illegible]ces	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Director Fees	0	0.00	0		0	0.00	0	0.00	[illegible]	0.00

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Allowable Costs -- Regional Averages

For Fiscal Years Ending Between 01/01/1996 and 12/31/1996

	Region 1		Region 2		Region 3		Region 4		Combined	
	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD	Total Cost	Cost PPD
lization Review	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
ome Taxes	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
es	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
ıployee Agency Fees	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
ntributions	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
d Debts	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
ıt-of-State Travel	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
lvertising (Non Personnel)	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
escription Drugs	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
te Fees and Penalties	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
on-Reimbursable Interest	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
on-Reimb Gross Receipts Tax	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
her Non-Reimbursable Costs	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
tal Non-Reimbursable Expenses	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Grand Total	3,417,050	126.10	2,864,031	114.84	2,436,720	110.04	2,455,692	101.02	2,918,267	116.77

	% of Total	CPD
Salaries and Contract Nursing		57.89
Benefits		15.36
	62.73023	73.25
Admin Allowance	2.4064%	2.81
Owner's/Officer's Comp	0	0
Central Office Costs	.7964	.934
Mgt. Fees	0	0

Staffing Analysis -- Regional Averages

For Fiscal Years Ending Between 01/01/1996 and 12/31/1996

	Region 1		Region 2		Region 3		Region 4		Combined	
	Rate	Hours PPD	Rate	Hours PPD	Rate	Hours PPD	Rate	Hours PPD	Rate	Hours PP
RECT CARE										
I's	15.69	0.71	15.82	0.63	15.90	0.54	13.70	0.45	15.65	0.63
'N's	12.27	0.41	12.05	0.42	12.29	0.47	10.86	0.35	12.10	0.42
JA's	8.56	2.63	7.85	2.71	7.75	2.70	7.29	3.16	8.03	2.72
:tivities	9.78	0.14	9.01	0.13	9.12	0.14	8.25	0.14	9.25	0.14
M.T.	9.97	0.08	10.33	0.10	9.10	0.04	9.02	0.04	9.99	0.08
ard Clerks..	10.10	0.03	7.27	0.03	7.87	0.04	7.45	0.00	8.51	0.03
tal DIRECT CARE	66.37	4.00	62.33	4.02	62.03	3.93	56.57	4.14	63.53	4.02
DIRECT CARE										
.O.N.	21.12	0.08	19.12	0.08	18.56	0.09	18.60	0.08	19.65	0.08
ocial Service	13.18	0.11	12.72	0.09	12.73	0.10	11.76	0.09	12.83	0.10
tal INDIRECT CARE	34.30	0.19	31.84	0.17	31.29	0.19	30.36	0.17	32.48	0.18
OUTINE COSTS										
ledical Records	9.78	0.03	7.94	0.02	9.58	0.02	11.59	0.01	9.28	0.02
laintenance	10.31	0.15	9.59	0.12	9.98	0.15	10.48	0.14	10.03	0.14
lousekeeping	7.32	0.37	6.78	0.32	6.77	0.28	6.74	0.29	7.00	0.33
aundry	7.23	0.19	6.72	0.20	6.46	0.15	6.93	0.17	6.89	0.19
Dietary	8.05	0.77	7.24	0.69	7.37	0.69	6.93	0.69	7.55	0.72
Administrator	30.33	0.07	26.45	0.07	25.11	0.08	25.92	0.08	27.43	0.07
Controller	0.00	0.00	0.00	0.00	7.55	0.00	22.19	0.00	10.49	0.00
Acct. / Bookkeeper	11.69	0.19	11.21	0.15	11.85	0.16	11.85	0.11	11.57	0.16
Sec. / Rec.	11.68	0.06	9.19	0.05	10.82	0.04	7.44	0.05	10.28	0.05
otal ROUTINE COSTS	96.39	1.83	85.12	1.62	95.49	1.57	110.07	1.54	100.52	1.68

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Staffing Analysis -- Regional Averages

For Fiscal Years Ending Between 01/01/1996 and 12/31/1996

	Region 1		Region 2		Region 3		Region 4		Combined	
	Rate	Hours PPD	Rate	Hours PPD	Rate	Hours PPD	Rate	Hours PPD	Rate	Hours PP
IXED COSTS										
dministrator in Training	11.97	0.00	20.16	0.00	9.81	0.01	0.00	0.00	11.80	0.00
otal FIXED COSTS	11.97	0.00	20.16	0.00	9.81	0.01	0.00	0.00	11.80	0.00
Grand Total	209.03	6.02	199.45	5.81	198.62	5.70	197.00	5.85	208.33	5.88

APPENDIX N

Comparison of Reimbursable to Actual Costs, from Michael McNeil, Berry, Dunn, McNeil and Parker

Comparison of Reim... ...ble to Actual Costs

Facility	Fiscal Year Begin	Fiscal Year End	Reimb. Rate	Actual	Savings	State Days	Dollar Value of Savings
Amenity Manor	01/01/96	12/31/96	$95.05	$96.42	($1.37)	16,605	($22,749)
Aroostook Medical Center The - Health Center	01/01/96	12/31/96	$97.71	$109.67	($11.96)	15,695	($187,712)
Aroostook Medical Center The - Community General	01/01/96	12/31/96	$138.80	$164.02	($25.22)	4,673	($117,853)
Augusta Convalescent Center	01/01/96	12/31/96	$102.72	$111.99	($9.27)	17,815	($165,145)
Bangor City Nursing Facility	07/01/95	06/30/96	$119.36	$135.64	($16.28)	17,316	($281,904)
Bangor Convalescent Center	01/01/96	12/31/96	$108.46	$117.89	($9.43)	17,097	($161,225)
Barnard Nursing Home - Atlantic Rehab.	01/01/96	12/31/96	$81.94	$85.17	($3.23)	24,365	($78,699)
Barron Center	07/01/95	06/30/96	$110.69	$129.04	($18.35)	62,748	($1,151,426)
Bolster Heights Health Care	07/01/95	06/30/96	$95.06	$108.77	($13.71)	20,958	($287,334)
Borderview Manor	01/01/96	12/31/96	$115.25	$109.03	$6.22	21,989	$136,772
Brentwood Manor	01/01/96	12/31/96	$123.96	$158.64	($34.68)	13,340	($462,631)
Brewer Rehab & Living Center	01/01/96	12/31/96	$125.08	$136.92	($11.84)	22,815	($270,130)
Bridgton Hlth. Care Center	01/01/96	12/31/96	$107.82	$116.28	($8.46)	16,104	($136,240)
Camden Health Care Center	04/01/95	03/31/96	$103.61	$120.19	($16.58)	49,479	($820,362)
Caribou Nursing Home	10/01/95	09/30/96	$106.24	$103.16	$3.08	31,445	$96,851
Cedar Ridge Nursing Care Center	10/01/95	09/30/96	$128.54	$132.90	($4.36)	20,921	($91,216)
Cedars Nursing Care Center	05/01/95	04/30/96	$131.17	$144.69	($13.52)	24,645	($333,200)
Charles A. Dean Memorial Hospital	04/01/95	03/31/96	$104.54	$161.75	($57.21)	10,070	($576,105)
Clover Manor, Inc.	09/01/95	08/31/96	$109.10	$110.24	($1.14)	29,101	($33,175)
Collier's Health Care Center	01/01/96	12/31/96	$102.65	$105.91	($3.26)	10,706	($34,902)
Colonial Acres Nursing Home	01/01/96	12/31/96	$82.99	$85.55	($2.56)	18,975	($48,576)
Country Manor Nursing Home	01/01/96	12/31/96	$101.35	$94.90	$6.45	10,021	$64,635
Courtland Living Center	01/01/96	12/31/96	$107.63	$108.40	($0.77)	21,223	($16,342)
Cove's Edge	05/01/95	04/30/96	$145.93	$163.09	($17.16)	12,925	($221,793)
Dexter Nursing Home	01/01/96	12/31/96	$88.50	$97.80	($9.30)	15,839	($147,303)
Dionne Commons	01/01/96	12/31/96	$89.40	$92.06	($2.66)	21,747	($57,847)
Dixfield Health Care Center	01/01/96	12/31/96	$98.36	$114.94	($16.58)	9,889	($163,960)
Eastport Memorial Nursing Home	01/01/96	12/31/96	$97.02	$97.80	($0.78)	8,205	($6,400)
Edgewood Manor	01/01/96	12/31/96	$103.46	$110.33	($6.87)	14,461	($99,347)
Evergreen Manor	01/01/96	12/31/96	$97.77	$109.71	($11.94)	9,087	($108,499)
Falmouth By The Sea	01/01/96	12/31/96	$107.23	$127.04	($19.81)	11,247	($222,803)
Fieldcrest manor Nursing Home	01/01/96	12/31/96	$102.50	$111.28	($8.78)	15,666	($137,547)
Forest Hill Manor	10/01/95	09/30/96	$103.11	$102.63	$0.48	15,656	$7,515
Freeport Nursing Home	01/01/96	12/31/96	$110.34	$112.09	($1.75)	15,330	($26,827)
Gardiner Nursing Home	01/01/96	12/31/96	$87.96	$85.45	$2.51	17,794	$44,663
Gorham House	10/1/95	9/30/96	$140.76	$145.89	($5.13)	9,847	($50,515)
Gorham Manor	10/1/95	9/30/96	$129.16	$159.32	($30.16)	5,798	($174,868)
Greenwood Center	07/01/95	06/30/96	$120.50	$125.78	($5.28)	26,027	($137,423)
Harbor Home	01/01/96	12/31/96	$107.56	$111.00	($3.44)	13,882	($47,754)

from Mike McNeil

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Comparison of Rein. [illegible]ble to Actual Costs

Facility	Fiscal Year Begin	Fiscal Year End	Reimb. Rate	Actual	Total Savings	State Days	Dollar Value of Savings
Hawthorne House	01/01/96	12/31/96	$93.41	$99.25	($5.84)	20,121	($117,507)
Heritage Manor	01/01/96	12/31/96	$95.79	$109.51	($13.72)	13,062	($179,211)
Hibbard Nursing Home	10/01/95	09/30/96	$88.74	$94.09	($5.35)	23,237	($124,318)
High View Manor	01/01/96	12/31/96	$87.54	$86.84	$0.70	22,783	$15,948
Hillcrest Manor Division	06/01/95	05/31/96	$97.53	$114.04	($16.51)	23,055	($380,638)
Homestead, Inc.	10/01/95	09/30/96	$104.72	$110.94	($6.22)	13,385	($83,255)
Houlton Regional Hospital	10/01/95	09/30/96	$187.71	$253.92	($66.21)	3,687	($244,116)
Island Nursing Home	07/01/95	06/30/96	$108.43	$130.10	($21.67)	11,757	($254,774)
Jackman Region Health Center	04/01/95	03/31/96	$105.37	$153.96	($48.59)	5,178	($251,599)
Katahdin Nursing Home	07/01/95	06/30/96	$99.75	$98.81	$0.94	16,120	$15,153
Ken. Long Term Care G.Birch	07/01/95	06/30/96	$99.59	$106.91	($7.32)	28,747	($210,428)
Kennebec Long Term Care	07/01/95	06/30/96	$94.61	$101.03	($6.42)	29,580	($189,904)
Kennebunk Nursing Home	01/01/96	12/31/96	$121.55	$133.13	($11.58)	9,014	($104,382)
Knox Center for Long Term Care	04/01/95	03/31/96	$100.92	$123.38	($22.46)	15,809	($355,070)
Ledgeview Nursing Home	07/01/95	06/30/96	$98.21	$98.44	($0.23)	33,491	($7,703)
Ledgewood Manor	01/01/96	12/31/96	$95.48	$102.75	($7.27)	17,060	($124,026)
Madigan Estates	07/01/95	06/30/96	$94.24	$88.53	$5.71	22,855	$130,502
Madigan Estates	07/01/96	12/31/96	$90.39	$90.23	$0.16	11,936	$1,910
Maine Stay Nursing Home	01/01/96	12/31/96	$110.23	$132.78	($22.55)	8,158	($183,963)
Maine Vet. Home - Bangor	10/03/95	06/30/96	$130.86	$170.66	($39.80)	4,803	($191,159)
Maine Vet. Home - So. Paris	07/26/95	06/30/96	$140.61	$217.97	($77.36)	5,351	($413,953)
Maine Veterans Home - Augusta	07/01/95	06/30/96	$108.55	$121.35	($12.80)	25,160	($322,048)
Maine Veterans Home-Caribou	07/01/95	06/30/96	$113.68	$128.40	($14.72)	12,388	($182,351)
Maine Veterans Home-Scar.	07/01/95	06/30/96	$115.52	$128.21	($12.69)	29,739	($377,388)
Maplecrest Living Center	01/01/96	12/31/96	$104.18	$107.61	($3.43)	13,753	($47,173)
Market Square Health Center	01/01/96	12/31/96	$111.70	$111.59	$0.11	29,597	$3,256
Marshall's Health Care Facility	10/01/95	09/30/96	$86.33	$88.41	($2.08)	18,930	($39,374)
Mercy Home	07/01/95	06/30/96	$103.76	$118.99	($15.23)	17,384	($264,758)
Mere Point Nursing Home	10/01/95	09/30/96	$107.54	$114.91	($7.37)	5,993	($44,168)
Merrill Memorial Manor	01/01/96	12/31/96	$107.31	$105.90	$1.41	12,641	$17,824
Montello Manor	01/01/96	12/31/96	$114.05	$112.81	$1.24	26,818	$33,254
Mountain Heights Health Care Facility	01/01/96	12/31/96	$102.30	$114.12	($11.82)	5,651	($66,795)
Narraguagus Bay Health Care Facility	01/01/96	12/31/96	$115.91	$126.96	($11.05)	17,598	($194,458)
Nicholson's Nursing Home	07/01/95	06/30/96	$82.60	$88.32	($5.72)	10,635	($60,832)
Norway Convalescent Center	01/01/96	12/31/96	$100.32	$120.53	($20.21)	11,430	($231,000)
Oceanview Nursing Home	01/01/96	12/31/96	$105.59	$106.24	($0.65)	12,730	($8,275)
Odd Fellow's Home of Maine	07/01/95	06/30/96	$113.79	$119.47	($5.68)	8,013	($45,514)
Orchard Park Living Center	01/01/96	12/31/96	$110.49	$118.32	($7.83)	10,239	($80,171)
[illegible] Nursing Home, Inc.	01/01/96	12/31/96	$99.71	$103.05	($3.34)	23,101	($77,157)

Comparison of Reimbu[illegible] to Actual Costs

Facility	Fiscal Year Begin	Fiscal Year End	Total Reimb. Rate	Actual	Savings	State Days	Dollar Value of Savings
Penobscot Nursing Home	01/01/96	12/31/96	$95.29	$95.54	($0.25)	17,797	($4,449)
Pine Point Nursing Care Center	10/01/95	09/30/96	$121.21	$139.11	($17.90)	15,367	($275,069)
Presque Isle Nursing Home	10/01/95	09/30/96	$103.78	$104.07	($0.29)	26,887	($7,797)
Promenade Health Care Facility	07/01/95	06/17/96	$111.67	$120.58	($8.91)	7,817	($69,649)
Riverwood Health Care Center - Renaissance	01/01/96	12/31/96	$93.84	$99.04	($5.20)	19,063	($99,128)
Robinson's Hlth. Care Facility	01/01/96	12/31/96	$82.62	$83.66	($1.04)	15,271	($15,882)
Ross Manor	01/01/96	12/31/96	$122.20	$157.50	($35.30)	14,062	($496,389)
Rumford Community Home	07/01/95	06/30/96	$103.30	$105.49	($2.19)	24,965	($54,673)
Russell Park Manor	08/01/95	07/31/96	$100.29	$105.96	($5.67)	27,886	($158,114)
Sanfield Living Center	01/01/96	12/31/96	$103.15	$106.52	($3.37)	12,669	($42,695)
Sanford Health Care Facility	01/01/96	12/31/96	$121.32	$143.24	($21.92)	7,747	($169,814)
Seaside Nursing and Ret. Home	01/01/96	12/31/96	$116.31	$143.78	($27.47)	17,860	($490,614)
Sebasticook Valley Health Care facility	01/01/96	12/31/96	$89.82	$90.80	($0.98)	17,883	($17,525)
Schooner Retirement - Seville Park Plaza	01/01/96	12/31/96	$117.23	$124.64	($7.41)	5,390	($39,940)
Shore Village Nursing Center	01/01/96	12/31/96	$99.06	$107.97	($8.91)	9,309	($82,943)
So. Portland Nursing Home	01/01/96	12/31/96	$105.02	$115.28	($10.26)	17,007	($174,492)
Somerset Manor	01/01/96	12/31/96	$104.88	$112.08	($7.20)	8,637	($62,186)
Sonogee Estates	01/01/96	12/31/96	$114.59	$120.84	($6.25)	19,098	($119,363)
Southridge Living Center	01/01/96	12/31/96	$101.50	$104.32	($2.82)	30,489	($85,979)
St. Andre Health Care Facility	12/01/95	11/30/96	$105.42	$110.66	($5.24)	25,093	($131,487)
St. Joseph Nursing Home	01/01/96	12/31/96	$104.38	$103.29	$1.09	13,782	$15,022
St. Joseph's Manor	07/01/95	06/30/96	$114.37	$119.85	($5.48)	50,165	($274,904)
St. Marguerite D'Youville Pav.	01/01/96	12/31/96	$112.19	$129.33	($17.14)	70,207	($1,203,348)
Stillwater Health Care	01/01/96	12/31/96	$101.56	$100.53	$1.03	17,181	$17,696
Summit House Health Care Ctr.	01/01/96	12/31/96	$98.74	$97.29	$1.45	11,808	$17,122
Sunrise Residential Care Facility	01/01/96	12/31/96	$109.74	$107.54	$2.20	9,619	$21,162
Tallpines Health Care Facility	01/01/96	12/31/96	$114.47	$122.72	($8.25)	15,615	($128,824)
Trull Nursing Home	07/01/95	06/30/96	$85.35	$89.42	($4.07)	12,048	($49,035)
Varney Crossing Nursing Care Center	07/01/95	06/30/96	$111.40	$111.96	($0.56)	17,205	($9,635)
Victorian Villa Nursing Home	01/01/96	12/31/96	$98.51	$99.22	($0.71)	16,345	($11,605)
Viking ICF The	11/01/95	10/31/96	$101.37	$108.56	($7.19)	11,017	($79,212)
Westgate Manor	01/01/96	12/31/96	$106.89	$102.20	$4.69	23,169	$108,663
Winship Green Nursing Center	01/01/96	12/31/96	$122.67	$133.53	($10.86)	12,087	($131,265)
Woodlawn Nursing Home	01/01/96	12/31/96	$103.47	$111.78	($8.31)	11,332	($94,169)
Total							($16,169,517.00)

APPENDIX O

Total Costs Schedule A versus G, from John Bouchard, Department of Human Services, Division of Audit

counter	# of Beds	Facility	Fiscal Year Begin	Fiscal Year End	Reimb. Rate	Actual	Total Gain/ (Loss)	State Days	Dollar Value of Gain/(Loss)
1	69	Amenity Manor	01/01/97	12/31/97	$96.05	$96.10	($0.05)	15,449	($772)
2	70	Aroostook Medical Center The - Health Center	01/01/97	12/31/97	$107.62	$117.27	($9.65)	15,433	($148,928)
3	26	Aroostook Medical Center The - Community General	01/01/97	05/14/97	$137.46	$189.89	($52.43)	1,494	($78,330)
4	99	Atlantic Rehab - Barnard	01/01/97	12/31/97	$79.42	$86.69	($7.27)	21,440	($155,869)
5	48	Auburn Nursing Home	01/01/97	12/31/97	$97.84	$99.53	($1.69)	13,757	($23,249)
6	78	Augusta Rehab. Center (Augusta CC)	01/01/97	12/31/97	$97.24	$113.09	($15.85)	17,929	($284,175)
7	61	Bangor City Nursing Facility	07/01/96	06/30/97	$117.53	$142.38	($24.85)	15,910	($395,364)
8	235	Barron Center	07/01/96	06/30/97	$108.97	$116.70	($7.73)	63,011	($487,075)
9	30	Birch Grove Nursing Care Center	01/01/97	12/31/97	$101.83	$105.60	($3.77)	7,169	($27,027)
10	94	Bolster Heights Health Care	07/01/96	06/30/97	$94.61	$127.01	($32.40)	19,447	($630,083)
11	71	Borderview Manor	01/01/97	12/31/97	$115.53	$111.55	$3.98	20,002	$79,608
12	83	Brentwood Manor	01/01/97	12/31/97	$117.95	$148.25	($30.30)	12,435	($376,781)
13	114	Brewer Rehab & Living Center	01/01/97	12/31/97	$115.12	$121.12	($6.00)	20,718	($124,308)
14	75	Bridgton Hlth. Care Center	01/01/97	12/31/97	$115.88	$120.98	($5.10)	14,041	($71,609)
15	8	Calais Regional Hospital	01/01/97	12/31/97	$189.82	$449.60	($259.78)	1,457	($378,499)
16	165	Camden Health Care Center	04/01/96	03/31/97	$111.94	$129.55	($17.61)	37,271	($656,342)
17	105	Caribou Nursing Home	10/01/96	09/30/97	$104.68	$103.06	$1.62	31,265	$50,649
18	75	Cedar Ridge Nursing Care Center	10/01/96	09/30/97	$123.26	$130.07	($6.81)	20,192	($137,508)
19	75	Cedar Ridge Nursing Care Center	10/01/97	12/31/97	$123.54	$127.91	($4.37)	4,657	($20,351)
20	202	Cedars Nursing Care Center	05/01/96	04/30/97	$126.45	$140.73	($14.28)	23,941	($341,877)
21	36	Charles A. Dean Memorial Hospital	04/01/96	03/31/97	$110.93	$135.79	($24.86)	9,610	($238,905)
22	36	Charles A. Dean Memorial Hospital	04/01/97	06/30/97	$112.52	$147.01	($34.49)	2,196	($75,740)
23	42	Clover Manor, Inc.	09/01/96	08/31/97	$108.53	$107.82	$0.71	25,446	$18,067
24	110	Clover Manor, Inc.	09/01/97	12/31/97	$103.79	$95.32	$8.47	8,421	$71,326
25	34	Coastal Manor	01/01/97	12/31/97	$79.61	$84.00	($4.39)	11,846	($52,004)
26	44	Collier's Health Care Center	01/01/97	12/31/97	$99.41	$104.59	($5.18)	9,875	($51,153)
27	80	Colonial Acres Nursing Home	01/01/97	12/31/97	$77.39	$76.78	$0.61	20,787	$12,680
28	54	Country Manor Nursing Home	01/01/97	12/31/97	$96.38	$88.97	$7.41	8,687	$64,371
29	80	Courtland Living Center	01/01/97	12/31/97	$103.62	$109.31	($5.69)	18,613	($105,908)
30	70	Cove's Edge	05/01/96	04/30/97	$134.44	$150.24	($15.80)	12,317	($194,609)
31	44	Cummings Health Care Facility	01/01/97	12/31/97	$90.96	$91.21	($0.25)	12,439	($3,110)
32	66	Dexter Nursing Home	01/01/97	12/31/97	$85.10	$90.15	($5.05)	16,733	($84,502)

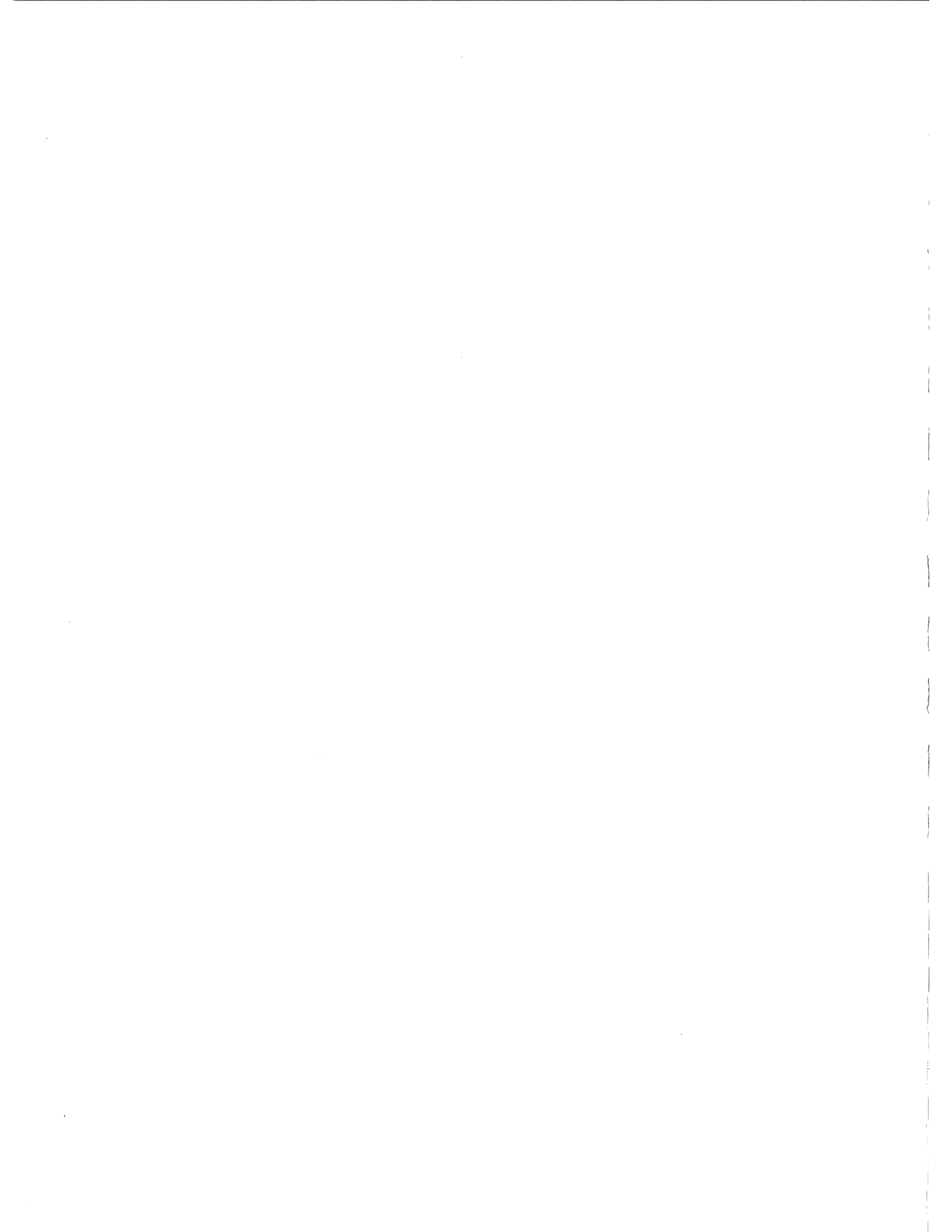
from John Breahard DHS. (unaudited)

counter	# of Beds	Facility	Fiscal Year Begin	Fiscal Year End	Reimb. Rate	Actual	Total Gain/ (Loss)	State Days	Dollar Value of Gain/(Loss)
33	82	Dionne Commons	01/01/97	12/31/97	$86.25	$87.63	($1.38)	20,616	($28,450)
34	55	Dixfield Health Care Center	01/01/97	12/31/97	$96.31	$129.62	($33.31)	7,850	($261,484)
35	15	Eastern Maine Medical Center - Ross Division SNF	09/29/96	09/27/97	$161.91	$290.62	($128.71)	627	($80,701)
36	26	Eastport Memorial Nursing Home	01/01/97	12/31/97	$92.22	$94.65	($2.43)	8,468	($20,577)
37	78	Eastside Rehab & LC (Bangor CC)	01/01/97	12/31/97	$107.17	$121.09	($13.92)	15,293	($212,879)
38	58	Edgewood Manor	01/01/97	12/31/97	$99.35	$100.30	($0.95)	14,350	($13,632)
39	42	Evergreen Manor	01/01/97	12/31/97	$95.72	$107.80	($12.08)	8,910	($107,633)
40	75	Falmouth By The Sea	01/01/97	12/31/97	$99.85	$125.27	($25.42)	9,762	($248,150)
41	70	Fieldcrest manor Nursing Home	01/01/97	12/31/97	$94.90	$105.94	($11.04)	12,908	($142,504)
42	45	Forest Hill Manor	10/01/96	09/30/97	$102.67	$102.14	$0.53	15,000	$7,950
43	65	Freeport Nursing Home	01/01/97	12/31/97	$108.75	$123.10	($14.35)	14,209	($203,899)
44	82	Fryeburg Health Care Center	01/01/97	12/31/97	$98.64	$97.44	$1.20	14,602	$17,522
45	60	Gardiner Nursing Home	01/01/97	12/31/97	$87.36	$86.05	$1.31	18,201	$23,843
46	50	Gorham House	10/01/96	09/30/97	$133.32	$138.55	($5.23)	9,192	($48,074)
47	17	Gorham Manor	10/01/96	09/30/97	$118.08	$134.57	($16.49)	5,677	($93,614)
48	96	Greenwood Center	07/01/96	06/30/97	$115.37	$115.68	($0.31)	26,181	($8,116)
49	40	Harbor Hill	01/01/97	12/31/97	$134.30	$142.45	($8.15)	11,195	($91,239)
50	65	Harbor Home	01/01/97	12/31/97	$94.56	$95.77	($1.21)	13,786	($16,681)
51	100	Hawthorne House	01/01/97	12/31/97	$91.28	$98.20	($6.92)	20,823	($144,095)
52	61	Heritage Manor	01/01/97	12/31/97	$93.14	$102.50	($9.36)	10,425	($97,578)
53	102	Hibbard Nursing Home	10/01/96	09/30/97	$91.12	$98.02	($6.90)	21,918	($151,234)
54	51	High View Manor	01/01/97	12/31/97	$86.31	$84.46	$1.85	20,790	$38,462
55	57	Homestead, Inc.	10/01/96	09/30/97	$98.28	$101.84	($3.56)	14,624	($52,061)
56	28	Houlton Regional Hospital	10/01/96	09/30/97	$157.58	$186.77	($29.19)	4,298	($125,459)
57	66	Island Nursing Home	07/01/96	06/30/97	$112.76	$118.08	($5.32)	7,199	($38,299)
58	18	Jackman Region Health Center	04/01/96	03/31/97	$103.35	$136.52	($33.17)	5,103	($169,267)
59	0	Jackman Region Health Center	04/01/97	06/30/97	$98.83	$145.00	($46.17)	1,061	($48,986)
60	50	Katahdin Nursing Home	07/01/96	06/30/97	$109.75	$107.87	$1.88	14,103	$26,514
61	120	Ken. Long Term Care G.Birch	07/01/96	06/30/97	$100.94	$112.84	($11.90)	21,218	($252,494)
62	125	Kennebec Long Term Care - Glenridge	07/01/96	06/30/97	$96.00	$106.62	($10.62)	30,604	($325,014)
63	29	Kennebec Valley Medical Center Gardiner	07/01/96	06/30/97	$190.10	$427.53	($237.43)	644	($152,905)
64	80	Kennebunk Nursing Home	01/01/97	12/31/97	$112.37	$119.87	($7.50)	7,383	($55,373)

			Fiscal Year				Total		
	# of				Reimb.	Actual	Gain/	State	Dollar Value
ounter	Beds	Facility	Begin	End	Rate		(Loss)	Days	of Gain/(Loss)
65	57	Knox Center for Long Term Care	04/01/96	03/31/97	$98.09	$122.21	($24.12)	16,230	($391,468)
66	76	Lakewood Manor Nursing Home	01/01/97	12/31/97	$93.73	$94.86	($1.13)	15,608	($17,637)
67	125	Ledgeview Nursing Home	07/01/96	06/30/97	$99.21	$99.06	$0.15	27,825	$4,174
68	60	Ledgewood Manor	01/01/97	12/31/97	$91.39	$92.38	($0.99)	16,637	($16,471)
69	87	Madigan Estates	01/01/97	12/31/97	$86.16	$87.02	($0.86)	22,625	($19,458)
70	35	Maine Stay Nursing Home	01/01/97	12/31/97	$113.55	$131.35	($17.80)	8,152	($145,106)
71	120	Maine Veterans Home - Augusta	07/01/96	06/30/97	$109.03	$124.45	($15.42)	20,391	($314,429)
72	80	Maine Vet. Home - Bangor	07/01/96	06/30/97	$140.92	$151.11	($10.19)	19,977	($203,566)
73	40	Maine Veterans Home-Caribou	07/01/96	06/30/97	$112.35	$121.18	($8.83)	13,030	($115,055)
74	120	Maine Veterans Home-Scar.	07/01/96	06/30/97	$114.56	$117.27	($2.71)	31,392	($85,072)
75	30	Maine Vet. Home - So. Paris	07/01/96	06/30/97	$141.89	$162.94	($21.05)	11,901	($250,516)
76	58	Maplecrest Living Center	01/01/97	12/31/97	$97.24	$101.57	($4.33)	13,318	($57,667)
77	114	Market Square Health Center	01/01/97	12/31/97	$112.19	$114.81	($2.62)	26,336	($69,000)
78	66	Marshall's Health Care Facility	10/01/96	09/30/97	$87.15	$88.58	($1.43)	17,459	($24,966)
79	120	Marshwood Nursing Care Center	01/01/97	12/31/97	$117.41	$128.28	($10.87)	27,793	($302,110)
80	60	Mercy Home	05/01/97	06/30/97	$113.48	$109.20	$4.28	2,241	$9,591
81	26	Mere Point Nursing Home	10/01/96	09/30/97	$102.85	$110.54	($7.69)	5,288	($40,665)
82	16	Mid-Coast Hospital Bruns. Div.	10/01/96	09/30/97	$234.93	$303.03	($68.10)	776	($52,846)
83	121	Montello Manor	01/01/97	12/31/97	$118.11	$119.13	($1.02)	24,957	($25,456)
84	25	Mountain Heights Health Care Facility	01/01/97	12/31/97	$104.40	$132.31	($27.91)	5,756	($160,650)
85	88	Mt. St. Joseph Nursing Home	01/01/97	12/31/97	$131.60	$135.94	($4.34)	24,642	($106,946)
86	66	Narraguagus Bay Health Care Facility	01/01/97	12/31/97	$108.47	$126.08	($17.61)	15,844	($279,013)
87	74	Newton Center - Hillcrest Manor	06/01/96	05/31/97	$103.12	$128.35	($25.23)	15,558	($392,528)
88	46	Nicholson's Nursing Home	07/01/96	06/30/97	$78.83	$80.63	($1.80)	10,259	($18,466)
89	73	Norway Convalescent Center	01/01/97	12/31/97	$102.17	$115.71	($13.54)	9,291	($125,800)
90	82	Oak Grove Nursing Care Ctr.	01/01/97	12/31/97	$107.15	$116.42	($9.27)	18,860	($174,832)
91	50	Oceanview Nursing Home	01/01/97	12/31/97	$100.24	$99.72	$0.52	10,971	$5,705
92	26	Odd Fellow's Home of Maine	07/01/96	06/30/97	$108.35	$115.88	($7.53)	7,271	($54,751)
93	38	Orchard Park Living Center	01/01/97	12/31/97	$106.34	$107.58	($1.24)	9,982	($12,378)
94	109	Orono Nursing Home, Inc.	01/01/97	09/24/97	$94.20	$93.67	$0.53	16,533	$8,762
95	103	Orono Nursing Home, Inc.	09/25/97	12/31/97	$101.90	$108.72	($6.82)	5,341	($36,426)
96	60	Parkview Nursing Home	01/01/97	12/31/97	$101.56	$98.44	$3.12	10,272	$32,049

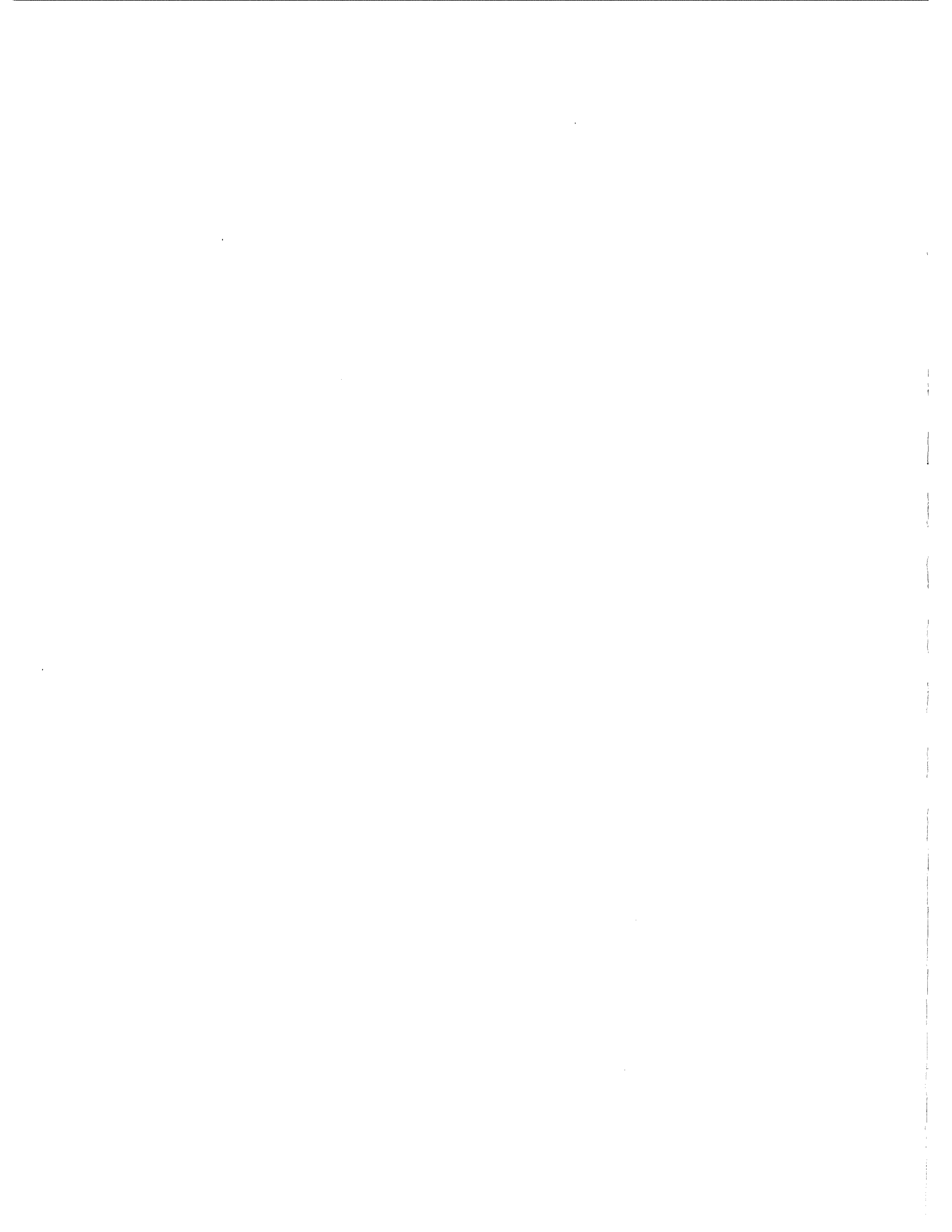
ounter	# of Beds	Facility	Fiscal Year Begin	End	Reimb. Rate	Actual	Total Gain/ (Loss)	State Days	Dollar Value of Gain/(Loss)
97	98	Penobscot Nursing Home	01/01/97	12/31/97	$95.23	$94.63	$0.60	13,354	$8,012
98	9	Penobscot Valley Hospital	01/01/97	12/31/97	$198.63	$277.68	($79.05)	493	($38,972)
99	77	Pine Point Nursing Care Center	10/01/96	09/30/97	$124.86	$139.47	($14.61)	11,861	($173,289)
100	0	Pine Point Nursing Care Center	10/01/97	12/31/97	$120.78	$128.28	($7.50)	3,043	($22,823)
101	95	Pleasant Hill Health Facility	01/01/97	12/31/97	$88.18	$78.51	$9.67	11,936	$115,421
102	87	Presque Isle Nursing Home	10/01/96	09/30/97	$102.32	$102.62	($0.30)	26,568	($7,970)
103	64	Riverridge	01/01/97	12/31/97	$131.63	$163.25	($31.62)	8,295	($262,288)
104	66	Riverwood Health Care Center - Renaissance	01/01/97	12/31/97	$91.37	$94.97	($3.60)	18,631	($67,072)
105	50	Robinson's Hlth. Care Facility	01/01/97	12/31/97	$77.06	$78.66	($1.60)	14,252	($22,803)
106	65	Ross Manor	01/01/97	12/31/97	$116.19	$114.56	$1.63	11,897	$19,392
107	97	Rumford Community Home	07/01/96	06/30/97	$103.55	$107.69	($4.14)	21,828	($90,368)
108	120	Russell Park Manor	08/01/96	07/31/97	$98.15	$97.39	$0.76	26,232	$19,936
109	95	Sandy River Nursing Care Ctr.	01/01/97	12/31/97	$91.00	$103.75	($12.75)	19,234	($245,234)
110	47	Sanfield Living Center	01/01/97	12/31/97	$98.64	$104.72	($6.08)	11,169	($67,908)
111	34	Sanford Health Care Facility	01/01/97	12/31/97	$115.15	$130.63	($15.48)	7,800	($120,744)
112	122	Seaside Nursing and Ret. Home	01/01/97	10/31/97	$110.58	$134.37	($23.79)	14,121	($335,939)
113	122	Seaside Nursing and Ret. Home	11/01/97	12/31/97	$108.09	$130.16	($22.07)	2,812	($62,061)
114	69	Sebasticook Valley Health Care facility	01/01/97	12/31/97	$88.78	$88.06	$0.72	16,108	$11,598
115	67	Sedgewood Commons	01/01/97	12/31/97	$135.47	$147.75	($12.28)	15,897	($195,215)
116	37	Schooner Retirement - Seville Park Plaza	01/01/97	12/31/97	$111.64	$130.01	($18.37)	5,796	($106,473)
117	61	Shore Village Nursing Center	01/01/97	12/31/97	$93.09	$110.77	($17.68)	7,828	($138,399)
118	73	So. Portland Nursing Home	01/01/97	12/31/97	$106.44	$109.57	($3.13)	17,180	($53,773)
119	34	Somerset Manor	01/01/97	12/31/97	$99.01	$104.25	($5.24)	7,820	($40,977)
120	83	Sonogee Estates	01/01/97	12/31/97	$109.86	$121.10	($11.24)	15,568	($174,984)
121	122	Southridge Living Center	01/01/97	12/31/97	$95.48	$101.74	($6.26)	32,105	($200,977)
122	126	Springbrook Nursing Care Center	01/01/97	12/31/97	$116.83	$120.21	($3.38)	26,958	($91,118)
123	96	St. Andre Health Care Facility	12/01/96	11/30/97	$102.76	$111.71	($8.95)	25,828	($231,161)
124	30	St. Andrews Hospital	10/01/96	09/30/97	$131.43	$127.43	$4.00	8,117	$32,468
125	41	St. Joseph Nursing Home	01/01/97	12/31/97	$104.30	$104.93	($0.63)	14,334	($9,030)
126	200	St. Joseph's Manor	07/01/96	06/30/97	$114.58	$121.88	($7.30)	44,749	($326,668)
127	288	St. Marguerite D'Youville Pav.	01/01/97	12/31/97	$108.21	$131.74	($23.53)	72,003	($1,694,231)
128	67	Stillwater Health Care	01/01/97	12/31/97	$96.02	$95.98	$0.04	14,959	$598

...unter	# of Beds	Facility	Fiscal Year Begin	End	Reimb. Rate	Actual	Total Gain/ (Loss)	State Days	Dollar Value of Gain/(Loss)
129	80	Summit House Health Care Ctr.	01/01/97	12/31/97	$97.89	$100.77	($2.88)	11,524	($33,189)
130	28	Sunrise Residential Care Facility	01/01/97	12/31/97	$103.74	$111.94	($8.20)	8,788	($72,062)
131	70	Tallpines Health Care Facility	01/01/97	12/31/97	$110.96	$111.40	($0.44)	15,882	($6,988)
132	49	Trull Nursing Home	07/01/96	06/30/97	$81.73	$90.99	($9.26)	10,144	($93,933)
133	64	Varney Crossing Nursing Care Center	07/01/96	06/30/97	$108.71	$109.13	($0.42)	16,617	($6,979)
134	56	Victorian Villa Nursing Home	01/01/97	12/31/97	$98.85	$97.49	$1.36	14,702	$19,995
135	60	Viking ICF The	11/01/96	10/31/97	$96.98	$109.13	($12.15)	10,034	($121,913)
136	118	Westgate Manor	01/01/97	12/31/97	$106.35	$101.65	$4.70	21,190	$99,593
137	79	Willows Nursing Care Center The	01/01/97	12/31/97	$108.01	$114.55	($6.54)	19,462	($127,281)
138	72	Winship Green Nursing Center	01/01/97	12/31/97	$110.62	$114.96	($4.34)	13,839	($60,061)
139	32	Winward Gardens	01/01/97	12/31/97	$137.01	$167.01	($30.00)	5,189	($155,670)
140	154	Woodford Park Nursing Care	10/01/96	09/30/97	$122.51	$133.74	($11.23)	31,488	($353,610)
141	50	Woodlawn Nursing Home	01/01/97	12/31/97	$100.27	$106.10	($5.83)	10,709	($62,433)
142	13	York Hospital	07/01/96	06/30/97	$188.33	$429.34	($241.01)	60	($14,461)
									($16,918,525)



APPENDIX P

Maine Health and Higher Educational Facilities Authority, Not for Profit Nursing Homes Outstanding Balances and Locations



TAXABLE RESERVE FUND RESOLUTION

OUTSTANDING BALANCES AND LOCATION

INSTITUTION AND CLASSIFICATION		ORIGINAL LOAN BAL.	LOAN BAL. OUTSTANDING	LOCATION
SEDGEWOOD COMMONS	TNH	8,266,510	7,171,510	FALMOUTH
CEDAR RIDGE NURSING CARE CENTER	TNH	4,111,591	3,436,591	SKOWHEGAN
FALLBROOK WOODS	TBH	2,751,569	2,296,569	FALMOUTH
FREEPORT NURSING HOME	TNH	2,278,713	1,843,713	FREEPORT
THE WILLOWS NURSING HOME	TNH	1,490,621	1,245,621	WATERVILLE
BIRCH GROVE NURSING CARE CENTER	TNH	409,808	349,808	PITTSFIELD
OAK GROVE NURSING CARE CENTER	TNH	1,387,043	1,162,043	WATERVILLE
PINE POINT NURSING CARE CENTER	TNH	4,129,605	3,449,605	SCARBOROUGH
RIVERRIDGE	TNH	6,741,569	5,636,569	KENNEBUNK
SANDY RIVER NURSING CARE CENTER	TNH	2,846,140	2,381,140	FARMINGTON
SEBASTICOOK VALLEY NURSING HOME	TNH	1,121,343	821,343	PITTSFIELD
SPRINGBROOK NURSING CARE CENTER	TNH	7,493,634	6,258,634	WESTBROOK
VARNEY CROSSING NURSING CARE CE	TNH	2,161,625	1,811,625	NORTH BERWICK
WINDWARD GARDENS	TNH	6,529,910	5,614,910	CAMDEN
WOODFORD PARK NURSING CARE CEN	TNH	7,998,014	6,688,014	PORTLAND
DOLLEY FARM RETIREMENT HOME	TBH	1,980,000	1,675,000	WESTBROOK
F.C.R., INC.	TBH	1,317,568	867,568	VARIOUS
HIGH VIEW MANOR	TNH	1,478,616	1,198,616	MADAWASKA
PARKVIEW NURSING HOME	TNH	1,686,792	1,421,792	LIVERMORE FALLS
REDDING HOMES, INC.	TNH	1,698,768	1,278,768	CANTON
COUNTRY MANOR NURSING HOME	TNH	1,973,632	1,563,632	COOPERS MILLS
PLEASANT HILL NURSING HOME	TNH	1,039,744	684,744	PITTSFIELD
ROBINSON HEALTH CARE FACILITY	TNH	1,354,744	1,114,744	GARDINER
RUSSELL PARK MANOR	TNH	2,898,680	2,453,680	LEWISTON
THE VIKING	TNH	6,261,616	5,036,616	CAPE ELIZABETH
TALL PINES MANOR, INC.	TNH	3,346,836	3,051,836	BELFAST
HARBOR HILL	TNH	8,180,522	7,730,522	BELFAST

MAINE H[illegible]LTH AND HIGHER EDUCATIONAL FACILITIES AUTHORI[illegible]

TAXABLE RESERVE FUND RESOLUTION

OUTSTANDING BALANCES AND LOCATION

INSTITUTION AND CLASSIFICATION		ORIGINAL LOAN BAL.	LOAN BAL. OUTSTANDING	LOCATION
FALMOUTH CONVALESCENT CENTER	TNH	5,448,334	5,098,334	FALMOUTH
FREEPORT CONVALESCENT CENTER	TNH	3,037,852	2,842,852	FREEPORT
MARSHWOOD NURSING CARE CENTER	TNH	6,398,271	6,018,271	LEWISTON
TOTALS		107,819,670	92,204,670	

TAXABLE NURSING HOME
TAXABLE BOARDING HOME

APPENDIX Q

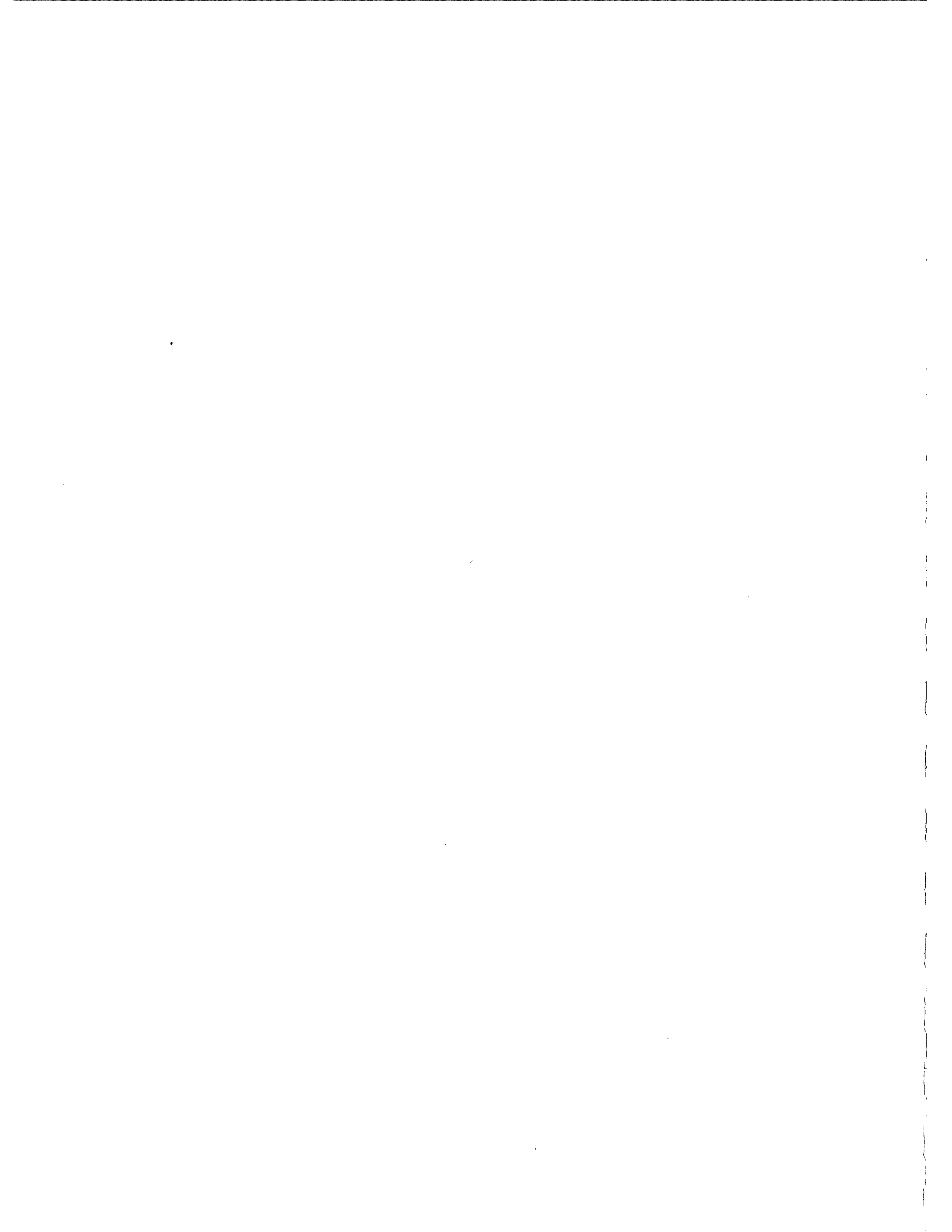
Maine Health and Higher Educational Facilities Authority, Not for Profit Nursing Homes Outstanding Balances and Locations

MAINE [illegible]LTH AND HIGHER EDUCATIONAL FACILITIES AUT[illegible]RITY

NOT FOR PROFIT NURSING HOMES OUTSTANDING BALANCES AND LOCATIONS

18-Aug-98

INSTITUTION NAME	ORIGINAL LOAN BAL.	LOAN BAL. OUTSTANDING	HOSPITAL AFFILIATION	LOCATION
COVE'S EDGE NURSING FACILITY	5,270,331	4,715,331	MILES	DAMARISCOTTA
MT. ST. JOSEPH NURSING HOME	11,137,137	10,242,137		WATERVILLE
KENNEBEC LONG TERM CARE	9,817,810	8,452,810	MGMC	AUGUSTA
CEDAR'S NURSING CARE CENTER	6,254,238	5,704,238		PORTLAND
D'YOUVILLE PAVILLION	9,750,000	9,215,000	ST. MARY'S	LEWISTON
LAKEWOOD MANOR	2,880,000	2,335,000	INLAND	WATERVILLE
MARKET SQUARE NURSING CARE CENTE	2,463,625	2,318,625	STEPHENS	NORWAY
	47,573,141	42,983,141		



APPENDIX R

Maine Health and Higher Educational Facilities Authority, Estimated Savings from Use of Moral Obligation Reserve Fund Program vs. Traditional Financing

TAXABLE RESERVE FUND RESOLUTION

ESTIMATED SAVINGS FROM USE OF MORAL OBLIGATION RESERVE FUND PROGRAM VS. TRADITIONAL FINANCING

MHHEFA TOTAL DEBT SERVICE	(PRIME@8.341) ESTIMATED CONVENTIONAL FINANCING	ESTIMATED GROSS SAVINGS	CALCULATED REFINANCING SAVINGS	EST. NEW MONEY SAVINGS OVER CONVENTIONAL FINANCING
212,892,757	269,057,734	56,164,977	33,066,537	23,098,440

ESTIMATED CONVENTIONAL FINANCING was calculated using the ten year average of prime+2%, amortized over twenty years with annual payments.

Upon review of loans refinanced from bond proceeds, it was noted that of the 23 loans refinanced, the majority of the loans were variable rate based anywhere from 1%-4% over prime with rates usually reset either quarterly or annually, with a 3 to 5 year balloon. Therefore, prime+2% was selected as a conservative estimate of available loan terms with the 10 year average of prime used to estimate the prime rate over the 20 year life of the loan.

CALCULATED REFINANCING SAVINGS is the amount of gross savings calculated using the debt service from the debt refinanced compared with the debt service from the new bonds.

APPENDIX S

Maine Health and Higher Educational Facilities Authority, Taxable Nursing Home Advance and Payment History

MAINE HEALTH AND HIGHER EDUCATIONAL FACILITIES AUTHORITY

TAXABLE NURSING HOME ADVANCE AND PAYMENT HISTORY

30-Sep-98

	The Viking	Country Manor	Robinson's NCF	Pleasant Hill	* Merrill Memorial Manor	** F.C.R.	Tall Pines	*** Riveridge	Woodford Park	
Total Advances	293,018.59	172,795.80	61,416.20	163,861.16	629,081.53	112,198.58	238,696.72	149,353.00	1,700,888.10	
Date of first advance	12/28/95	6/27/96	6/27/96	6/27/96		7/8/97	12/31/97	6/30/98	12/31/97	
Date of most recent advance	6/26/96	11/4/96	10/8/96	12/13/96		6/30/98	6/30/98	6/30/98	8/5/98	
Total repayment of advances	293,018.59	35,000.00	35,000.00	-	6,090.00	41,548.90	-	149,353.00	-	
Date of most recent payment	7/15/96	8/21/98	8/21/98			5/8/98		9/29/98		
Outstanding Balance	-	137,795.80	26,416.20	163,861.16	622,991.53	70,649.68	238,696.72	-	1,700,888.10	2,961,299.19

* - Merrill Memorial Manor closed October 1997. The Authority foreclosed on the property and is currently attempting to sell the licensed beds and is listing the real estate with a local agent.

** - F.C.R. has signed a sales agreement with Medical Care Development. The Authority advances will be made current at the closing date with the debt assumed by Medical Care Development.

APPENDIX T

Nursing Home Quality Indicator Development, Center for Health Systems Research and Analysis, University of Wisconsin, February 9, 1998

CHSRA

Center for Health Systems Research and Analysis University of Wisconsin

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Madison, WI 53705

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Nursing Home Quality Indicator Development

Researchers at the Center for Health Systems Research and Analysis (CHSRA), University of Wisconsin-Madison have developed and tested a set of indicators of quality of care in nursing homes and quality monitoring system for using the indicators for internal and external quality review and improvement. The development of the quality indicators (QIs) and quality monitoring system (QMS) results from two related developments in the field of nursing home quality assurance. The first is the growing interest among health care professionals, consumers, policy makers, and advocates about issues related to the quality of care and quality of life of nursing home residents. The second is the Multistate Nursing Home Case Mix and Quality (NHCMQ) Demonstration funded by the Health Care Financing Administration (HCFA).

The QIs and QMS originally were derived from items on the Minimum Data Set Plus (MDS+). The MDS+ is an enhanced version of the MDS, developed for use within the NHCMQ Demonstration. Comparable QIs have been developed more recently to make use of the more commonly used MDS version 2.0. The differences between QIs based on different data sets are discussed more fully elsewhere (MDS+ and MDS 2.0 QI Variants).

The QIs were formulated and developed through a systematic process involving extensive interdisciplinary clinical input, empirical analyses, and field testing. Clinical and research staff at the University of Wisconsin-Madison developed an initial draft of a set of indicators and potential associated risk factors based on an extensive review of relevant clinical research literature and the care-planning guidelines from the RAPs. Several national clinical panels representing the major disciplines involved in the provision of nursing home care reviewed the initial draft. These disciplines included nursing, medicine, pharmacy, medical records, social work, dietetics, physical therapy, occupational therapy, and speech and language therapy, as well as resident advocates and administrators. The clinical panels provided a rigorous critique and assisted in refining or deleting proposed QIs and defining new QIs. The clinical review culminated in the panels being convened in July, 1991 to provide an assessment of the QIs within and across disciplines. This important step was followed with in-depth review by a research advisory panel convened to provide consultation in areas of analytic concern. The panel members have continued to provide consultation throughout the project. The result of the clinical panel meeting was a set of 175 QIs organized into the following twelve care domains:

1. Accidents
2. Behavioral & Emotional Patterns
3. Clinical Management
4. Cognitive Functioning
5. Elimination & Continence
6. Infection Control
7. Nutrition & Eating
8. Physical Functioning
9. Psychotropic Drug Use
10. Quality of Life
11. Sensory Function & Communication,
12. Skin Care

These 175 QIs have served as the basis for empirical analyses. QI development has been guided by several criteria including clinical validity, feasibility or usefulness of the information, and empirical analyses. Extensive analyses have been performed to further reduce the set of QIs to a comprehensive set of 30 QIs covering the twelve domains. (See QI Descriptions.) The QIs and QMS have been subjected to validation testing, and are now being used by some states' survey agencies and by a number of nursing facilities (PIP and ORYX projects) for quality assurance and improvement.

Last Updated February 09, 1998 04:51 PM

APPENDIX U

Nursing Facility Quality Indicator Descriptions, Center for Health Systems Research and Analysis, University of Wisconsin, February 6, 1998

CHSRA

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Reimbursement & Other Topics

Nursing Facility Quality Indicator Descriptions

Below is a list of quality indicators (QIs), by domain, along with brief descriptions. Depending upon the version of MDS 2.0 assessment being used, the computation of some of these QIs varies or cannot be performed. Please see the precise definitions available for download elsewhere on this web site.

Accidents

QI 1.1 Incidence of New Fracture

Residents who have a hip fracture or other fracture that is new since the last assessment. This QI is not risk adjusted and the denominator (the denominator is the number of residents who could have flagged on the QI) is all residents on most recent assessment.

QI 1.2 Prevalence of Falls

Residents who have been coded with a fall within the most recent assessment (last 30 days). This QI is not risk adjusted and the denominator is all residents on the most recent assessment.

Behavioral / Emotional Patterns

QI 2.1 Prevalence of Behavioral Symptoms Affecting Others

Residents who have displayed any type of problem behavior toward others on the most recent assessment. Behavioral symptoms includes verbal abuse, physical abuse, or socially inappropriate/disruptive behavior. The behavior has had to occur at least once in the assessment period (7 days).

This QI is RISK ADJUSTED. Residents are considered more likely (are at HIGH RISK) to exhibit behavior symptoms if they are cognitively impaired or have any psychotic conditions. Residents who do not have any of these conditions are considered LOW RISK. The denominator for the QI is all residents on most recent assessment.

QI 2.2 Prevalence of Symptoms of Depression

Residents with symptoms of depression on the most recent assessment. This is a complex definition. Residents are considered to have this QI if they have a sad mood and have 2 or more symptoms of functional depression (defined below).

The symptoms of functional depression that are used in deciding whether a person meets one of these criteria also are complex. There are five symptoms, and some of those involve more than one item. These symptoms occurring within the most recent assessment period are: (1) negative statements exhibited up to 5 days or more per week; (2) agitation or withdrawal exhibited up to 5 days per week or more, or resists care at least 1-3 days in the last 7 days; (3) waking with an unpleasant mood up to 5 days or more, or not being awake most of the day and not comatose; (4) being suicidal or having recurrent thoughts of death up to 5 days or more; and (5) weight loss. This QI is not risk adjusted and the denominator is all residents on the most recent assessment

QI 2.3 Prevalence of Depression Without Antidepressant Therapy

Residents with symptoms of depression and no antidepressant therapy on the most recent assessment. Symptoms of depression are defined using the same criteria described above and no antidepressant therapy was provided. This QI is not risk adjusted and the denominator is all residents on the most recent assessment.

Clinical Management

QI 3.1 Use of 9 or More Different Medications

Residents who received 9 or more different medications on the most recent assessment. This QI is not risk adjusted and the denominator is all residents on the most recent assessment.

Cognitive Patterns

QI 4.1 Onset of Cognitive Impairment

This QI measures the onset of cognitive impairment between the most recent and previous assessments. It identifies those residents who were not cognitively impaired on the previous assessment, but who are

cognitively impaired on their most recent assessment. Cognitive impairment is defined as having impaired decision making abilities and impaired short term memory problems. The denominator is only residents who were not cognitively impaired on the previous assessment. This QI is not risk adjusted.

Elimination / Incontinenece

QI 5.1 Prevalence of Bladder or Bowel Incontinence

Residents who were determined to be incontinent or frequently incontinent on the most recent assessment. (Remember that this means bladder or bowel.) The denominator for this QI does not count those people who were comatose, had indwelling catheters, or ostomies at the most recent assessment.

This QI is RISK ADJUSTED. Residents are considered more likely to be incontinent if they have a severe cognitive impairment or are totally dependent (self performance) in ADL's having to do with mobility (bed mobility, transfer, and locomotion). These residents are at HIGH RISK for incontinence. Those residents who do not have these conditions and are not excluded from the QI are considered LOW RISK.

QI 5.2 Prevalence of Occasional or Frequent Bladder or Bowel Incontinence Without a Toileting Plan

This QI focuses on those residents who are assessed as incontinent, either occasionally or frequently, and who do not have a toileting plan noted on the most recent assessment. In this case, the denominator would be those residents with frequent or occasional incontinence in either bladder or bowel on the most recent assessment. This QI is not risk adjusted.

QI 5.3 Prevalence of Indwelling Catheters

These are residents who were noted to have an indwelling catheter on their most recent assessment. The denominator is all residents on most recent assessment. This QI is not risk adjusted.

QI 5.4 Prevalence of Fecal Impaction

Residents who have been noted with a fecal impaction on their most recent assessment. This QI is considered to be a sentinel health event, meaning that even if one person flags on this QI, it is of such a serious nature, that it should be investigated. This QI is not risk adjusted and the denominator is all residents on the most recent assessment.

Infection Control

QI 6.1 Prevalence of Urinary Tract Infections

Residents identified on the most recent assessment as having had a urinary tract infection. This QI is not risk adjusted and the denominator is all residents on the most recent assessment.

QI 6.2 Prevalence of Antibiotic/Anti-infective Use

Residents identified on the most recent assessment as receiving any antibiotic/anti-infective medication. This QI is not risk adjusted and the denominator is all residents on the most recent assessment.

Nutrition / Eating

QI 7.1 Prevalence of Weight Loss

Residents noted with a weight loss (5% or more in 30 days or 10% or more in last 6 months) on the most recent assessment. This QI is not risk adjusted and the denominator is all residents on the most recent assessment.

QI 7.2 Prevalence of Tube Feeding

Residents noted to have feeding tubes on the most recent assessment. This QI is not risk adjusted and the denominator is all residents on the most recent assessment.

QI 7.3 Prevalence of Dehydration

Residents who have been either coded with the condition of dehydration (MDS check box) or with a diagnosis of dehydration (MDS ICD-9 CM 276.5). This QI is not risk adjusted and the denominator is all residents on most recent assessment.

Physical Functioning

QI 8.1 Prevalence of Bedfast Residents

Residents who have been determined to be bedfast on the most recent assessment. This QI is not risk adjusted and the denominator is all residents on the most recent assessment.

QI 8.2 Incidence of Decline in Late Loss ADLs

This QI measures decline in ADL functioning (self performance) over two assessment periods---the most recent and the assessment prior to that. Late loss ADLs are those which are considered the "last" to deteriorate—i.e., bed mobility, transferring, eating, and toileting. Over the assessment periods, there has been at least one level decline in two or more of these ADLs or there has been at least two levels of decline in one or more of them. In other words, the resident has experienced a gradual decline in two or more areas or a rather significant decline in one.

The denominator does not include residents who already were determined to be totally dependent or comatose on the previous assessment. This QI is not risk adjusted.

QI 8.3 Incidence of Decline in ROM

Residents with increases in functional limitation in Range of Motion (ROM) between previous and most recent assessment.

This QI is RISK ADJUSTED. Residents at HIGH RISK for the increases in functional limitations are those who are comatose on the most recent assessment. HIGH RISK residents also include people who were coded as being totally dependent in the mobility ADLs on the previous assessment. All other residents are considered to be LOW RISK. This QI includes only residents with the previous and most recent assessments on file.

QI 8.4 Lack of Training/Skill Practice or ROM for Mobility Dependent Residents

Cannot be defined because certain information is not available on the MDS 2.0 Quarterly.

Pyschotropic Drug Use

QI 9.1 Prevalence of Antipsychotic Use in the Absence of Psychotic and Related Conditions

This QI identifies those residents who are receiving antipsychotics on the most recent assessment. The denominator for this QI excludes those residents with psychotic disorders, schhizophrenia, Tourette's, Huntington's or those with hallucinations.

This QI is RISK ADJUSTED. Residents who exhibit both cognitive

impairment and behavior problems at the most recent assessment are considered at HIGH RISK to receive antipsychotic medication. All others are considered at LOW RISK.

QI 9.2 Prevalence of Antipsychotic Daily Dose in Excess of Surveyor Guidelines

This QI identifies those residents with an average daily antipsychotic dose in excess of the surveyor guidelines on the most recent assessment. The denominator for this QI excludes those residents with psychotic disorders, schhizophrenia, Tourette's, Huntington's or those with hallucinations.

QI 9.3 Prevalence of Antianxiety/Hypnotic Drug Use

Residents who received antianxiety medications or hypnotics on the most recent assessment. The denominator for this QI excludes those residents with psychotic disorders, schhizophrenia, Tourette's, Huntington's or those with hallucinations. This QI is not risk adjusted.

QI 9.4 Prevalence of Hypnotic Use More Than Two Times in the Last Week

Residents who received hypnotics more than twice in the last week on the most recent assessment. This QI is not risk adjusted and the denominator is all residents on the most recent assessment.

QI 9.5 Prevalence of Use of Any Long-Acting Benzodiazepine

Residents who received long-acting benzodiazepines on most recent assessment. This QI is not risk adjusted and the denominator excludes those residents with seizure disorders, cerebral palsy, tardive dyskinesia or spinal cord injury.

Quality of Life

QI 10.1 Prevalence of Daily Physical Restraints

Residents who were restrained (trunk, limb, or chair) on a daily basis on the most recent assessment. This QI is not risk adjusted and the denominator is all residents on the most recent assessment.

QI 10.2 Prevalence of Little or No Activity

Residents who, on the most recent assessment, were noted with little or no activity. The denominator includes all residents except those who are

comatose. This QI is not risk adjusted.

Sensory Functioning

QI 11.1 Lack of Corrective Action for Sensory or Communication Problems

Residents with visual impairment, hearing impairments or poor expression or understanding, without corrective action. This QI is not risk adjusted and the denominator is all residents on the most recent assessment.

Skin Care

QI 12.1 Prevalence of Stage 1-4 Pressure Ulcers

Residents who have been assessed with any stage pressure ulcer(s) Stage 1-4 on the most recent assessment. Pressure ulcers can be identified on the MDS either by a checkbox or an ICD-9 707.0 code. The denominator is all residents on most recent assessment.

This QI is RISK ADJUSTED. Residents are considered to be at HIGH RISK for the development of pressure ulcers if they have any one or more of the following conditions: they are impaired for bed mobility or transfer; or are comatose; or are malnourished; or have an end stage disease on the most recent assessment. All other residents are considered to be at LOW RISK. Residents at low risk that flag should be investigated since this would be considered a sentinel event.

QI 12.2 Insulin-dependent Diabetes with No Foot Care

Insulin-dependent residents with diabetes that do not have a foot care program. This QI is not risk adjusted and the denominator includes all residents on the most recent assessment.

Last Updated February 06, 1998 04:24 PM

APPENDIX V

Summary of Minnesota Nursing Home Contract Project

NURSING HOME CONTRACT PROJECT

The Nursing Home Contract Project:

* Authorized by 1995 Laws of Minnesota, Chapter 207, Article 7, Section 32 (hereinafter Minn. Stat. Section 256B.434) and enables the Commissioner of the Department of Human Services to establish a contractual alternative payment system as an alternative way to pay for nursing facility services under the Medical Assistance (MA) program. To implement this legislation, the Department has developed the "Nursing Home Contract Project."

* The purpose of the Nursing Home Contract Project is to explore a contract-based payment system as an alternative to the current cost-based system for reimbursement of nursing facility services under Rule 50 and Minn. Stat., Section 256B.432.

* The Nursing Home Contract Project enables the Commissioner to determine whether a contract-based payment system reduces the level of regulation, reporting, and procedural requirements, and provides greater flexibility and incentives for nursing facilities to stimulate competition and innovation.

* Special attention will be paid to whether this project promotes consumer satisfaction, maximizes Medicare utilization, maintains the best outcomes for consumers, and networks with community long-term care resources.

* The Department established an external advisory committee to assist in the development and implementation of the Nursing Home Contract Project.

Requests for Proposals:

* The Commissioner was authorized to issue three requests for proposals ("RFPs") prior to July 1, 1997. The Commissioner could contract with up to 40 nursing facilities as part of each RFP.

* The 1997 Laws of Minnesota amended Minn. Stat. Section 256B.434. Effective July 1, 1997, the Commissioner is required to issue a RFP from nursing homes to provide services on a contract basis at least twice annually. The Commissioner may select the number of proposals that can be adequately supported with state resources.

Implementation Schedule:

* RFPs issued: Round 1 - 9/5/95; Round 2 - 2/20/96; Round 3 - 8/5/96.
  A total of 111 facilities are currently under contract based on selections from the first three rounds.

* A fourth RFP was issued on 7/28/97. An additional 50 facilities have been selected to participate in the project. Contract negotiations are currently in process and expect to fully executed by December 31, 1997.

Reimbursement:

* Selected nursing facilities will be paid the case mix rate (total payment rate) that they would have received under Minn. Stat. Section 256B.432, for the first year of the contract. Nursing facilities will receive an inflation adjustment effective each July 1 thereafter, for up to a total of four consecutive years.

* The nursing facility is not subject to audits of historical costs or revenues, or paybacks; or retroactive adjustments based on those costs or revenues for any reporting year after the base year that is the basis for the calculation of the first rate year of the project.

* The nursing facility may charge a short-stay private pay rate for residents admitted to the nursing facility who are likely to be discharged less than 101 days after admission. The maximum private pay rate for short-stay private paying residents is an amount equal to the greater of the estimated Medicare payment rate for the nursing facility or the resident case mix payment rate.

* If the resident remains in the facility longer than 100 days, the nursing facility shall retroactively reduce the resident's payments to the contract payment rate effective from the date of admission and shall reimburse the resident.

* The nursing facility must agree to comply with Minn. Stat. Section 256B.48, subd. 1 regarding the provision of, and charges for special services. If the nursing facility included a special service beyond those required to comply with licensure or certification standards in the total payment rate for the base year rate, the nursing facility must agree not to charge separately for this same service while under contract.

Medicare Certification: A nursing facility selected to participate in this project may negotiate Medicare participation requirements as conditions of the contract. Requirements of the RFP are designed to maximize Medicare participation and prevent discrimination against MA patients.

Moratorium Exception: Contract payment rates will not be adjusted for any additional cost that a nursing facility incurs as a result of a construction project. Rates for a nursing facility under contract will not reflect any additional costs attributable to the sale of a nursing facility, or to any construction undertaken during the term of the contract. A nursing facility participating in the Project is not prevented from seeking approval of an exception to the moratorium, and if approved, the nursing facility's rates shall be adjusted to reflect the cost of the project.

For additional information, please contact Allan Weinand at the DHS - (612) 297-3711.
11/4/97

APPENDIX W

Report to the 1998 Minnesota Legislature on the Alternative Payment System for Nursing Facility Care

AW

REPORT TO THE 1998 LEGISLATURE ON NURSING HOME OUTCOMES: A COMPONENT OF THE ALTERNATIVE PAYMENT SYSTEM (APS) PROJECT

JANUARY 1998

MINNESOTA DEPARTMENT OF HUMAN SERVICES
AGING INITIATIVE: PROJECT 2030
444 Lafayette Road
St. Paul, Minnesota 55155-3844
612-296-2062

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SUMMARY

The Laws of Minnesota 1997, Chapter 203, article 9, section 23 requires that the Commissioner of Human Services report to the Legislature on the plan to develop a system of incentive-based payments for nursing facilities in the Alternative Payment System Demonstration Project.

The Minnesota Department of Human Services is establishing a system of outcome-based measures for quality in nursing homes as a required component of the legislatively authorized Alternative Payment System Demonstration Project. This project is testing the feasibility of a new way of paying nursing facilities in Minnesota that is based upon a negotiated contract for services instead of a cost-based reimbursement system under Rule 50. The outcome measures developed could be used to pay nursing facilities in the project up to 5% above each facility's contract rate for achieving pre-determined benchmarks within these outcome measures.

The department is facilitating a public/private work group composed of key stakeholders to design and implement the system of quality outcome measures for nursing homes. The formation of this work group was suggested by the two nursing home associations and other stakeholders that responded to an RFI in March 1997. The department established this group in June 1997. Prior to this, the department had tried unsuccessfully for several months to find an appropriate and affordable outside contractor to complete this work.

Since its formation, the group has resolved a large number of policy and procedural issues related to the design and implementation of an outcomes-based system of measuring quality of care in nursing facilities. The group has proven to be an excellent example of problem-solving and system development by those most directly affected by the decisions made. All members agree on the critical importance of establishing widely accepted outcome measures for nursing homes, but have various perspectives on how to accomplish the task. Thus far, the group has agreed on the quality indicator system to use and how the data will be collected, and chosen a subset of indicators to focus on. Still to be finalized in 1998 are the process to use for obtaining and using consumer satisfaction information on "quality of life" measures, the establishment of benchmarks for each of the quality indicators, and design of the actual incentive payment system.

Status of Work

Facilities in the APS demonstration project will begin transmitting Minimum Data Set (MDS) data to the Minnesota Department of Health on April 1, 1998, and the public/private group will begin tracking key quality indicators. The group hopes to set baseline benchmarks, begin the process of testing these benchmarks and develop a method for tying achievement of outcomes to incentive payments by June 1998. Once this work is successfully completed, the department estimates the first possible date for implementation of an incentive payment system would be July 1, 1999, if approved by the Legislature.

Why Outcomes are Important

Establishing a system of quality of care outcomes in nursing facilities and a way to regularly measure whether nursing facilities are achieving them is essential as the department moves forward in its transition from cost-based provider reimbursement to performance-based contracts where high achievement of outcomes can be rewarded. This project also helps prepare nursing facilities for the future, in which they will increasingly be under contract with managed care organizations to provide nursing facility care to managed care enrollees.

ADDITIONAL DETAILS ABOUT THE WORK ON NURSING HOME OUTCOMES

Purpose of Contract Project
The 1997 Legislature requested a progress report on the development of a system of outcome-based measures for nursing home care.

The outcomes-based system is being developed as a component of the Nursing Home Contract Project which the department has established to implement 1995 Minnesota Statutes, Section 256B.434. This law authorized the Commissioner of the Department of Human Services to establish a contractual alternative payment system as an alternative way to pay for nursing facility services under the Medical Assistance (MA) program. The purpose of this project is to explore a contract-based payment system as an alternative to the current cost-based system for reimbursement of nursing facility services under Rule 50. Facilities in the contract project sign a contract with the state agreeing to per diem rates adjusted for inflation and case mix only. This means that the facilities do not receive payments adjusted retroactively based on cost reports submitted and audited by the state, as is done under Rule 50.

Along with this new way of paying for nursing facility services, the 1995 legislation also authorized the Commissioner to develop outcome-based measurement standards and data collection processes related to the provision of nursing facility services and to develop incentive-based payments for achieving outcomes. Payments of up to 5% of each facility's contract rate may be paid to facilities that achieve specified outcomes.

Facilities must apply and be selected to participate in the Nursing Home Contract Project. As of January 1998, 160 nursing facilities (out of the 444 facilities in the state) have been selected and now participate in the project. As three more RFPs are issued between now and 1999, it is expected that up to 150 additional facilities may be added to the Contract Project. The facilities selected for the Nursing Home Contract Project are required to participate in the development and implementation of an outcome-based incentive payment system.

Implementation of the Outcomes Component of Contract Project
Soon after the establishment of the Contract Project in 1995, the department created a work group on outcomes. The work of this group resulted in the publication of an RFP in the State Register to hire an outside contractor to complete the work necessary to design a system of outcomes, test and validate these outcomes within contract facilities, design and test a system of incentive payments, and make recommendations for how the state could implement both these systems.

In March 1996, eight proposals were received and reviewed by both internal and external reviewers. However, the top-rated responders most capable of completing the large amount of work included in the RFP requested more funds than were available. Midway through the RFP process, HCFA had limited the amount of funds the project could request from each of the contract facilities to pay for the outcomes and incentive payment development work, thus reducing the amount of funding the department had anticipated to have available. Attempts by the state to secure other funds to supplement these existing funds were unsuccessful.

The RFP was cancelled, and state staff spent the next few months talking with national and local experts about outcomes systems, quality indicators, and payment systems based upon outcomes about alternative ways of completing the necessary work within the available budget. In early 1997, an RFI was published in the State Register, requesting ideas and suggestions for how best to complete the project. Responders to the RFI included the nursing home associations, other provider groups as well as national and local research and academic organizations.

As a result of the suggestions submitted under the RFI, the department formed a partnership with the other key stakeholders on this issue and began to facilitate a public/private work group comprised of these stakeholders—the nursing home associations, health plans, Minnesota Senior Health Options Project, the Department of Health, and consumer organizations (see Attachment A for the membership list). There was consensus among these stakeholders that together the group could define and resolve the issues surrounding outcomes and incentive payments more acceptably and effectively than an outside contractor. In particular, the two nursing home associations were moving ahead on outcomes-based systems and were hopeful that any system developed by the state would be based on already existing work and not be a separate or duplicative effort.

The public/private work group began meeting in June 1997, and held eight meetings between June and December to work on the design and implementation of the project. The group will continue to meet throughout 1998 to complete their work. The key elements of the project as designed by the group are described and summarized below.

Outcome-based Measures for Nursing Home Care
Even though a large number of data and reporting systems are required of nursing facilities by the federal and state governments, until recently, none have been comprehensive and detailed enough at the resident level to measure quality across facilities in a consistent and useful way. To address this problem, the Health Care Financing Agency (HCFA) developed a comprehensive system of resident-level data that includes a data system called the Minimum Data Set (MDS), under its mandate contained in the 1987 Omnibus Budget Reconciliation Act (OBRA),

The MDS includes information about a resident's functional, nutritional, cognitive, social, emotional, and clinical health status. HCFA has required all nursing facilities to complete and maintain MDS data on all their residents since 1991. However, by June 1998, all nursing facilities will be required to electronically transmit MDS data at least on a monthly basis to a state repository (the Minnesota Department of Health in Minnesota) that will in turn transmit the data to HCFA. Actually, facilities have between December 22, 1997 and June 22, 1998 to gear up to meet this requirement, but by the June date, they *must* be transmitting MDS data to the state.

This requirement has been anticipated for a number of years, but the dates for implementation have just now been established The MDS data will provide the consistent, system-wide data base necessary for the development of a valid outcomes and incentive payment system.

Over the past several years, researchers at the Center for Health Systems Research and Analysis (CHSRA) at the University of Wisconsin-Madison have developed and tested a set of quality indicators of care in nursing homes that uses resident-level data from the MDS. The quality indicators (QIs) are derived from items on the MDS and are markers that indicate either the

presence or absence of potentially poor care practices or outcomes. These indicators were developed through a systematic process involving extensive interdisciplinary clinical input, empirical analysis and field testing, and are considered by many (including HCFA that paid for most of the research) to be the best system available for measuring clinical outcomes in nursing home care.

Currently, there are 30 quality indicators within 12 quality of care domains (see Attachment B). Those who designed this system (led by Dr. David Zimmerman) acknowledge that while it does capture many *clinical* measures, it does not adequately address *quality of life* measures since the types of data needed to fully assess these domains are not collected as a part of MDS.

Work Group Decisions on Quality Indicators (See Attachment C)

- The system of quality indicators used within the outcomes system will be the system developed by the CHSRA in Wisconsin and based upon the MDS data set. Beginning April 1, 1998, all contract facilities will be required to submit their MDS data to the Minnesota Department of Health. Tracking of quality indicators will begin as soon as possible after data collection begins.
- The group has identified approximately 15 of the 30 CHSRA quality indicators that measure outcomes they consider most related to quality of care in nursing homes. On January 23, 1998, a group of clinicians selected by work group members will meet to review the quality indicators and make their recommendations on which most accurately measure quality of care in nursing facilities. The work group will then use this information to finalize a subset of measures for which to set benchmarks and to include in the incentive payment system.
- Contract facilities will be required to use these quality indicators and the related outcomes in their continuous quality improvement (CQI) process, and show that they are integrating the information into their required quality improvement plans.

Decisions Yet to be Made

- The contract facilities will be required to complete consumer satisfaction surveys, and the results of these surveys will be the basis for quality indicators that measure "quality of life" outcomes. The details on the actual instrument(s) and questions, who to survey and who will administer the survey will be finalized in early 1998. At this point, the work group does not necessarily see these quality of life measures being connected to the incentive payment system.
- Specific benchmarks or standards for achieving outcomes still need to be established for the chosen subset of quality indicators. This work will be completed in 1998.
- A method of tying these benchmarks to a system of incentive payments still needs to be described, analyzed, tested and be prepared for implementation. This work will hopefully be completed by June 1998.

Additional Information Available

Additional detailed information on any of the issues, decisions and future work efforts on nursing home outcomes is available from LaRhae Knatterud, Aging Initiative: Project 2030, Minnesota Department of Human Services, 296-2062.

ATTACHMENT A

Public/Private Work Group on Outcomes in Nursing Homes

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ATTACHMENT B

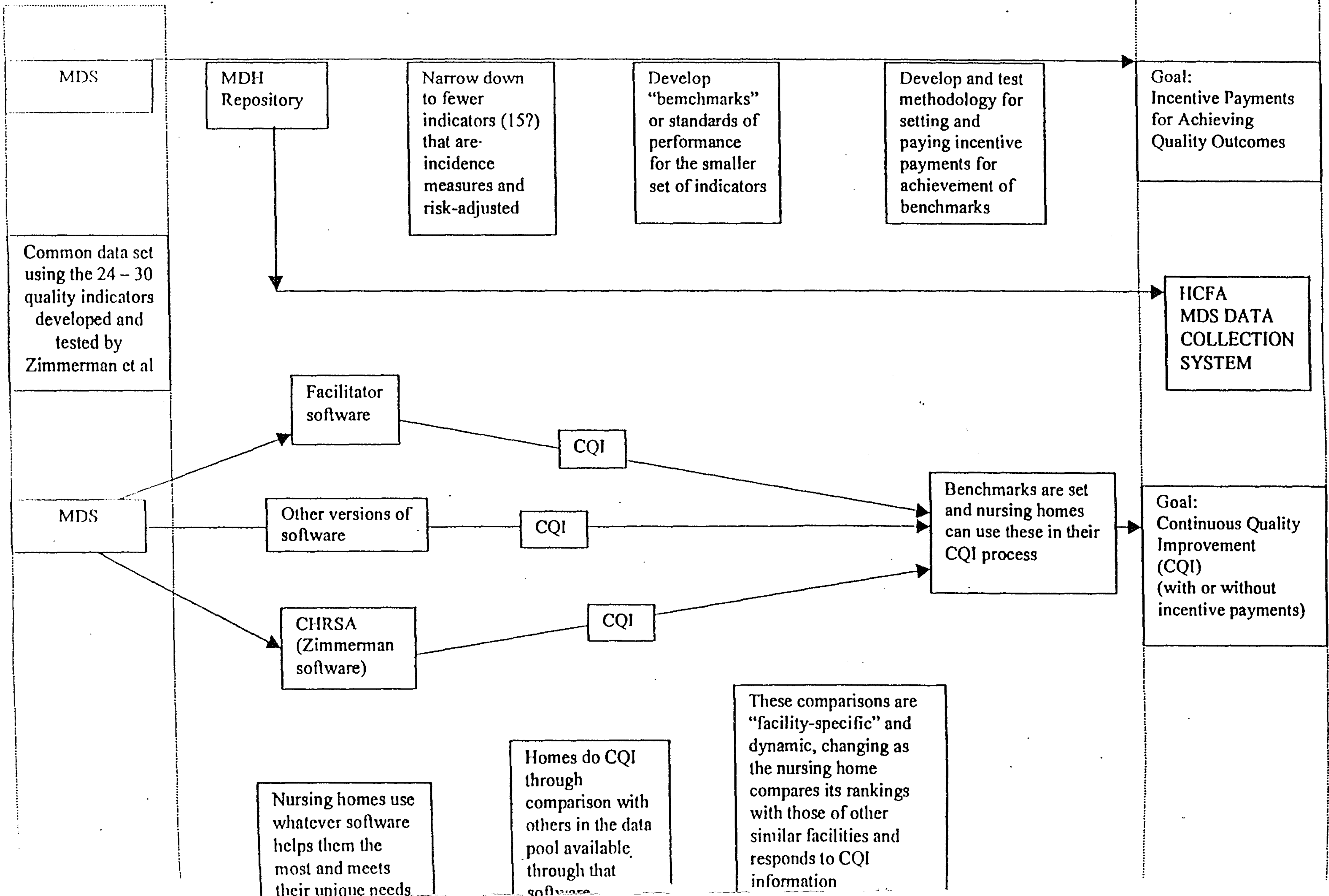
Nursing Home Quality Indicators

Domain	Quality Indicators	Process/ Outcome	Risk Adjustment
accidents	1. Prevalence of any injury	Outcome	No
	2. Prevalence of falls	Outcome	No
behavioral & emotional patterns	3. Prevalence of problem behavior toward others	Outcome	Yes
	4. Prevalence of symptoms of depression	Outcome	No
	5. Prevalence of symptoms of depression with no treatment	Both	No
clinical management	6. Use of nine or more scheduled medications	Process	No
cognitive patterns	7. Incidence of cognitive impairment	Outcome	No
elimination & continence	8. Prevalence of bladder/bowel incontinence	Outcome	Yes
	9. Prevalence of occasional bladder/bowel incontinence without a toileting plan	Both	No
	10. Prevalence of indwelling catheters	Process	Yes
	11. Prevalence of fecal impaction	Outcome	No
infection control	12. Prevalence of UTI's	Outcome	No
	13. Prevalence of antibiotic/anti-infective use	Process	No
nutrition & eating	14. Prevalence of weight loss	Outcome	No
	15. Prevalence of tube feeding	Process	No
	16. Prevalence of dehydration	Outcome	No
physical functioning	17. Prevalence of bedfast residents	Outcome	No
	18. Incidence of decline in late loss ADL's	Outcome	Yes
	19. Incidence of contractures	Outcome	Yes
	20. Lack of training/skill practice or ROM for mobility dependent residents	Both	No
psychotropic drug use	21. Prevalence of antipsychotic use in the absence of psychotic and related conditions	Process	Yes
	22. Prevalence of antipsychotic daily dose in excess of surveyor guidelines	Process	No
	23. Prevalence of antianxiety/hypnotic use	Process	No
	24. Prevalence of hypnotic use on a scheduled basis or PRN greater than two times in last week	Process	No
	25. Prevalence of use of any long-acting benzodiazepin	Process	No
quality of life	26. Prevalence of daily physical restraints	Process	No
	27. Prevalence of little or no activity	Outcome	No
sensory function/ communication	28. Lack of corrective action for sensory or communication problems	Both	No
skin care	29. Prevalence of stage 1-4 pressure ulcers	Outcome	Yes
	30. Insulin dependent diabetes with no foot care	Both	No

Source: Zimmerman et al. The Development and Testing of Nursing Home Quality Indicators. *Health Care Financing Review, 16(4)*: 107-123. Summer 1995

ATTACHMENT C

AGREEMENT BY MDS WORK GROUP ON PROCESS FOR USE OF MDS NURSING HOME OUTCOMES PROJECT SEPTEMBER 4, 1997



APPENDIX X

"Assessing the Outcomes of Nursing Home Care," by Dr. Robert Kane, June 6, 1998

June 6, 1998

Assessing the Outcomes of Nursing Home Care

Robert L. Kane

The State legislature authorizing the Contractual Alternative Payment Demonstration Project (CAPDeP) identified five areas within its outcomes framework for the demonstration project:

1. improved **cost-effectiveness** and **quality of life**, where effectiveness and quality of life are measured as clinical outcomes;
2. successful **diversion or discharge** to community alternatives;
3. decreased **acute care costs**;
4. improved **consumer satisfaction**;
5. the achievement of **quality care** (interpreted as better services or processes of care).

In one sense, this coupling of cost-effectiveness (especially the increased use of community care and the decrease in acute care costs) can be viewed as part of the overall thrust toward managed care. In a narrower sense, this effort can be seen as an attempt to link directly payment with the achievement of desired outcomes.

Defining and Measuring Quality Care in Long-term Care Nursing Facilities

Different dimensions of quality are included in the discussions of this topic. It may be helpful to distinguish among them. **Quality of care** usually refers to process measures that indicate whether the right things were done (and sometimes whether they were done with adequate skill). Quality of care also can be assessed in terms of outcomes. These outcomes may be thought of as both the absence of bad events and the presence of good ones. They can be expressed in clinical terms, such as death or measures of morbidity (e.g., decubiti) or physiology (e.g., blood sugar, blood pressure); or they can be expressed as more general domains such as function, cognition, social roles, and affect. The latter (in whole or in part) are often referred to as measures of **quality of life**. Most observers include **resident satisfaction** with care, services, and the living environment as an important quality outcome domain. Some people include **cost** as an outcome, but others, including the Institute of Medicine (Institute of Medicine, 1990), treat it separately, in order to calculate more rational cost-effectiveness ratios. The relevant cost as an outcome is not the cost of nursing home care, but the savings accrued by discharging a resident to some less expensive form of care or the savings from reduced use of expensive medical care, like hospitals.[1]

The Resident Assessment Instrument (RAI)

Assessing quality of care among residents in nursing facilities has been a great challenge. The 1986 report of the Institute of Medicine and the subsequent 1987 federal legislation (Nursing Home Reform Act), affirmed the importance of emphasizing clinical outcomes as a way to identify and measure quality care in nursing facilities. A central aspect of that effort was the institution of a national standard for the collection of resident assessment data, the Resident Assessment Instrument (RAI). A major component of the RAI is the Minimum Data Set (MDS). The MDS is a core set of screening and assessment elements which form the foundation of a comprehensive assessment for nursing home residents. The other components of the RAI include the Resident Assessment Protocols (RAPs) which prompt nursing home staff to do further assessments to determine the cause, extent, and nature of the actual or potential problems associated with the well-being of the resident. The RAI is to be used as the basis of developing and implementing an interdisciplinary plan of care to achieve the highest, practicable level of well-being for the resident.

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[1] There may be a net saving as a result of spending more money on primary care but less on hospital care.

The MDS has significant importance in that it is being used in all nursing facilities in Minnesota to systematically collect longitudinal data about all residents. Because it is an existing data collection system, it will serve as an important data source for developing an outcome-based measurement system.

The MDS is both a singular advance and a limitation. For many states, the MDS greatly increased the quality of information being collected as well as effective use of that information for planning and implementing care. However, the MDS was designed to be just that, a **minimum** data set. It was designed to be applied to all residents and thus used a lowest common denominator approach. The MDS uses only observational data; that is, information is reported by a third party who must infer from observable behaviors as many components of a total evaluation as are feasible from such a method. In effect, the MDS treats all respondents as though they were cognitively impaired, inferring outcomes from observed behaviors rather than asking directly. As a result, some important aspects of quality of life measures are absent and others can be only approximated. Although stringent efforts have been made to create measures from these observations that correspond to actual client reports, these quality of life measures cannot be interpreted as the real thing.

A second problem with the MDS is that the data are collected by nursing home staff (or sometimes by contractors). This approach can represent a real advantage in terms of increasing opportunities to use the data actively for care planning, but it means that certain aspects of questions cannot be realistically asked, such as questions related to how satisfied residents are with their care, living environment, and their overall quality of life. The RAI does not adequately address resident satisfaction and the construct quality of life. Nonetheless, quality of life is the essence of quality in nursing facilities.

The following table compares the dimensions of quality of life usually recommended for nursing home care appraisals (Kane, Bell, Riegler, Wilson & Kane, 1983) with the elements available from the revised MDS.

Measure	MDS Treatment
Physiological Function	minimal coverage
ADL Function	observed behavior, services provided
Pain/discomfort	observed symptoms
Cognition	observed confusion; some specific items
Affect (depression)	observed sadness, agitation
Social participation	observed behavior
Social interaction, intimacy	MISSING
Satisfaction	MISSING

Despite these limitations, however, the MDS data set will serve as the basis for most of the outcomes work to be used in this project, at least initially. Substantial work has already been done to develop quality indicators based on MDS data. Zimmerman (Zimmerman et al., 1995) has created a series of measures that attempt to assess quality for either the entire nursing home population or defined subsets.

Developing Valid Outcome-based Measurement Systems

A major philosophical issue around determining quality in nursing facilities and for residents is *what represents a good outcome.* Much of the past emphasis on quality assessment for nursing home residents and nursing homes has emphasized the absence of bad (undesired) events. Thus, great efforts have been spent establishing the use of chemical or physical restraints or the presence

of pressure sores, or other untoward elements of care. While no one would want to condone the presence of these undesired elements of care, their absence alone does not indicate good care. An ideal outcomes system would include both measures of adverse events and the production of desired ends. To assess the latter, one needs to examine the rate that improvement in the major classes of resident outcome is achieved, where feasible, or at least that the rate of inevitable decline is slowed. In essence, assessing outcomes requires a comparison of observed outcomes to expected outcomes (Kane et al., 1983). It is critical to recognize that good nursing home care does not require that residents improve, only that their course is as good or better than expected. Hence slowing the rate of decline can constitute a positive outcome. The key to this approach lies with selecting the appropriate comparison group. For example, if (as in the case of demo) homes are selected from among those believed to be giving good care, comparing these homes to each other could subject them to a very stringent standard. All could be giving good care (compared to the general level of care in the area), even though some were doing better than others.

Basically, there are two ways to look at the achievement of outcomes. 1] One can examine the outcome at a certain point in time (e.g., three months after admission). In this instance, one is effectively looking at an outcome as a discrete event. Was a goal reached? For example, is a patient walking or able to perform certain ADLs? 2] One can look at outcomes as a measure of change (e.g., the difference in outcome status between admission and three months later); the change can be expressed as either improving, getting worse or staying the same, or it can be expressed in a more continuous form as the actual difference in score between the two times. For example, a patient has improved his functional score by 10 points or by 10%.

The standard applied to the outcomes can likewise be looked at in two ways. 1] One can establish an absolute threshold (e.g., the outcome must be above a given level or at least a minimum amount of improvement must be shown). In this instance, the provider is essentially being compared to himself. 2] The outcomes can be judged in comparison to what other providers have achieved (either those offering the same type of care or others given alternative forms of care for the same clientele). In this case, the provider's achievement is compared to how well others did. For example, one providers' patients may have gotten better but they did not improve as much as the average. Thus, the relative achievement is less than average, although it is still positive.

The following diagram shows how these two concepts can be combined.

	Measure of Achievement (role of time)	
Standard (compared to whom)	Fixed	Change
Absolute	*walking or # ADLs*	*improved 10%*
Relative	*90th percentile*	*improved more than average*

The demonstration project has identified 10 nursing home quality indicators from the 24 developed by Zimmerman et al. (Zimmerman et al., 1995)

- prevalence of any injury
- prevalence of problem behavior toward others
- prevalence of bladder/bowel control incontinence
- prevalence of occasional bladder/bowel control incontinence without a toileting plan
- prevalence of UTIs
- prevalence of bedfast residents
- incidence of decline in late loss ADLs
- lack of training/skill practice or ROM for mobility dependent residents
- prevalence of little or no activity
- prevalence of stage 1-4 pressure sores

Under the schema described above almost all of these would fall under the fixed column, because their existence at a point in time is the standard. In fact one is not outcome at all (i.e., lack of training/skill practice or ROM for mobility dependent residents); and one is mixture of outcome and process (i.e., prevalence of occasional bladder/bowel control incontinence without a toileting plan). These topics could be converted to change measures by comparing the rates at different times. Several would be better measures of quality if they used incidence in lieu of prevalence (e.g., prevalence of stage 1-4 pressure sores, prevalence of any injury, prevalence of UTIs). One implies a change measure (i.e., incidence of decline in late loss ADLs), but could be more explicitly organized to look at change more directly.

The fundamental basis of an outcomes approach lies in its ability to relate the outcome of interest to the care provided. To do this, it has to eliminate the effects of other factors that might influence the outcome. There are several ways to accomplish this goal. 1] One can use a randomized controlled design, where cases are randomly assigned to one type of treatment (or treater) or another. Because the cases are assigned by chance, presumably the other factors would be equally divided between both groups. Such a design is difficult to accomplish and certainly would not fit the realities of daily practice. 2] Another approach recognizes that the groups receiving different care are not randomly assigned. However, specific efforts are made to create homogenous subgroups that share the risk factors believed to be most pertinent to the outcomes of interest (e.g., bedfast residents with stroke at risk for pressure sores). However, it is hard to create such subgroups using more than a couple of variables. 3] Instead, statistical approaches can be utilized that correct or adjust for differences among cases. The key to this approach is to think of the definition of an outcome result as the comparison between the observed result of care and the expected result, where the latter is based on statistical predictions that adjust for relevant clinical and social factors associated with the case.

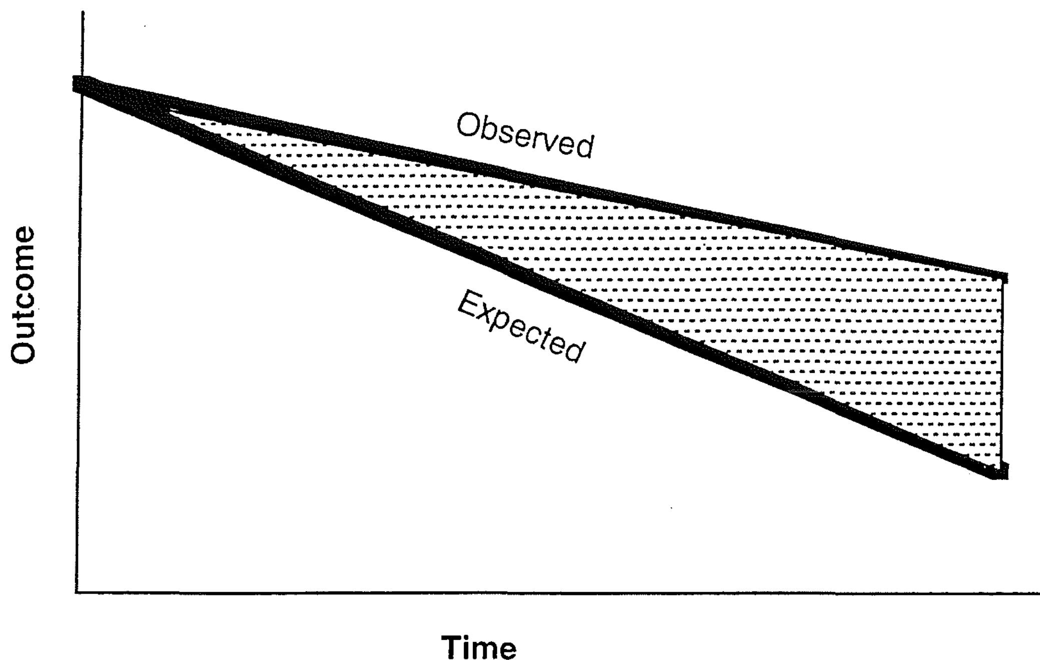
One way to think about outcomes analysis is to use the following conceptual model:

Outcomes = f(baseline, patient clinical factors, patient demographic factors, treatment)

The goal of the analysis is to separate the effects attributable to treatment from those influenced by patient characteristics. This correction for case mix is usually accomplished by statistical methods (like regression), but Zimmerman has developed explicit clinical subgroups for many of his various quality indicators to accomplish the same general goal.

Because many, but certainly not all, of the residents in nursing facilities suffer from serious chronic problems for which the prognoses imply functional decline, good outcomes should be thought of as **trajectories** that are at least as good or more positive *than would be expected* under conditions of good care. Good LTC may mean that the patient does less poorly than otherwise. Of course, deteriorating condition should not be accepted as inevitable. For many parameters improvement is possible. New studies have suggested that even in some areas like mobility, improvement is feasible for at least some patients. The goal of an outcomes system is not to base expectations on opinions or beliefs, but to use actual experience to compare the performance of one provider with that of all others. In this way, as knowledge and the skill in the field grow, so too will expectations.

The definition of what constitutes a good outcome is thus not based on how a given patient does over time, but how that course compares to what can be realistically (statistically determined) expected. The outcome can be based on performance in a specific domain or some sort of composite score based on a combination of several domains. The following diagram illustrates the relationship between observed and expected outcomes.



This diagram is the general outcomes model for any outcome. As shown, the observed course shows a decline over time, but this course is better than what would be expected for similar patients. The shaded area represents the extent of improvement between the observed and expected courses. If the outcome were something bad (e.g., a complication like an infection or becoming more depressed), then doing better than expected might be portrayed as having less of that attribute.

A payment system could be created that was proportionate to the size of the shaded area or one could simply opt for a dichotomous payment that would reward any improvement (or perhaps any improvement greater than some minimal level) over the expected. For example, a 10% difference between observed and expected outcomes could lead to a 10% bonus; whereas any improvement over 5% could also lead to a fixed bonus amount regardless of the amount of improvement over 5%. A third condition offers a hybrid; it could create bonus categories, for example 5-15% improvement could generate a 10% bonus, more than 15% would generate a 20% bonus.

Indeed, the appropriate interpretations of both the absence of bad events and the presence of good ones requires adjustments to recognize the differences in risk factors. These factors are often referred to as case-mix, although they should not be confused with the case-mix used for payment, which may or may not cover the same elements. Sophisticated statistical approaches are needed to correct for the differences in risk factors to assure that comparisons across institutions or among groups of residents (or across settings) are valid (Kane, Bell, Riegler, Wilson & Keeler, 1983); (Kane, 1994). We are proposing such statistical approaches in the development of outcome-based measures which will be outlined later.

One can use this approach for individual outcomes, but in most cases some summary measure is sought that combines a number of outcomes into a single conclusion.[2] This step requires some method for weighting the components to assure they are proportionately included in the aggregate measure. In all likelihood, not all elements are suitable for all residents. For example, cognitively impaired residents may not be able to express satisfaction. One can either use proxy information or

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[2] Some observers would argue that a single summary score may obscure too much and would prefer to use several separate outcome measures.

exclude that component. We have had experience collecting the value weights for the relevant outcomes from a variety of constituencies, including residents, providers, family members, regulators, policy makers, and the general citizenry. In general, we found a high level of concordance in the relative weights assigned to the various outcomes (Kane, Bell & Riegler, 1986). Moreover, our studies have shown that various raters apply different weights to different classes of residents (i.e., physically and cognitively impaired). Work to data has focused on weighing the positive functional outcomes). More work is needed to incorporate the negative outcomes as well.

Developing an Incentive System

The legislation for the Contractual Alternative Payment Demonstration Project (CAPDeP) requires that the alternative payment system contain some features. During the first year of the facility's contract with the Commissioner under this project, the Contractual Alternative Payment must be the rate the facility would have received under Minnesota's case mix system. In the second and subsequent years, the total payment to the nursing home can *be no larger* than the rate from the initial year (1) adjusted for inflation using the Consumer Price Index-All Items (United States City average), as is specified in the legislation, and (2) an additional 5 percent. Again, the incentive payment will be based on the facility's performance in achieving the five types of outcomes outlined in the legislation.

Until now nursing facilities have been paid under the prospective case-based payment system adopted in Minnesota in 1985. Under this system, Minnesota nursing homes are paid on the basis of 11 patient case types. Payments to a nursing home for resident days vary with the weight assigned to the resident's case type. Therefore, each facility has its own rate schedule for the 11 case types, based on past expenditures.

Each resident in Minnesota nursing homes is classified into one of 11 case-mix categories. Assessment for classification is done at admission, every six months, and after hospitalization. Classification is determined by key items in the Minnesota Department of Health Quality Assurance and Review (QAR) assessment instrument. Each of the 11 categories has an assigned average resource utilization weight.

Classification occurs in three steps. First, scores for key activities of daily living (bathing, dressing, grooming, eating, bed mobility, transferring, toileting, and walking) are converted from scale to a binary classification: "not dependent" or "dependent." Second, the "dependent" ratings for the ADLs are totaled and the total is used to classify residents into one of three "meager categories:" Light ADL, Medium ADL, and Heavy ADL. Third, assessments of key behavior, special nursing, and neurological conditions are incorporated to subclassify residents into their final case mix category:

Classification	Weight (relative resource use)
A. Light ADL	1.00
B. Light ADL Behavior	1.30
C. Light ADL Special Nursing	1.64
D. Medium ADL	1.95
E. Medium ADL Behavior	2.27
F. Medium ADL Special Nursing	2.56
G. Heavy ADL	3.07
H. Very Heavy ADL (Eating 3-4)	3.25
I. Heavy ADL Severe Neuro Impairment	3.53
J. Heavy ADL Special Nursing	4.12

Payment rates are based on facility costs from the previous year, plus an inflation factor, constrained by cost limits. Limits are a function of the average base year cost (plus an inflation factor) for all nursing homes in the facility's geographic group. Limits are more stringent for non-patient-care costs. There are also payments for cost components which are thought not to vary with volume or case mix. Costs which are assumed not to vary with case mix comprise about 3/4 of total home inpatient costs.

Facilities may also earn a profit, called an "efficiency incentive," of $2 per patient day if their non-patient-care costs are lower than the limit for their geographic area. Since there is a one-year lag in cost-based payments, facilities may also earn a one-time profit from the previous year. However, this one-time profit will disappear in the next year unless the costs continue to fall. Due to the limits and state-determined inflation factors, and the tying of the private price to the Medicaid reimbursement rate, there are also ample opportunities for facility losses (i.e., payments lower than actual costs).

Operating costs are divided into (1) care-related costs and (2) other operating costs, for limits and efficiency incentives. Care-related costs, in turn, are composed of nursing costs (including salaries, benefits, and payroll taxes).

It is important to recognize that the case-mix payment system (with whatever modifications) is likely to provide perverse incentives for outcomes that are directed at aspects of function. In effect, a case-mix reimbursement system rewards poorer functioning because poorer functioning is usually associated with needing more care and hence receiving a higher payment. These inherent contradictions need to be addressed.

Incentive Payments

Several approaches to rewarding good outcomes can be considered. Before considering the options, one wants to think about several issues: 1] Is this system designed to limit the state's risk? In essence, this question raises the issue about whether it should be feasible for every home to get the bonus, or should the bonus be reserved for only a few homes. Ideally, a bonus system should at least have the potential to be financially neutral by applying both rewards and penalties. However, it does not appear that the state wants to consider penalties at this stage. Hence, the rewards need to be constrained. 2] How important is simplicity of operation? For example, it is easier to administer a system that uses a fixed standard and rewards every home that exceeds it. A somewhat more complicated system would rank homes and reward only those in the top x%. A still more sophisticated system would make the payment proportional to the degree of improvement.

1. The simplest approach is some sort of goal attainment model, where nursing homes are paid a fixed amount if milestones are reached. This approach, which corresponds to the upper left-hand cell in the table shown earlier (absolute-fixed), was used as the basis for the QIP program in Illinois, a variant of which was later implemented in Florida as well. An evaluation of the Quality Improvement Project (QIP) suggested that it did not achieve its goals. Almost every home that applied was a winner and the measures became readily corrupted. The least satisfactory area was satisfaction (Geron, 1991). The MDS data could be used to create the criteria for the milestones. The standard would be a predetermined rate of performance (e.g., x % of cases above a certain level). Alternatively, the nursing home could be paid an incentive for each case that exceeds the threshold criteria.

For some outcomes, like decreased acute care costs, nursing homes could be paid a bonus proportionate to the amount saved. Such a system would require sophisticated accounting and

could produce undesired incentives to avoid potentially useful care, especially for presumably terminal patients.

2. The goal attainment model could be made less expensive if, instead of rewarding any home that achieved the target, the system used a relative end point, whereby only those homes in the upper "x%" on a given item were rewarded. In effect, the homes would be ranked on the basis of their performance and only those at the upper end of the distribution would receive the bonus. This ranking method, which corresponds to the lower left-hand cell in the table (relative-fixed), poses special problems if the system is confined to only those homes participating in the demonstration. Because these homes are already pre-screened, the state may end up ranking homes that are already located in the upper end of the full statewide distribution. The homes would be competing with the best of the best rather than with the overall state average.

3. The next step in the progression of payment schemes would be to use a zero sum approach, which would feature not only winners but losers as well. Those at the top of the distribution would be rewarded, but those at the bottom would be penalized. This is another version of the relative-fixed approach from the table, but it could use relative-change if the comparison was based on changes in resident outcomes. The proportion of reward to penalty need not be equal; it can be adjusted such that level for rewards could be more generous than that for penalties.

The ultimate goal of an outcomes approach is to use the outcomes information as the basis for a payment system. We have previously proposed such a scheme (Kane, Bell, Hosek, Riegler & Kane, 1983). Several variations are feasible. At one level, one can use an adjustment factor based on the outcomes to adjust either the total payment or the portion attributable to variable costs. At least two options are available for the adjustment factor. One can create a variable that is proportional to the net (adjusted) amount of improvement or worsening or one can use a more categorical approach, where outcomes significantly better than expected are given a fixed positive bonus and those significantly worse a negative bonus. The payment system can be developed to be budget neutral by allocating payments in a redistributional (zero sum) model, where the rewards to winners equal the penalties to losers; or one can alter the balance such that more rewards are paid than penalties. Alternatively, one can design a system where nursing homes do not compete against each other, allowing all to win or to lose. One would probably not want to base the full nursing home payment on outcomes. A better formula would be something along the lines of

Outcome = fixed payment (based on case-mix) + *bonus* (based on outcomes)

The "bonus" could have a negative as well as a positive sign (i.e., it could be penalty as well as a reward).

If an outcomes payment approach is contemplated, the question then arises of how to merge it with the case-mix payment approach. If improved function is a goal, one would not want to pay more for functional decline. Hence case-mix should be used on admission and possibly at infrequent intervals, say once a year.

A final option would be not to use financial rewards at all but to rely on market motives by announcing/publicizing the names of the best homes. Discussions with the nursing home representatives some years ago, when this concept was first being discussed, suggested that this positive image would be incentive enough.

In calculating outcomes for determining rewards, there are two choices: 1] One can assign a reward to each outcome separately. 2] One can create an aggregated score for each resident as the basis for assessing improvement or decline. The latter will ultimately prove simpler but it requires making explicit statements about the relative importance of each outcome. Such decisions must inevitably be made in any event. Ignoring them and treating all outcomes as equivalent simply assigns a value of "1" to each; the value weights are hidden but they are still there. Equal weighting

may not be appropriate. Techniques have been developed and used on a variety of constituencies to assess the values held by various groups. (Kane et al., 1986)

Potential Effect on Constituents

It is helpful to examine these alternative uses of incentive payments might affect the salient constituents, namely, the nursing homes, the clients, and the state. The following table summarizes some of the possible effects.

Scenario	Effect on:		
	Nursing Homes	Clients	State
Goal attainment	win only everyone can win	should benefit from better care	can raise costs
Reward best performers	force competition (best of the best)	should benefit from better care	limit costs
Zero sum	winners and losers; risky; likely to challenge system	could get caught in gaming	budget neutral
Proportional incentives	likely to challenge adjudications	could affect admission policies	could be expensive; could be operated as budget neutral; more work to administer; conflict with case-mix payment incentives
Reputation only	no risk; interest would vary with market conditions	information on which to base entry decisions	no cost; some potential political heat

The payer and the recipient of payment seem to have the most at stake. Nursing homes seem most likely to favor an approach where everyone can win and they are not placed in competition with each other. A system that includes penalties as well as rewards will be much less popular. An approach that tries to measure the size of the benefit will be more likely to be challenged.

Consumers should benefit from all of these approaches. The proportional incentive approach could cause nursing homes to be less anxious to admit patients where they did not feel they could make a difference.

The state faces some important choices. These options present different financial risks. The overall size of the risk can be capped by the amount placed at risk, but the size of the reward has to be large enough to warrant attention.

In general the more sophisticated systems (those that try to make the reward parallel to the performance) are the most complicated to understand and administer but the most likely to be fair. Because there will likely be more losers than winners, the pressure to change the system to make it easier to win will be great. The disadvantaged will want to challenge the system's fairness. A similar response to the market-driven approach may ensue if reputation is viewed as a major influence on admissions.

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APPENDIX Y

"Assuring Quality in Nursing Home Care," by Dr. Robert Kane, Journal of the American Geriatrics Society, Vol. 46, No. 2, February, 1998

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SPECIAL ARTICLE

Assuring Quality in Nursing Home Care

Robert L. Kane, MD

HISTORICAL PERSPECTIVE

The role of regulation and external monitoring is more stringent in nursing home care than in any other type of social service. The reasons are several. Unlike other professional groupings, such as medicine, nursing, social work, and hospitals, the nursing home industry failed to establish itself as a professional activity at the time of its growth surge in the mid 1960s. This growth coincided with the establishment of substantial federal investment in nursing home care, an investment that was unexpected and for which the governmental bureaucracy and the nursing home industry were unprepared. The initial experience was marked by exploitation and, subsequently, by scandal. The population served is viewed as very vulnerable, both physically and mentally.

Any private industry that uses substantial public funds is likely to be regulated. When the private organizations are largely proprietary and often without sophisticated operational structures, the role of regulation becomes even more dominant. Because catastrophes catalyze regulation, the notoriety that came from state and federal commissions that uncovered gross instances of flagrant exploitation fanned the flames of stringent regulation.

Nonetheless, the pressures for regulation of nursing homes have not been consistent, either temporally, or geographically, or politically. The 1986 Institute of Medicine (IoM) report[1] occurred as a result of conflict between forces that wanted more and less regulation. Until the passage of the 1987 Omnibus Budget Reconciliation Act (OBRA '87), there was great interstate variation in the stringency of regulations and standards. There is still substantial variation in the enthusiasm with which remedies to substandard care are pursued.

Theoretical Basis for Nursing Home Regulation

It may be helpful to distinguish among different dimensions of quality. The dominant paradigm in quality assessment continues to be the formulation developed by Donabedian, which distinguishes three categories of information about quality: structure, process, and outcomes. The three are linked conceptually, with the first two expected to increase the likelihood of the latter. Better structure and more appropriate processes are expected to yield better outcomes. The linkage between these elements remains more theoretical than empirical. Although there is some evidence that structural elements, such as staffing, can affect the outcomes of care, there are many areas in which the relationship between structure and outcomes is not established, including the necessity for specific training. Likewise, many professional orthodoxies about how care should be given have not been linked to better outcomes.

Quality of care usually refers to *process* measures that indicate whether the right things were done (and sometimes whether they were done with adequate skill). Quality of care also can be assessed in terms of *outcomes*. These outcomes may be thought of as both the absence of bad events and the presence of good ones. They can be expressed in clinical terms, such as death or measures of morbidity (e.g., decubiti) or physiology (e.g., blood sugar, blood pressure); or they can be expressed as more general domains such as function, cognition, social roles, and affect. The latter (in whole or in part) are often referred to as measures of quality of life. Most observers include resident satisfaction with care, services, and the living environment as an important quality outcome domain. Some people include cost as an outcome, but others (including the IoM)[2] treat it separately in order to calculate more rational cost-effectiveness ratios.

The second major distinction around quality efforts is the difference between quality assessment (where the Donabedian paradigm is applicable) and quality assurance. In general, it is much easier to detect a quality problem than to fix it. Quality assurance efforts with regard to nursing home care have been marked by active litigation and extended legal challenges that have made the experience extremely adversarial. As a consequence, the role of the regulatory agent has become exclusively external lest any efforts to offer suggestions for improving care compromise the potential for enforcement. In the same vein, sanctions are directed toward increasingly specific and measurable transgressions, which are easier to defend but which may not address the m[illegible] clinical germane aspects of care problems (e.g., unsanitary conditions, food temperature).

Studies of the outcomes of care are usually conducted for two reasons: (1) to provide a basis of accountability and (2) as a basis for improving the level of knowledge in a field. The former purpose is related directly to regulation, but the latter can play a significant role as well. Outcomes are the [illegible] direct window on the effects of care. They are not used as often as process measures because the latter are more professionally comfortable. Process measures are usually based on

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determining whether actions deemed to be appropriate for the situation are performed. The difficulty lies in deciding what is appropriate. In most cases, there is insufficient evidence to form a scientific opinion, and the decision rests on professional judgment. Carefully collected outcomes information linked to process items and client characteristics would alleviate this situation. An approach to implementing such a system is described later.

1987 OBRA

The passage of the nursing home reforms incorporated into the 1987 OBRA represent an important milestone in nursing home regulation. This law and its subsequent regulations were hailed as a dramatic shift in emphasis away from structure and process toward outcomes. Many of the mandates of the 1986 IoM report were incorporated into the bill, but the outcomes emphasis was oversold. The OBRA reforms went a long way toward standardizing quality standards for nursing homes and raising the expectations in many states, but the efforts were still largely structural and process.

One of the significant steps that came out of this reform was the introduction of a uniform set of information to be collected on every nursing home resident at regular intervals from admission through the duration of his/her nursing home stay. This Minimum Data Set (MDS) prescribed specific elements of information on various aspects of residents' status. It was intended to form the basis for both outcomes tracking as well as care planning. Unfortunately, the MDS was designed by a committee. In meeting the needs of a heterogeneous constituency, the information burden was increased, and the emphasis on outcomes tracking was undermined.

MDS STRENGTHS AND LIMITATIONS

The MDS represents an important shift in focus for nursing home regulation. It provides, for the first time, a universal set of information about residents that permits tracking and comparisons across nursing homes and among (and within) different classes of residents. It was designed to create a consistent set of information, with uniform definitions and reasonable levels of reliability for what is essentially a clinical tool.

A series of papers published in this journal suggested that the introduction of the Resident Assessment Instrument (RAI), which contains the MDS, was responsible for major improvements in nursing home care, including elements in the process of care,[3] improved function, cognition and psychosocial status,[4] health conditions,[5] and reduced hospitalization.[6] As noted in an accompanying editorial,[7] there are fundamental problems with the study designs. All of these studies rely on comparisons of care before and after the MDS was implemented. Because the RAI was mandated nationally, no comparable data are available to look for similar historical improvements in nursing homes where the RAI was not used. Such a causal argument is tenuous at best. The period covered saw major attention to nursing home quality as a result of the Nursing Home Reform Act, which was part of OBRA 1987. The changes in nursing home accountability, the emphasis on controlling the use of psychoactive drugs, and restraints that came in the wake of this new approach to monitoring quality of care in nursing homes make it very difficult to attribute the changes seen to a single component. Indeed, if one were to argue strongly for an RAI effect, one might be disappointed at the modest results reported. Even in areas where one could make a persuasive case that more complete and more structured record-keeping should influence the process of care, significant process improvement was found in only five of the 18 areas covered by the Resident Assessment Protocols although there was a consistent picture of more attention given to each.[3] The direct causal case for the claimed benefits is even harder to make. The inability to detect stronger effects may reflect a weakness in the MDS as a potential research tool.[8]

These results do not detract from the demonstrated value of introducing the RAI as part of an overall effort to improve nursing home quality. No one would argue with the desirability of using a systematic, structured approach to assessing residents. However, because the MDS is useful does not mean it cannot be improved.

The MDS' most serious flaw as an outcomes tool stems from its deliberate effort to provide uniform data. This decision has reduced the information to the lowest common denominator. For a nursing home population, this means that all residents are treated as though they were cognitively impaired. Cognitively intact residents, who could have provided insights into their status, are treated as if they could not respond directly to questions. In effect, all items are reported by an external judge, usually a nurse. As a result, several important domains of outcomes are either uncovered (satisfaction, meaningful social activity, and social interaction) or covered by use of third-party judgments that rely on observations (pain/discomfort, cognition, emotional state).

Although in some cases (e.g., depression) the training manual suggests specific behaviors to observe, these observations are used to form a judgment. It would be better to record the actual answers to specifically determined questions posed. Such a step would provide a better basis for any summary score and would increase the consistency across the raters. Although the RAI has been revised, no changes have been made to address this problem.[9]

Several studies have been undertaken to establish the validity of MDS information in areas where it does not seem to work especially well. Although there are no direct measures of cognitive function, a series of behavioral reports are used to create a cognitive score, which has been shown to correlate highly with more traditional measures of cognition.[10] In effect, what has been demonstrated is the ability to discriminate between those who are cognitively impaired and those who are not. Indeed, the results of a wide variety of cognitive measures correlate very highly in general. The critical issue for outcomes purposes is the sensitivity to change in resident status that each measure can provide. The same observations can be offered for the efforts to establish a measure of emotional function based on observed behaviors.

Some of the problems associated with the MDS are hard to avoid. Although it was intended to be used proactively to improve care by identifying areas that needed attention and by directing that attention to specific actions, the MDS was viewed by many from the outset as primarily a regulatory device imposed from without. Nursing homes, which had become adept at meeting the demands of external regulation, responded by making sure that the forms were completed as required. But the task was sometimes accomplished by dissociating the data from its use. In the most flagrant cases, external data collectors were contracted to complete the forms, and the information was never used clinically. [illegible]

theless, even if its proactive role is not universally achieved, the MDS can still provide useful outcome information, by focusing on those domains that are covered best.

NEED FOR MORE OUTCOMES EMPHASIS

Conceptual Issues

In an area like long-term care, where so little is established about the relationship between process and outcomes, there is a strong argument for concentrating regulatory activities on assuring that satisfactory outcomes are achieved. Such a philosophy is at odds with practice. Often when uncertainty about the best path to follow is greatest, the press for orthodoxy becomes most intense. One argument for eliminating variation under such circumstances is the need to collect systematic data, but the more fitting response to that challenge is to emphasize the collection of information, not to eliminate alternative approaches to care.

There are problems with an exclusive focus on outcomes. The most glaring is the need to make necessary adjustments to assure that the groups being compared are comparable. The key to any outcomes approach is comparing the actual result with that expected if comparable cases were treated under regular (or better) circumstances. One can set the standard for good care by using different comparison groups. Ordinarily one would want to use something that approximates what is believed to be good care, not just average care. However, it may be more feasible to begin by comparing results to the 50th percentile and gradually raising the standard over time. Sophisticated statistical methods are available for such purposes, but none can assure absolute comparability.

One way to enhance the comparisons between actual and expected outcomes is to focus the comparison on specific subgroups of patients. Good care may have dramatically different effects on different types of patients. Nursing homes house a heterogeneous cluster of residents. One classification system could utilize major diagnostic groupings similar to the DRGs. A more basic taxonomy would at least recognize the differences in natural history among the residents. At least five clusters can be identified:

1. Persons seeking rehabilitation or active recuperation; these people are expected to have short stays and to improve, with most discharged to the community
2. Persons with primarily severe chronic physical disability; these people will likely decline gradually over time; many will stay for some time; most are cognitively intact although some may be depressed by their circumstances
3. Persons with primarily cognitive impairments; these people are often very active and disruptive; their activities may adversely affect the quality of life for others; they will usually stay a very long time and decline over time
4. Persons in vegetative state; these people may have reached this stage by virtue of a physical or mental problem; they have lost the capacity to respond to their environment
5. Terminally ill persons; these people are too advanced to profit from active treatment; they have poor prognoses and need some form of hospice care.

Another problem outcomes present is that they are, by nature, retrospective. One assesses outcomes only after enough time has elapsed to measure the effects of actions taken earlier. Hence, problems can be addressed only after they have occurred. Efforts to head them off require addressing aspects of process. Likewise, outcome performance does not automatically point to the care deficiency; it simply tells you where to look. Subsequent detailed examination of the process of care is needed.

A major philosophical issue around determining quality in nursing facilities and for residents is *what represents a good outcome?* Much of the past emphasis on quality assessment for nursing home residents and nursing homes has emphasized the absence of bad (undesired) events. Thus, great efforts have been made to establish the use of chemical or physical restraints or the presence of pressure sores or other untoward elements of care. Whereas no one wants to condone the presence of these undesired elements of care, their absence alone does not indicate good care. An ideal outcomes system would include both measures of adverse events and the production of desired ends. To assess the latter, one needs to examine the rate that improvement in the major classes of resident outcome has achieved, where feasible, or at least that the rate of inevitable decline is slowed. In essence, assessing outcomes requires a comparison of observed outcomes with expected outcomes.[11]

The basis of an outcomes approach is its ability to relate the outcome of interest to the care provided. To do this, it has to eliminate the effects of other factors that might influence the outcome. One way to accomplish this goal is to use a randomized controlled design, where cases are randomly assigned to one type of treatment (or treater) or another. Because the cases are assigned by chance, presumably the other factors would be equally divided between both groups. Such a design is difficult to accomplish and certainly would not fit the realities of daily practice. Instead, statistical approaches need to be utilized that correct or adjust for differences among cases. The key to this approach is to think of the definition of an outcome result as the comparison between the observed result of care and the expected result, where the latter is based on statistical predictions that adjust for relevant clinical and social factors associated with the case.

One way to think about outcomes analysis is to use the following conceptual model:

Outcomes = f(baseline, patient clinical factors, patient demographic factors, treatment) (1)

The goal of the analysis is to separate the effects attributable to treatment from those influenced by patient characteristics.[12]

Because many, but certainly not all, of the residents in nursing facilities suffer from serious chronic problems for which the prognoses imply functional decline, good outcomes should be thought of as trajectories that are at least as good or more positive than would be expected under conditions of good care. Good long-term care may mean that the patient does less poorly than would otherwise be expected. Of course, deteriorating condition should not be accepted as inevitable. For many parameters, improvement is possible. New studies have suggested that even in some areas like mobility, improvement is feasible for at least some patients. The goal of an outcomes system is not to base expectations on opinions or beliefs but to use actual experience to compare the performance of one provider with that of all other

this way, as knowledge and skill in the field grow, so too will expectations.

The definition of what constitutes a good outcome is, thus, not based on how a given patient does over time but rather how that patient's course compares with what can be (statistically determined) expected realistically. The outcome can be based on performance in a specific domain or on some sort of composite score based on a combination of several domains. Figure 1 illustrates the relationship between observed and expected outcomes. This diagram is the general outcomes model for any outcome. As shown, the observed course exhibits a decline over time, but this course is better than what would be expected for similar patients. The shaded area represents the extent of improvement between the observed and expected courses. If the outcome were something bad (e.g., a complication like an infection or becoming more depressed), then doing better than expected might be portrayed as having less of that attribute.

The definition of what constitutes an outcome should be broad enough to include both positive and negative events. The absence of bad outcomes does not, per se, represent good care. Because the expected course of many people receiving long-term care is gradual deterioration in many sectors, a good outcome may well be doing better than expected, i.e., slowing the rate of decline.

Multiple Outcomes

Outcomes can be assessed across several domains. There is good consensus about the most relevant domains for long-term care. They include:

- Physiological (e.g., blood pressure, blood sugar, skin condition)
- Functional (e.g., ADLs/IADLs)
- Pain and discomfort
- Cognition
- Affect
- Social activities
- Social relationships
- Satisfaction (with both setting and care)

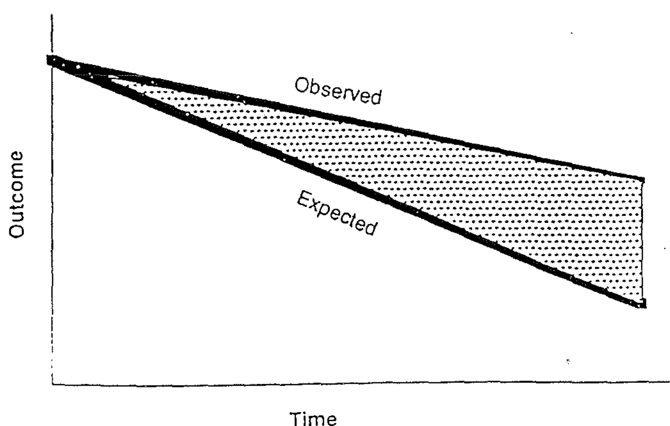

Figure 1. The relationship between observed and expected outcomes for a hypothetical patient. The figure applies to any outcome parameter. It suggests that a course which does better over time than would be expected should be judged as success. The shaded area represents the extent to which the patient's course exceeded expectations.

Each of these can be measured by a variety of instruments with established reliability and validity.,[13–16] Many, but not all, of these are captured in the MDS.

For some purposes, it may be preferable to treat each of these outcomes separately, especially to link various aspects of care to the results, but to arrive at a summary judgment about the overall quality of care some type of summary measure is needed. Too often outcomes are summed by simply adding together the values of the individual components. Such a process ignores the relative importance of each component and may add further bias by virtue of the individual scoring system used for each element. A more deliberate weighting of the individual scores is needed, but whose value weights should be used?

Some early work on this question suggests that the issue may not be as difficult as some expect. There was substantial agreement on the relative importance of the outcome components among residents, regulators, policy makers, providers, and the general public. Family members tended to be less discriminating, rating everything as important. There were, however, substantial differences in the weights assigned to different types of patients. Those most disabled, especially cognitively, received lower scores.[17] The results of this study suggest a composite scoring system can incorporate value preferences for different domains. Such weights could be obtained from surveys of the general public or other defined constituencies, or they could be obtained from the clients themselves. Indeed, it is feasible to allow each client, at least for those who are cognitively intact, to establish his/her own preference weights for the outcomes of their care.

Role of Outcomes

Outcomes may be used as ends in themselves (with rewards and punishments designed to respond to them) or they may be used as indicators of where to look for more detailed determinations about the quality of care rendered. In the latter case, they represent some form of screening.

The demands on the data and the measures are different under these two auspices. When used simply as screeners to identify suspected areas of poor care, substantial error can be tolerated because subsequent steps will be used to verify the presumed result. When the outcomes are used as the basis for subsequent actions to reward or punish care providers, then the measures must demonstrate a level of accuracy and discrimination that justifies such use. Part of the concern about accuracy will stem from being able to obtain sufficient numbers of cases from any single provider to generate a statistically significant sample. Undoubtedly, some type of aggregation of cases will be necessary in many instances.

Incentives can be linked to outcomes in various ways. The most direct is to tie payment to outcomes (expressed as the relationship between observed and expected). Better than expected outcomes could generate some form of bonus or reward; conversely, poor outcomes would lead to a penalty. The size of reward needs to represent a significant portion of the total costs of care lest providers focus on other ways to maximize their income by providing inadequate care. At some point, the dominant underlying reimbursement system may come into direct conflict with an outcomes approach. For example, a cost-based technique such as Resource Utilization Groups (RUGS) that tends to reward deterioration in client function when that deterioration is associated with the need for more care would be in direct conflict with [illegible]

incentive system based on outcomes. It is important to recognize that systems like RUGS (and diagnosis-related groups (DRGs)) capture the current state of care. At best, they model how many resources are presently being used, on average, to provide care in the way it is currently given. They say nothing about what is required to give good care.

The reward/penalty need not be solely monetary. In many instances, public notoriety may be as strong a motivator as the modest financial rewards or penalties usually proposed. Publishing the results of outcomes assessments may become an important part of a nursing home's community reputation, both with potential consumers and those who refer cases. The effect on the demand for care may be more substantial than the bonuses associated with good results. Another way to reward good outcomes is to impose less oversight. Earlier programs, such as NYQAS in New York State[18] or the Quality Assessment Index in Wisconsin,[19] used the results of marker outcomes as indicators of nursing homes that needed more or less intense regulatory attention. The sentinel events that those programs used relied on specific indicators of potential problems, but the same approach could be applied to measures that reflected functional trajectories.

One of the advantages of an outcomes system is that it permits comparisons across modalities of care. At a time when new forms of care (or variations on extant themes) are developing continuously, it is helpful to be able to assess the relative effectiveness of alternative approaches to caring for comparable clients in different ways and even in different environments. Focusing on outcomes facilitates such comparisons, because none of the relevant variables are linked directly to a particular site of care or even a specific way of rendering that care.

Relying exclusively on post-hoc measures of outcomes may limit regulatory programs too severely. There are some outcomes that should be prevented. Waiting to respond to their appearance is too late. For example, one would not want to wait for a nosocomial infection before assuring that adequate infection controls were in place. Likewise, there are some aspects of care that are best measured directly. Although it is possible to capture the results of some process variables, such as courtesy and respect, through dimensions of client satisfaction, the latter measures may be too insensitive and are certainly too late to affect the care. It is preferable to observe these behaviors directly.

EFFECTING AN OUTCOMES APPROACH

One of the concerns about implementing an active system of outcomes determination is the cost associated with data collection. Because the information should be collected directly from clients (or their proxies), it requires an investment of considerable time. Although some may argue that it is time well spent, such an outlay for regulatory purposes would not be well received in times of budgetary constraints. Some of the costs could be offset by reducing other, less satisfactory regulatory actions, but the overall effect on regulatory costs would likely still be positive.

One way to implement an outcomes system within extant budgetary constraints is to adopt the MDS. The first step might utilize those variables that are best covered in the data collected, namely those addressing function. Models that compare actual and expected values for this domain could be developed at very modest costs.

A second step would be to create two forms of the MDS, one for cognitively intact respondents and a second that retains the current approach of external rating. The interview form could cover many of the missing or modestly addressed outcomes domains not easily accessible in the current MDS. Using cognitive intact clients as the basis for determining some aspects of care that might also affect the cognitively impaired has precedent. This sentinel approach forms the rationale for requiring that risk-based Medicare HMOs have at least 50% non-Medicare enrollees. The underlying belief is that private sector market forces at work will protect the Medicare beneficiaries' interests by speaking out against inadequate care. Likewise, cognitively intact nursing home residents can serve as bellwethers for poor interpersonal care on behalf of those unable to voice a protest.

Using the data generated by the staff being judged may raise some concerns about the possibilities of manipulation, but the outcomes system is not easy to game. Although it is possible to exaggerate the initial levels of impairment in order to create more sympathetic trajectories of expected values, such a step works only at the first round. Because the outcomes from the first follow-up also serve as the baseline for the second round, such distortions are difficult to sustain. Any operational system would likely require some method for randomly checking the assessment results to assure valid responses, but this validity testing would be much less expensive than a full blown primary data collection.

TWO-TIERED REGULATORY APPROACH

The overall regulatory approach that could best incorporate an outcomes principle would use a two-level system similar to that proposed for quality assurance for acute care under Medicare.[1] The primary investment in quality improvement would come from continuous quality improvement (CQI) techniques employed by the institution to foster its own care. Nursing homes that could not mount such CQI efforts would be subject to stricter oversight.

Outcomes (generated from analyses of data collected as suggested above) would be used to monitor the overall quality of care. As problem areas are detected (types of care or patterns of outcomes), special studies would be mounted to examine those areas in greater detail. These studies would be primarily process oriented, but they could entail more detailed examination of the outcomes of care as well. The oversight system would be responsible for assuring the validity of the data collected as part of the clinical routines.

The Role of CQI

In the current parlance, CQI stands as the engine that drives quality improvement. The term quality improvement is seen as kinder and gentler than quality assurance. The latter assumes a more regulatory tone. Classic CQI looks very much like an earlier version of cybernetic management with a phase of problem identification, a planned response, and evaluation to assess whether the intervention actually led to an improvement.[20] This earlier experience suggests some potential problems with this approach. The nursing home may be an even more difficult environment in which to introduce this concept.[21] Perhaps the most serious is the danger that, especially under outside pressure to conduct such efforts, the institution will opt for problems that can be managed. Rather than looking for the most important problems, those that create the greatest threat to successful ou

comes, the staff charged with the responsibility for conducting CQI may choose the problems they think they can fix, thereby improving their track record. For example, when hospitals were required by PSROs to conduct a certain number of Medical Care Evaluation studies, they chose the topics that produced the most accessible data.

As CQI has entered the age of medical marketing, with its emphasis on addressing consumer expectations, nursing homes at the cutting edge of implementing CQI seem to be focusing on aspects of care that address family concerns. Thus, they may put more effort into finding ways to make visitors feel comfortable than into improving the care provided to residents. Those things that are most obvious to outsiders will get attention before the generally more critical infrastructure is tackled. Customer focus has been perverted into customer appeasement.

The fundamental concept of customer responsiveness has been widely misunderstood. It is one thing to work with customers to develop better ways of coordinating activities. It is quite another thing to define outcomes solely on the basis of customer expectations. The world is filled with important inventions that would never have been created if industries simply relied on their customers to define their needs. The key to customer focus is using that input to look beneath the surface to address the issues that bear on the things that create the problems that provoke customers. Superficial implementation of CQI can lead to satisficing (i.e., doing just enough to keep critics happy, rather than addressing the issues in earnest).

In light of these concerns, some form of external monitoring that holds care providers accountable for meaningful outcomes seems especially necessary in the era of CQI.

CONCLUSION

Long-term care is still in a state of evolution. Regulations will need to evolve with these changes. The goal should be to create a climate of accountable innovation. An emphasis on outcomes will provide such a condition. Outcomes can be used in a variety of settings and can compare results across settings. As new forms of long-term care arise, the challenge will be to regulate them such that the regulatory process does not preordain the structure. Requiring that any type of long-term care achieve reasonably expected functional and quality of life results across a variety of domains after adjustments for client characteristics should provide for fair competition on the basis of socially relevant parameters.

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APPENDIX Z

"Predicting the Outcomes of Nursing Home Patients," by Kane, Bell, Riegler, Wilson and Keeler, The Gerontologist, Vol. 23, No. 2., 1983

We propose a system of nursing home reimbursement based on attaining achievable outcomes. The crux of the system rests on our ability to predict patient outcomes from one point in time to the next. Using three waves of data collected at 3-month intervals on approximately 250 patients, we were able to predict patient functioning in six domains (physiologic, activities, affective, cognitive, social, and satisfaction) with R^2 values ranging from 0.51 to 0.93. Predictions of discharge (better, worse, or dead) were less accurate, with R^2 values of 0.36 to 0.39.

Predicting the Outcomes of Nursing Home Patients[1]

Robert L. Kane, MD, Robert Bell, PhD, Sandra Riegler, MS, Alisa Wilson, MA, and Emmett Keeler, PhD[2]

The nursing home symbolizes the failure of the American society (Valdeck, 1980). We seem to be spending more to buy less. It is an institution shunned by both patients (U.S. Comptroller General, 1979) and physicians (U.S. Congress, 1975). But the problem is too big to ignore. In 1979 we spent almost $18 billion on nursing home care, more than half of that from public funds (Fox & Clauser, 1980). Demographic predictions indicate that this level of expenditure will accelerate as the population ages.

Efforts to improve the quality of nursing home care have met with limited success. Despite protestations about the need to consider quality of life concepts, most regulatory effort has addressed the nursing home as a miniature hospital (Kane and Kane, 1979). But it is difficult to establish clear links between the process of care and its results. In comparison to acute care, long-term care (LTC) is a low-technology endeavor where substitution of personnel and technique seems possible. Nor is it easy to apply traditional quality of care approaches to the nursing home setting (Kane et al., 1979). Meaningful criteria that monitor important process of care dimensions are difficult to create and apply. Consequently, the present regulatory system has concentrated, for the most part, on identifying substandard care at the cost of working to improve the general level of care.

Reform of the system should have the following overall goals:

1. To provide an incentive for high-quality care, defined in broad terms to include social and psychologic health as well as physical health.
2. To discourage market skimming whereby certain patients (usually those needing the least care in a category) are admitted while others with greater care needs are not.
3. To overcome the general tendency toward assuming that more is necessarily better and especially the perverse incentive of cost reimbursement that rewards the development of increased dependency.
4. To minimize the negative aspects of regulation (i.e., to avoid both the recordkeeping burden and the constraints on creativity).
5. To use the free market as much as possible to encourage the expansion of good homes and the closure of poor ones.

The core of our proposed approach links payment for care to the outcomes of that care, but we seek to achieve that linkage in a way that will not reward patient selection. The general thrust of the proposal is shown in the following basic payment formula: Nursing Home Payment = Cost × Prognostic Adjustment Factor.

In this approach, a nursing home is paid the sum of the payments for each patient. These individual payments are based on the product of the average cost of caring for such a patient times the prognostic adjustment factor (PAF). This PAF reflects the extent to which the actual outcome of care exceeds or falls short of an expected level. In its simplest form, one might assign a PAF value of 1.5 if the actual outcome is better than expected, 1.0 if it is as good as expected, and 0.5 if it is worse than expected. In practice, the PAF can be used as a continuous variable directly tied to the ratio of observed/expected outcomes.

Figure 1 offers a general model of the concept and illustrates how the predicted values are generated. At Time 1, an independent group (or individual) not part of the caregiving team (e.g., the state's utilization review team) gathers data on the patient. These data are used to generate a predicted course for that patient based on the experience of similar patients. The course can be essentially one of three: the patient gets better (A), stays the same (B), or gets worse (C). Each of these can be pictured not as a narrow line but as a band defined by confidence intervals to allow for variation.

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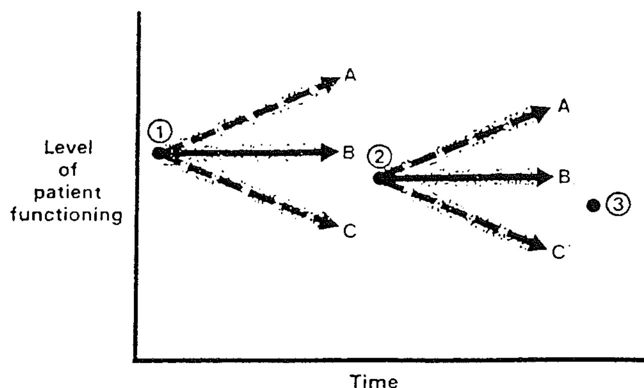

Figure 1. Diagrammatic representation of serial outcome assessments for a nursing home patient.

At Time 1, the patient's prognosis for the subsequent period is projected. (The grey areas indicate confidence intervals.) Basically one may look for some degree of improvement (here represented by line A), or maintenance (line B), or a worsening state (line C). When the patient is reassessed at Time 2, his actual outcome (shown as a point) is then compared with that expected by prognosis; if the prognosis had been along line C, the patient's status would be recorded as a positive outcome. However, if the prognosis had been along lines A or B, the outcome would be less than adequate. The actual outcome at Time 2 serves as the basis for a new prognosis, shown as A', B', or C'. These are in turn compared with actuality at Time 3 and so on.

The same data gatherer returns after a suitable period of time (perhaps 6 months) and again assesses the patient. By comparing the actual status of the patient to the predicted course, we arrive at the PAF for that patient over that interval of time. It is crucial to appreciate that we are primarily interested not in the outcome (i.e., the status at Time 2) but in how that state compares to the predicted state. Thus the same outcome could yield a better, the same, or a worse PAF, depending on what had been predicted.

The process is itself iterative in several respects. The data gathered at Time 2 are used to predict Time 3 as well as to reward Time 2. The prediction equation for Time 3 can also incorporate terms that reflect the changes from Time 1 to Time 2, thus providing a measure of self-correction for the system.

One must appreciate that the example shown in Figure 1 assumes a single point of data at each time. In fact, the data are a profile covering a variety of domains. It is necessary to reduce this profile to a point by applying appropriate weights to the several outcome measures. The weights represent the relative value placed on each outcome (Kane & Kane, 1982). Different groups (e.g., patients, policymakers, caregivers, taxpayers) may in fact place differing importance on the various outcome states. Ascertaining these thus becomes an essential component of the research. The overall system involves several steps:

1. Measuring multidomain functioning of each nursing home patient.
2. Measuring associated attributes that might be used to predict the future status of the patient.
3. Using data from earlier (Time 0) and current (Time 1) measurements to predict future (Time 2) status in each of several important domains.
4. Comparing actual status at Time 2 to expected (predicted) status in each domain.
5. Combining multidomain results into a single determination of how the outcome compared to what was expected.
6. Paying the nursing home for care of that patient using a formula that adjusts payment upward for better outcomes (actual/expected) and downward for poorer ones.

The fairness and utility of an outcome-based reimbursement system rest on the ability to develop an adequate predictive model for the outcomes used. Both by choice and by chance, nursing homes differ in their patient difficulty mixes. If the reimbursement system does not adequately account for the differences in expected outcomes (under normal care), nursing homes that take difficult patients will be unjustly penalized. If good prediction models can be developed, however, outcome-based reimbursement will provide an unbiased incentive for improved care.

Methods

To develop our prediction models, we have followed patients in four Los Angeles area nursing homes nominated by peers as giving good care. An instrument was developed to obtain data from patients via performance measures, structured interviews, and self-report on a broad set of functional aspects covering six distinct domains: physical, functional (ADL), cognitive, affective, social, and satisfaction. Extensive work was devoted to the development of reliable measures and suitable scales by which to aggregate these data (Kane et al., 1982). Virtually all data were obtained from the patients; we obtained only demographic information and diagnoses from medical records. The data are gathered by a specially trained collector (usually a nurse) in an interview/examination every 3 months. The sample sizes thus fluctuate as new patients are added and previous ones discharged; the average number of patients in any wave of examinations is about 250.

The data from earlier waves are used to predict the patient's status at later waves. The mathematical models have relied primarily on regression analyses. Beginning with the second wave of data collection, the interviewers were asked to make clinical predictions about expected change in domain over the subsequent three-month interval. The accuracy of these predictions is compared to that of the mathematical approach.

Several independent (predictor) variables have been tested with varying degrees of success. Most of the regressions have included age, length-of-stay (LOS), sex, and nursing home. LOS is measured in months from the date of the most recent admission to the date of the first interview. Because of the long tail of the LOS distribution and the expectation that its effect diminishes for long stays, the actual variable used is log (LOS − 1). Other independent variables include scale scores from earlier waves.

Admission diagnoses were collected from the patient's chart. To reduce the diagnosis list to a manageable number, relationships were studied using a

series of eight variables, indicating whether the resident had any of the diagnoses associated with various organs or functions such as brain, cardiac, vascular, etc. Proportions of patients with some diagnosis in each of the eight groups appear in Table 1. Correlations among the diagnosis variables are generally small. Somewhat more of the correlations are statistically significant (usually negative) than we would expect under the hypothesis of independence, but the correlations are small enough that we need not worry about multicollinearity in the regressions.

Many of the regressions also include the variable "total," the sum of the eight diagnosis indicators as a measure of ill health at admission. It should be noted that the total variable may differ from the actual number of diagnoses.

Results

Predicting scale scores. — Of the variables available to us, by far the best predictor of any scale score is the same scale score from a previous wave. Results appear below for three distinct sets of least-squares regressions using data from the first three waves:

- Predicting "first interview" outcomes from background variables (demographics and diagnoses)
- Predicting Wave 2 and 3 outcomes from background variables and information from the previous wave (scale scores and prognoses)
- Predicting Wave 3 outcomes from background variables and information from both prior waves

Table 1. Percentages of Patients with Each Diagnosis Type

Diagnosis	Frequency
Brain	60
Cardiac	38
Vascular	22
Arthritis	16
Hypertension	15
Decubiti	11
Pulmonary	9
Cancer	7
Renal	1

Table 2. R-square Values for Wave 3 Scale Score Outcomes

	Basis for Predictions		
Outcome Scale Score	Background Only	Background & Wave 2	Background & Waves 1 and 2
Cognitive	.13	.82	.86
MSQ	.19	.92	.93
Affect	.10	.69	.70
Frequency of emotion	.02	.40	.47
Satisfaction	.07	.78	.84
ADI	.15	.67	.74
Social	.18	.49	.58
Inside activities	.27	.64	.71
Pain	.15	.59	.64
Physical	.16	.42	.51

Table 2 compares R-square values (proportions of total variance explained by the model) for the three types of models. To maintain comparability across waves, each set of three R-squares is for the same dependent variables on the same samples: Wave 3 outcomes for all residents with complete data for all three regressions. Sample sizes range from 78 to 126 for the various domains.

Table 2 and other analyses indicate the following findings.

- Little predictive ability is derived from background characteristics only.
- The ability to predict scale scores jumps dramatically with information from a previous interview. Almost all of the increase is due to knowledge of the previous value for the same scale.

Knowing the scale score from two previous interviews provides a statistically significant improvement over knowing only one prior score, but this additional gain is small compared to that derived from knowing one prior score. The predictive power of the more recent interview (three months prior) is only slightly, if at all, greater than that of the earlier interview (6 months prior). Thus a measurable "momentum effect," where patients who are improving (or worsening) continue that trend, does not appear to exist.

Status Changes

Status changes (deaths and discharges) are often very important outcomes. First, they are likely to accompany dramatic alterations for better or worse in the patient's functioning abilities. Depending on when the changes occur, they may or may not be measured by the interview process. Second, a discharge to the community generally has positive implications going far beyond the improved condition that made it possible.

Four types of status changes have been used: death, discharged better (to the community), discharged worse (usually to a hospital), and other discharges. Just over one-half of the other discharges were classified (by the nursing homes) as "against medical advice." Some of the others were transfers to another nursing home, indicating no particular change of functioning.

The ability to predict status changes is decidedly worse than the ability to predict scale scores. For example, the *R*-square value for predicting death with two waves of data was only 0.36; for predicting those discharged worse, it was only 0.39. Although such low *R*-square values are common for 0-1 variables, they highlight the difficulty of predicting rare events. One reason for this outcome is that no strictly comparable data are collected during the interviews: any status change is qualitatively different from any other event in the patient's current tenure in the nursing home. Another reason is that we have observed relatively few status changes so far. Be-

cause our data analysis population was derived primarily from persons already resident in the nursing homes, long-stay residents, a relatively stable group, are over-represented.

Separate regressions for recent admissions (patients interviewed within 6 months of admission) and earlier admissions indicate tentatively that different models may fit best for these two groups (Table 3). As more new admissions are interviewed, the number of discharges should increase substantially; thus our ability to model this process should improve.

Recently admitted patients are much more likely to incur status changes of any type than are long-stay patients. This finding is consistent with the model of Keeler et al. (1981). They found that nursing home admissions (or discharges) consist of about equal numbers of short and long stayers. Short stayers are patients who enter with an acute problem that is typically resolved (for better or worse) in a few months' time. Long stayers are at relatively constai risk during their tenures in the nursing homes. Thu they may leave within a short period of time, or the may stay for several years. Figure 2 relates the like hood of various status changes to length of stay. Th highest curve in the figure (L) shows the probabili of leaving for any reason. For various LOS values (the time of a patient's interview) given on the hoi zontal axis, the vertical axis indicates the proportic who left the nursing home within the next thre month period (each data point represents about { observations). The graph indicates that recent admi sions are several times more likely to leave the hon than are more long-term residents, although th probability never drops below about 10 to 12%. Ne admissions had more than a 40% chance of leavir within 3 months.

Table 3. R-square Values for Status Change Outcomes Within Three Months

Outcomes	All	Recent Admissions[a]	Earlier Admissions
Discharged	.10	.13	.08
Discharged better	.12	.16	—[b]
Discharged dead	.08	.09	.12
Discharged worse or dead	.04	.06	.05

[a]Patients admitted within 6 months of the interview.
[b]Only one patient in this group was discharged better.

The other two curves show the same relationsh for two specific status changes: deaths (D) and di charges better (B). Although the highest probabili of each change occurs for newly admitted patient the relationship with LOS is much stronger for di charges to the community than for deaths. The figu indicates that only one patient who had been in nursing home for more than 8 months was d charged to the community. In contrast, the probab ity of death seems to stabilize for long LOS at a lev near 6%.

For a number of reasons, we have modeled stat changes separately for recent admissions, patier who were first interviewed within 6 months of th last admission to the nursing home. One reason that different variables may relate to status chang of short stayers than to long stayers. For examp

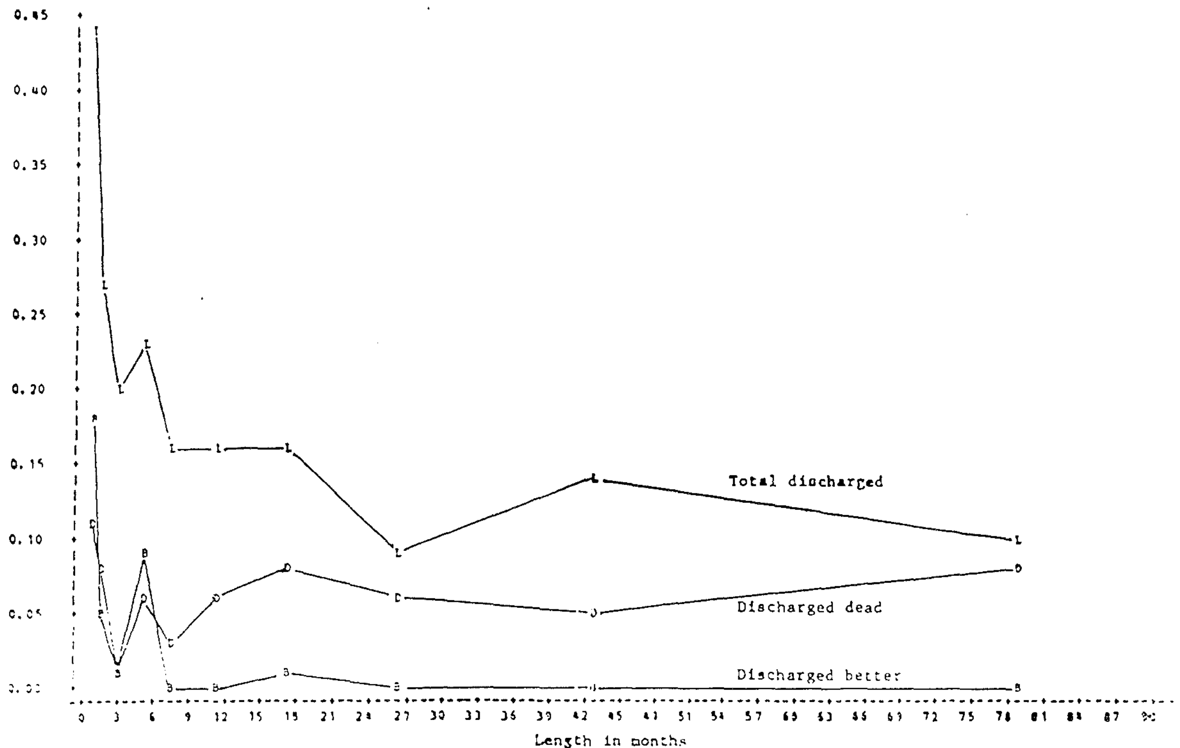

Figure 2. Lengths of stay for study patients discharged from nursing home.

admission diagnoses might be important for new admissions but lose importance as time passes. In that case, different models would be needed for the two groups. Also, because a status change may be the only measured outcome for many new admissions, it is more important to accurately model status changes for the group. Finally, model development is easier and more precise for a sample with a sizeable proportion of status changes.

Among the variables that related significantly to one or more of the status changes of new admissions are length of stay (measured more finely than "more or less than 6 months"), certain diagnoses, age, interviewer prognoses, and nursing home. Interestingly, no relationships were found with variables indicating potential living arrangements in the community—marital status, number of children or siblings, and frequency of recent family visits—nor was the patient's sex significantly related to any of the changes.

Table 4 shows that significantly different patterns of discharges among new admissions occurred at the four nursing homes. Nursing homes #1 and #2 had much more stable populations than did the other two homes. Homes #3 and #4 had higher rates in all three discharge categories. The higher turnover rates are also reflected in greater proportions of new admissions at those two homes.

To study other relationships with status changes, we have fitted simple linear regression models using status changes as 0-1 dependent variables (on the sample of new admissions). Although these models may not provide the best prediction equations (logistic regression or polytomous logistic regression might fit better), they do provide valid inference about which predictor variables are related to status changes.

Most of the demographic variables (marital status, sex, number of children, and number of siblings) were not statistically significant in any of the regressions. The relationship between age and leaving the home at all was marginal (p approximately 0.05, depending on the exact choice of variables). Older patients were somewhat less likely to leave the nursing home, especially to go to the hospital.

Considering the large number of possible comparisons, little evidence was found that individual diagnoses related to status changes. One hypothesized relationship, that patients with brain disorders would not return to the community, is supported by mild evidence (p ranging from 0.04 to 0.12). Despite the lack of findings for individual diagnoses, the total number of problem areas related to status changes was exactly as anticipated. Patients with diagnoses in many areas were both more likely to die and less likely to be discharged better. When neither the nursing home nor first interview scale scores are included in the regression, each relationship is significant at $p < 0.03$. The reliability of the diagnoses data is severely limited by the quality of the record-keeping on patients' charts. It is likely that much stronger relationships could be found if better data were available.

Two scale scores from the first interview, the cognitive and ADL scales, were assessed as predictors of status changes. Neither of those two exhibited a relationship with any of the status changes except discharges to the community. High cognitive and ADL scores were both positively related to being discharged within 3 months ($p < 0.03$ and 0.06, respectively). Not having a score (due to not completing that part of the interview) was neither a positive nor a negative indicator of any particular change.

As Table 4 suggests, the frequency of certain status changes differs significantly across nursing homes. The regressions that control for background characteristics and first interview scale scores support that assertion. Although there is no evidence for a difference in death rates, the comparison for discharges to the community and all discharges are very significant ($p < 0.001$). Unfortunately, it is difficult to discriminate among the factors that possibly contribute to this finding: different patient difficulty mixes, perhaps resulting from differences in admission policies; differences in the quality of care; and differences in discharge philosophy or policy.

Clinical prognoses. — Late in Wave 1, the interviewers began to predict future functioning in five of the domains. Because of the obvious difficulty of predicting meaningful change, a large majority of the residents were given prognoses of "the same" (see Table 5). Consequently, the effective sample sizes, those with prognoses of change, are on the order of 20 to 50. Not surprisingly, the correlations among the five prognoses are high, ranging from 0.28 (affect with medical) to 0.58 (cognitive with social) except for one correlation of 0.71 (medical with ADL).

Prognoses were generally not significant as predictors of the corresponding scale scores but were sig-

Table 4. Distribution of Patient Outcomes After Three Months for New Admissions at Each Nursing Home

	Percentage with Each Outcome Nursing Home				
Outcome After 3 Months	#1	#2	#3	#4	Total
Still in home	82	87	63	51	67
Dead	9	8	5	11	8
Discharged better	3	5	7	24	9
Discharged worse	6	0	12	11	11
Discharged otherwise	0	0	12	3	5

Note. Table includes only the 217 residents who were interviewed within 6 months of admission.

Table 5. Distributions of Interviewer Prognoses (Percentages)

Domain	Better	Same	Worse
Cognitive	1	90	9
Affective	7	81	12
Physical	7	85	8
Social	3	94	4
Medical	7	80	13

Table 6. Frequencies of Status Outcomes by Clinical Prognosis

Prognosis	Status after 3 months				
	Discharged Better	Still in Home	Discharged Worse	Dead	Total
Better	5	10	2	1	18
Same	7	168	20	9	204
Worse	2	25	2	8	37

nificant predictors of status changes. Table 6 shows the relationship between medical prognoses and status three months later. The interviewers were best able to predict those patients who would be discharged better and those who would die.

Discussion

Our prediction work has indicated that we can predict future scale scores quite well by using performance on the same scale from an earlier interview. Because of this stability for most residents, we can infer that unexpectedly large deviations from the predictions reflect real changes rather than unreliability of the predictive model.

In contrast to the findings for scale scores, predicting status changes is quite difficult. One reason is that no strictly comparable data are collected during the interviews; any status change is qualitatively different from any other event in the patient's current tenure in the nursing home. Another reason is that the data most likely to shed light on the patient's probable course—accurate information about the patient's medical condition and potential outside living arrangements—have been difficult to obtain. Finally, our sample has included fairly few recent admissions, the patients most likely to change status. This fact has severely limited our ability to develop and test models for that group.

Predictions of scale scores or status change will be diminished by the appearance of unforeseen events, some of which may be out of the immediate control of the nursing home. For example, a patient may develop a new serious medical problem. Such events represent, in essence, "noise" in the system. They can be handled in one of several ways. If they are assumed to be random events, they become part of the error term and are a source of imprecision necessitating the confidence intervals shown in Figure 1. Alternatively, major events could be the basis for negotiating an "exception" to the reimbursement policy. In general, we favor a system in which the predictions are presented to the nursing home administration in advance and the equivalent of a contract struck on the basis of an agreement that the prediction is a reasonable expectation for the patient over the next time interval. Frequent exceptions would clearly become a burden.

Critics may argue that we are prematurely advocating this prognostic reimbursement system because the predictions for change in status are not yet at the same level of precision as are the individual scale scores. We recognize this problem but anticipate greater accuracy as our experience grows. Consultation with a variety of statisticians and economists has reassured us that, even at our present levels of predictability, the approach can exert a useful positive effect on the nursing home industry. One of the great advantages of our approach is that it can continually update itself. Once put into operation, the predictions will become even more accurate as the data base expands substantially. These newer predictions will then form the basis of the next round and so on, in an iterative fashion.

Our prediction models use measures at two levels of aggregation. Although a number of individual variables can be used as predictor variables gathered at one point in time to predict the status of a patient at some later point, the measures used to identify that status must be reasonably few. Thus, a substantial amount of aggregation is needed to describe patient outcomes. We are seeking a single aggregated measure for each of the major outcome domains that we have identified. These outcomes, in turn, must be further aggregated by a second process if we are to be able to compare them, either to each other or to some set of norms. The ultimate goal of this project is to develop a means of predicting the expected course of a nursing home patient in order to compare the actual status of a patient with that predicted. A single term is thus needed.

The reduction of multiple outcome measures for each of the domains to a single summary outcome will be accomplished by applying appropriate weights derived from ascertaining relative value preferences (or utility weights).

The assignment of value weights to health outcomes is another area of research in this study. In a climate of diminishing resources, issues such as which outcomes of care are important, to whom, and at what cost are critical for both the recipients and the financers of care. Two components are involved in a valuation of health status: the resources needed to attain or maintain a certain health status and the preferences of the patient and his/her family concerning different health states. The resource need can be estimated directly on a time/cost basis, but the estimation of value preferences for different health states is much more complex. The progress in health status measurement and value preference measurement in the context of long-term care has recently been reviewed (Kane & Kane, 1982).

Especially at a time when the cost of long-term care is likely to make most policy-makers shudder, it is critical to appreciate that this system need not increase the cost of care. Indeed, one of its virtues is its adaptability to different constraints and reimbursement schemes. It is essentially a means of improving quality by redistributing resources from those homes with worse to those homes with better outcomes.

In our original formulation, we proposed a system of reimbursement that would set the PAF at 0.5 for outcomes worse than expected, 1.0 for those equal

to predicted, and 1.5 for those better than predicted. With the experience from this study and subsequent practice, the PAF can be set so that the outcome adjustments will average out. The system will then have no direct effect on total costs.

In the short run, costs can be controlled by substituting whatever share of true costs the payer is willing to pay in lieu of true costs (perhaps measured as average current expenditures plus inflation). In the long run, costs should fall to the extent that a less structurally regulated environment reveals more efficient ways of providing quality care.

The "costs" to be adjusted could come from any reimbursement scheme. They could be a flat fee based on level of care (as is now essentially the case), prospective fees based on a finer determination of the case mix need for both quantity and level of service (the equivalent of AUTOGP in hospitals), or fee for service. Some examples of case-mix adjustments have been developed (Cavaiola, 1975; Costa & Bice, 1980). The outcome adjustments, like other quality-inducing schemes, make more sense for prospective reimbursement (where the inherent problem is ensuring that patients get the quality we pay for) than for cost-reimbursement (where the problem is controlling costs). Moreover, the same data used to determine a finer gradation of prospective fees can be used to measure progress for the PAF.

Modifications of the prognostic factors can reflect decisions about how much we want to change the nursing home industry status quo. If we want to avoid disruption to the industry, even at a cost in long run inefficiency, we can tie the adjustment of reimbursement to variable costs, make the adjustment factors small, and pay everyone, including the homes with inefficient plants, their fixed costs. Risks of unlikely outcomes can be reduced by making the adjustment factors continuous, by making the size of the factors dependent on the size of the home, and other methods discussed by Keeler and his colleagues (1982). If we want to induce substantial changes, we can base "costs" on average total costs and make the adjustments substantial. It should be noted that this approach is an iterative system; the baseline (i.e., expectations) will rise as the system has a positive effect on the market. In aggregate, it will produce a distribution around that rising mean.

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APPENDIX AA

Report of the Task Force on Minimum Staffing and Memorandum from Brenda Gallant of the Task Force on Minimum Staffing

STATE OF MAINE
DEPARTMENT OF HUMAN SERVICES
BUREAU OF MEDICAL SERVICES

ANGUS S. KING, JR.
GOVERNOR

KEVIN W. CONCANNON
COMMISSIONER

August 19, 1997

TO: Senator Judy Paradis
Representative Elizabeth Mitchell
Co-Chairs
Joint Standing Committee on Health and Human Services
115 State House Station
Augusta, Maine 04333

TO: Kevin W. Concannon
Commissioner
Department of Human Services
11 State House Station
Augusta, Maine 04333

Dear Senator Paradis, Representative Mitchell and Commissioner Concannon:

In accordance with Chapter 34 Resolves (H.P. 828 - LD 1133 Resolve, to Ensure Quality Care to Residents of Nursing Facilities through the Establishment of a Task Force on Minimum Staffing), enclosed is a report concerning the findings and recommendations of the Task Force on Minimum Staffing.

If you have any questions, please contact me at 624-5443. Thank you.

Sincerely,

Louis T. Dorogi
Director
Division of Licensing & Certification
and Chair, Minimum Staffing Task Force

LTD:el
Enclosure

ADDRESS REPLY TO: DIVISION OF LICENSING & CERTIFICATION
STATE HOUSE STATION, AUGUSTA, MAINE 04333
FAX:

SUBJECT: REPORT OF THE TASK FORCE ON MINIMUM STAFFING

INTRODUCTION:

In September, 1996, the Commissioner, Department of Human Services, selected members of his licensing staff and the Ombudsman met in Brunswick, Maine with a delegation of Certified Nursing Assistants (CNAs) to discuss their concerns on minimum staffing in nursing facilities. The CNAs reported staffing patterns which they felt were inadequate to meet the needs of residents. Subsequently, the Director, Division of Licensing and Certification, established a working group of Bureau of Medical Services staff, advocates, providers and CNAs to review and study current minimum staffing in nursing facilities. This group began meeting in December, 1996. A participant list is included in this report (Tab A).

During the 118th Legislative Session, Representative David Etnier sponsored a bill establishing a Minimum Staffing Task Force (Chapter 34 Resolve). The resolve (see Tab B) required that the Task Force shall:

- Review the departmental rules concerning the current minimum staffing levels required of nursing facilities;

- Consider the appropriateness of increasing the minimum staffing level at nursing facilities;

- Identify and discuss other issues that are relevant to the study; and

- Make recommendations to change departmental rules concerning minimum staffing levels of nursing facilities, based on the findings of the task force.

The Task Force was to include representatives from the Department of Human Services, Long Term Care Ombudsman Program, the Alzheimer's Association, family members, CNAs, licensed nurses and nursing facility providers.

The Task Force was to submit a report concerning the findings and recommendations to the Commissioner of Human Services and to the Joint Standing Committee on Health and Human Services within 90 days after the effective date of the resolve.

BACKGROUND:

Maine's minimum staffing requirements were established in 1974. These ratios have remained constant since that time. These ratios are considered to be contingency level minimums and not a prescription for daily operational staffing levels. Yet, there appears to be a lingering belief among the public, including some long term care providers, that minimum staffing serves as a yardstick for routine nursing home operation. Chapter 9 of the nursing home licensing regulations states that facilities are required to staff according to the needs of residents. Federal regulations also require that nursing facilities provide the necessary care for residents to attain or maintain the highest practicable level of physical, mental and psychosocial well-being of each resident.

The existing nursing home licensing regulations (Tab C) specify in Chapter 9 that the minimum staffing ratios consist of a combination of licensed (Registered Nurses or Licensed Practical Nurses) and Certified Nursing Assistant staff for each shift at nursing homes. Chapter 9.A.4. states:

> "The nursing staff-to-resident ratio is the number of nursing staff to the number of occupied beds. Nursing assistants in training shall not be counted in the ratios.
>
> The minimum nursing staff-to-resident ratio shall be:
>
> a. One-to-eight on the day shift;
> b. One-to-twelve on the evening shift; and
> c. One-to-twenty on the night shift."

Effective October 1, 1993, the Department of Human Services implemented its nursing facility Case Mix Payment System on a facility fiscal year basis. The framework for this began in 1992, with changes to the *Principles of Reimbursement* (Tab D) for nursing homes. Reimbursement for direct care patient costs (including wages and benefits for RNs, LPNs, CNAs, ward clerks and patient activities staff) of each facility's rate were to be adjusted on a quarterly basis to reflect changes in the facility's case mix. Nursing facilities were now to be reimbursed on the basis of patient care acuity. Prior to the Case Mix Payment System, nursing facility staffing was set and approved by the

Division of Licensing and Certification Long Term Care staff on a case-by-case basis. Now the facilities are to staff in accordance with the needs of its residents, as determined by patient acuity and reimbursed by the Case Mix Payment System. The Principles of Reimbursement allow facilities to keep 25% of savings in the category of direct patient care costs. Representatives of the Division of Reimbursement and Financial Services reported that in 1996, 30% of nursing facilities had, in fact, experienced savings in their direct care costs. Some Task Force members felt that this presented a financial incentive to facilities for staff at levels which do not meet residents' needs.

With the advent of LD 418, beginning in January 1994, the Medicaid medical admission criteria for nursing home care changed. This change was in response to legislation which sought to "reallocate scarce long term care resources" while ensuring "appropriate and cost effective services". The legislation targeted nursing facility use to persons who could not be served in less restrictive settings. It also extended opportunities for home and community based care to those who otherwise might become nursing home residents. New pre-admission criteria required a higher level of functional impairment and nursing care needs. All nursing facilities were now required to participate in Medicare and establish a minimum number of Skilled Nursing Facility beds to maximize opportunities for Medicare reimbursement. Simply put, the legislative changes increased the acuity of nursing home residents and widened the gap between existing minimum staffing requirements and the needs of nursing home residents.

Task Force Deliberations

As noted in the Introduction, an ad hoc working group had been operational since December, 1996. Its membership and work was incorporated into the deliberations of the legislatively mandated Minimum Staffing Task Force. Its minutes and supporting documentation are enclosed at Tab E.

Appointments to the current Task Force membership are enclosed at Tab F. The original work group participants were expanded to include additional CNA, family and consumer representation. The Department of Human Services provided staff support and meeting sites for the Task Force. Minutes of the Task Force meetings are enclosed at Tab G.

The overall work of both groups combined, addressed the following:

- Institute of Medicine's Nursing Staff in Hospitals and Nursing Homes (1995)
    - The Ombudsman reported on this study.
- Current Licensing Requirements for Staffing in Nursing Facilities
    - Division of Licensing and Certification staff reviewed the *Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities*, as well as the lack of a minimum Federal staffing criteria. Additionally, Division staff reviewed and discussed State and Federal nursing home inspection procedures and requirements.
- Multi-State Nursing Home Case Mix and Quality Demonstration Project
    - The Project Director reviewed time studies used to determine reimbursement for staffing, case mix data, case mix national and state goals, salary data and the rate of inflation. The Director also assisted the Task Force in a staffing exercise to understand development of staffing for a nursing facility.
- North Country Associates participants (who operate nursing facilities in the state) reviewed their use of staffing decisions based on resident needs vs. case mix reimbursement.
- The Administrator and Director of Nursing from Marshwood Nursing Care Center (located in Lewiston) presented a discussion on how staffing is established in their facility.
- The Service Center, Division of Audit and Reimbursement and Financial Services reviewed direct and indirect costs, cost reports and cost analysis of transfer of specific direct care costs to indirect care.

- A Registered Nurse from First Atlantic Corporation (which operates nursing facilities in the state) reviewed a computer program showing staff needs based on the nursing facilities' case mix acuity levels.

- A representative from Howard Technical System presented "Staffing Standards from the MDS" (Tab H).

- Bureau of Medical Services, Reimbursement and Financial Services staff reviewed staffing shifts from the direct care component to the indirect care components for reimbursement and also reviewed actual nursing staff per facility by bed size, which varies significantly from nursing facility to nursing facility.

- Bureau of Medical Services, Reimbursement and Financial Services staff presented data showing disparities in staffing patterns.

- Bureau of Medical Services representatives reviewed the use of nursing facility licensed staff not utilized for direct care functions, such as for marketing functions and administrative functions.

- The Director of the Multi-State Nursing Home Case Mix and Quality Demonstration Project and an R.N. from North Country Associates reviewed actual staffing levels for a selected nursing facility and compared them to the staffing levels based on case mix. Some facilities staff higher than case mix allowances because of resident (acuity) needs. Initial indications show that the case mix acuity index could be considered as criteria for minimum staffing.

- Family members reviewed the difficulties faced by residents when a facility does not staff according to resident needs.

- The Maine Health Care Association and provider representatives reviewed the difficulties of staff retention currently experienced in many areas of Maine, due to the economic upturn.

- CNAs reviewed the increased work demands based on increased resident acuity levels and paperwork demands of licensed nurses.

Additionally, data (Tab I) was obtained from multiple sources to provide information on a variety of related areas:

- Data from the Muskie Institute was received on Nursing Facility ADL Comparison for 1993-1996 showing changes and an increase in aggregate ADL scores from 10.570 in 1993 to 12.827 in 1996.
- Staffing Models for Long Term Care, National Association of Directors of Nursing Administration/Long Term Care (1997)
- Combined Federal and State Nursing Services Staffing Standards for U.S. Medicare and Medicaid Certified Nursing Homes (1993)
- Nursing Facilities, Staffing, Residents and Facility Deficiencies, 1991 through 1995, by Charlene Harrington, Ph.D., University of California, January 1997
- Consumers' Minimum Standards for Nurse Staffing in Nursing Homes, National Citizens Coalition for Nursing Home Reform, 1995

FINDINGS:

Some major findings emerged from the deliberations of the Task Force. These findings precluded any consensus being reached by the Task Force for a simplistic numerical ratio increase in minimum staffing. They were as follows:

- The definition of direct care within the *Principles of Reimbursement* does not take into account that not all facility licensed nurses routinely provide hands-on direct care to residents. Staff defined as "direct care" under the *Principles of Reimbursement* are being utilized to fulfill non-direct care functions.
- Since Maine is one of the Case Mix Reimbursement System Demonstration states, the available Case Mix Assessment Data should be utilized to provide a more empirical staffing criteria based on fluctuating resident acuity.

- Increased patient acuity based on redefinition of nursing home admission criteria indicates a need for acuity-based staffing.
- Industry representatives pointed out that, given the existing reimbursement system, an increase in the number of CNA staff could result in less licensed nursing staff being available for direct care.
- Many Task Force members questioned the purpose of facilities keeping direct care costs low in order to maximize the financial incentive offered under the *Principles of Reimbursement*. Facilities are allowed to keep 25% of savings.
- The allotted 90 days to complete its deliberations was considered to be inadequate by all Task Force members, given the complexity of the issue.

RECOMMENDATIONS:

The Task Force will not, at this time, recommend a change of the minimum staff requirement in the regulations. The Task Force agrees with the October 1995 report by the Consumers' Minimum Standard for Nurse Staffing in Nursing Homes, National Citizens Coalition for Nursing Home Reform, which states:

> "...nursing home residents have sensory and functional disability, chronic illness and changes in health status and need nursing personnel to be available at all hours to observe and respond to their care needs, give timely, kind and competent assistance and notify both family and physician when there are significant changes."

The Task Force recommends:

1. That, in order to ensure that the needs of residents residing in nursing facilities are met, a Demonstration Project be initiated to determine a minimum staffing methodology using the Case Mix Acuity Index and to find efficiencies in the current system to ensure cost neutrality in the nursing home budget. The Demonstration Project would consist of representatives of the Minimum Staffing Task Force performing on-site

reviews of 12-15 statewide nursing facilities and examine staffing patterns, Case Mix data, resident needs, reimbursement and evaluation of existing staffing methodology.

2. That the following issues be addressed in the Demonstration Project:

   - Direct Care - That the Department of Human Services adopt a definition of direct care which specifies the functions of direct care staff for clarity and which would be the same for the licensing regulations and the *Principles of Reimbursement*.

   - Examine and analyze data from Maine's participation in the Multi-State Nursing Home Case Mix and Quality Demonstration. Due to the extent of current data available, it is expected that the data will assist the committee in creating recommendations for a minimum staffing criteria.

3. That the Task Force analyze the results of the Demonstration Project and provide those results to the Joint Standing Committee on Health and Human Services by March 1, 1998.

INDEX TO ENCLOSURES

Tab A Listing of Working Group Members

B L.D. 1133

C Nursing Home Licensing Regulations

D Principles of Reimbursement for Nursing Facilities

E Minutes of the Working Group and Supporting Documentation

F Task Force Membership

G Minutes of the Task Force Meetings

H Staffing Standards from the MDS

I Miscellaneous Documents used by the Task Force

Subject: ***ADDITIONS TO THE REPORT OF THE TASK FORCE ON MINIMUM STAFFING***

BACKGROUND

During the 118th Legislative Session, a Minimum Staffing Task Force was established under Chapter 34 Resolves (H.P. 828 - LD 1133 Resolve, to Ensure Quality Care to Residents of Nursing Facilities Through the Establishment of a Task Force on Minimum Staffing). [See Tab A]

The Resolve required that the Task Force shall:

- Review the departmental rules concerning the current minimum staffing levels required of nursing facilities;
- Consider the appropriateness of increasing the minimum staffing level at nursing facilities;
- Identify and discuss other issues that are relevant to the study; and
- Make recommendations to change departmental rules concerning minimum staffing levels of nursing facilities, based on the findings of the Task Force.

Task Force representation included staff from the Department of Human Services, Long Term Care Ombudsman Program, Alzheimer's Association, family members, Certified Nursing Assistants, licensed nurses and nursing facility providers. The Task Force was to submit a report of their findings and recommendations to the Commissioner, Department of Human Services, and the Joint Standing Committee on Health and Human Services within 90 days of the effective date of the Resolve.

On August 19, 1997, the Minimum Staffing Task Force submitted its report, findings and recommendations. [See Tab B] Given the allotted time, the Task Force listed a number of findings and recommendations, among which were the following:

- No recommended changes at this time to the minimum staffing requirements in the current regulations.

- Initiation of a Demonstration Project to ascertain whether a minimum staffing methodology could be determined using the Case Mix Acuity Index and find efficiencies within the current system to ensure cost neutrality in the nursing home budget. The Demonstration Project was to consist of reviews of 12-15 statewide nursing facilities and was to examine staffing patterns, Case Mix data, resident needs, reimbursement and conduct an evaluation of existing staffing methodology. The Task Force would review and adopt a definition of "direct care" that correlates with the *Principles of Reimbursement.* Additionally, The Task Force was to examine and analyze data from the Multi State Nursing Home Case Mix and Quality Demonstration to assist in creating recommendations for a minimum staffing criteria.

TASK FORCE ACTIVITIES

The Minimum Staffing Task Force did not ask for an extension to the 90 days allotted by the Chapter 34 Resolve, but continued its work unofficially to implement its recommendations, with most of its original membership intact. The Task Force developed a Demonstration Project and representatives of the Minimum Staffing Task Force performed on site visits to 11 nursing facilities. The purpose of the on-site visits was to examine staffing patterns, case mix data and resident needs and to determine nursing facilities staffing methodologies. Task Force representatives developed and followed a "Protocol for On Site Visits". [See Tab C] During the on-site visits, the Administrator, Director of Nursing, direct care staff and residents and family members were interviewed with specific questions developed by the Task Force. [See Tab D] All Task Force representatives performing on site visits signed a "Confidentiality Statement for the Minimum Staffing Task Force". [See Tab E] After the on-site visits were completed, the data from the visits was analyzed by the Task Force to assist the Committee in establishing recommended minimum staffing in nursing facilities. [See Tab F]

Key Findings

- One out of eleven nursing facilities uses the Case Mix Index information to determine the staffing needs of the facility.
- Ten of the eleven nursing facilities do not use the Case Mix Index information to determine staffing needs. In these facilities, the Case Mix Index information is viewed as a reimbursement issue.
- Administrators and Directors of Nursing have differing views on how the nursing facility census impacts staffing needs. Directors of Nursing focus more on the acuity level of residents.
- Maintaining optimum nursing staff to meet resident needs is difficult. CNA shortages are a statewide issue, although the most northern nursing facilities are maintaining needed staffing levels. Recruiting and maintaining CNA staff is difficult due to the low unemployment rate and the increasing care needs of residents.
- Regulatory requirements place paperwork demands on nurse managers and nurse supervisors, which take time away from providing direct care to residents.
- Staffing in nursing homes must remain consistent, even with fluctuating resident acuity levels, in order to retain staff.
- Residents, families and CNAs recommend lower nurse-to-resident ratios to assure quality of care.

The Task Force reviewed the direct care givers (RN, LPN, LVN or CNA) to residents staffing recommendations by the National Citizens Coalition for Nursing Home Reform. [See Tab G] Data was collected and presented by a Task Force member from the Bureau of Medical Services, Reimbursement and

Financial Services, to analyze the fiscal impact of lowering the minimum staffing ratios. [See Tab H] The fiscal impact of nursing ratios of 1:5 on the day shift, 1:10 on the evening shift and 1:15 on the night shift is an annual increase of $868,096.94 ($299,840.68 = State share). The annual cost for a minimum staff ratio of 1:6 on the day shift, 1:10 on the evening shift and 1:15 on the night shift is $103,372 ($35,705 = State share).

CONCLUSIONS

The Task Force reached the following conclusions:

- Minimum staffing is not the same as "best practice". Minimum staffing reflects a minimum safety threshold, not a prescription for daily staffing.

- It was not within its mandate to realign, for the purpose of reimbursement, the definition of direct care services as defined in the licensing regulations with those in the *Principles of Reimbursement*. The Task Force believes that this task should be given to the Commission to Examine Rate Setting and Financing of Long Term Care Facilities.

- That staffing ratios are only one factor in achieving best practice. Other factors include staff retention, recruitment, staff training and facility leadership. Reimbursement needs to match staffing levels. Those day-to-day levels are best set by the nursing facilities, based on meeting the needs of the residents.

- That assigning any set of ratios as a minimum staffing requirement is an inexact process and merely a temporary solution to the challenge of achieving quality of care throughout the Long Term Care system.

RECOMMENDATIONS

The Task Force recommends:

- That the following changes to the current minimum staffing requirements be implemented:

  1:6 Day Shift
  1:10 Evening Shift
  1:15 Night Shift

  A copy of the proposed changes to the *Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities* is enclosed. [See Tab I]

- That the Legislature examine the issue of CNA availability in many parts of the state.

- That the issue of CNA reimbursement be reviewed by the Commission to Examine Rate Setting and Financing of Long Term Care Facilities, with a focus on reimbursement for direct care and indirect care vs. routine services. The Commission should also examine these issues with the understanding that quality health care requires more than just direct care givers.

LONG TERM CARE OMBUDSMAN PROGRAM
21 BANGOR ST.
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Memorandum

To: Senator Judy Paradis, Representative J. Elizabeth Mitchell, Co-Chairs, Joint Standing Committee on Health and Human Services;

Kevin Concannon, Commissioner, Department of Human Services

From: Brenda Gallant, Long Term Care Ombudsman

Subject: L.D. 1133, Task Force on Minimum Staffing

Date: March 16, 1998

During last year's session, the Legislature established a Task Force on Minimum Staffing, pursuant to L.D. 1133. I participated in that Task Force as the representative of the Long Term Care Ombudsman Program. After a year of meetings, which included task force members' participation in a study of staffing patterns at 11 nursing homes, the Task Force has presented the Health and Human Services Committee with a report, dated March 2, 1998 entitled "Additions to the Report of the Task Force on Minimum Staffing." In that report, a recommendation was made to increase minimum staffing requirements to 1:6 on the day shift, 1:10 on the evening shift, and 1:15 on the night shift. (The current requirements set minimum staffing levels at 1:8 on the day shift; 1:12 on the evening shift and 1:20 at night.) **I respectfully disagree with this recommendation, and would like to offer my own views and recommendations in this report.** My position is based on complaints received by the Ombudsman Program from residents and families, information from licensed nursing staff and certified nurses' assistants working in facilities, as well as on the data collected by the Task Force.

Findings

I would like to add the following findings to those in the Task Force report:

- During fiscal year 1997 the Ombudsman program received 150 complaints related to staffing at nursing facilities.

- Only four facilities in the entire state have staffing ratios of less than 1 to 6 on the day shift, 1:10 on evenings and 1:15 on nights. *Consequently, an increase in the Department of Human Services' staffing requirements to 1 to 6 on days, 1:10 on evenings and 1:15 on nights as recommended in the Task Force report, will not serve to improve staffing in most facilities or address quality of care problems which result from inadequate staffing.*

- The Task Force has recommended an increase in reimbursement to nursing homes of approximately $103,372 ($35,705 State share), in connection with the proposed increases in minimum staffing. *This increased appropriation is unnecessary, when the proposed requirement would simply maintain the status quo.* Moreover, within nursing facilities, residents have varying levels of need. A blanket ratio does not take this into account.

- Current reimbursement to nursing homes for the purpose of paying direct care staff is made according to case mix reimbursement methodology, which gives facilities more money when they care for residents with a higher level of need. In fact, if facilities have savings in the direct care category, they are permitted to keep 25 percent of those savings. Thus, facilities may have an incentive to under-staff, so that savings may be realized. This sends a mixed message to providers.

- Reimbursement mechanisms, staffing requirements and quality of care are closely intertwined. The way that the DHS reimburses facilities for direct care to residents has a significant impact on staffing and on quality of care. The Task Force report concludes that "it was not within its mandate to realign, for the purpose of reimbursement, the definition of direct care services as defined in the licensing regulations with those in the Principles of Reimbursement," and recommends referral of this issue to the Commission on Rate Setting and Financing of Long Term Care Facilities. I disagree with this statement. I believe development of a definition of what constitutes "direct care" staff under DHS staffing requirements is essential.

- The Task Force report states that "Minimum staffing is not the same as 'best practice.' Minimum staffing reflects a minimum safety threshold, not a prescription for daily staffing." The question this raises is how does a minimum standard which reflects only a bare safety threshold, protect and preserve each resident's right to quality of care?

- ***It is evident from discussions among Task Force members, as well as from the data gathered by the Task Force, that facilities may include nurses engaged in paperwork functions as direct care staff, in meeting minimum staffing requirements. Other staff such as ward clerks or CNAs doing data entry may also be included as direct care staff.*** A "minimum staffing" regulation is not meaningful unless it defines what type of staff person is considered "direct care" staff for the purpose of ensuring that adequate staff are available to meet residents' needs.

Recommendations:

- *The concept of "minimum staffing" should be eliminated altogether and replaced **with a requirement that facilities maintain staffing which is adequate to meet the needs of the current mix of residents based on acuity***, as reflected in the facility's case mix data, drawn from the "MDS plus" assessments. Each facility has information about what its "case mix" is.

- New staffing requirements tied to resident acuity rather than staff to resident ratios would be framed like this: "Maine nursing facilities must provide direct care staff on all shifts based on the acuity of residents as it is determined by case mix data." The Department of Human Services should be directed by legislation to promulgate regulations in accordance with this principle.

- I agree with the Task Force findings that it is exceedingly difficult in some areas of the state to attract and retain qualified staff, particularly CNAs. There may well be justification for increased reimbursement to facilities in those areas, to reflect the higher wage scales and the need to rely on "temp" agencies to fill unexpected vacancies. ***This increased reimbursement should be carefully targeted to the particular staffing and labor shortage problems faced in particular areas of the state. A blanket increase in reimbursement which essentially maintains staffing at current, inadequate levels will do little to improve quality of care.***

Thank you for your attention to these important issues. I would be glad to answer questions.

APPENDIX BB

Report of the Task Force on Paperwork Reduction in Nursing Facilities

TASK FORCE ON PAPERWORK REDUCTION IN NURSING FACILITIES

FINAL REPORT TO THE MAINE LEGISLATURE
JANUARY 1997

BACKGROUND

In July ,1995, Shelly Lezer, RN (then Director of Nursing Services at the Freeport Nursing Home) contacted Senator Phil Harriman R- Brunswick in an attempt to get some regulatory relief from the ever increasing burden of repetitive paperwork in nursing facilities. The concern expressed at that time was that the paperwork requirements were:

1. costly
2. counterproductive in terms of resident care
3. causing experienced nurses to leave gerontological nursing

Senator Harriman requested that Shelly gather information from other nurses which would demonstrate the scope of the problem. Shelly and a small group of peers designed a questionnaire that would capture the needed information and mailed that questionnaire to 700 gerontological nurses throughout the state in August. Forty three percent of the nurses responded in less than one week.

Of the nurses responding more than half indicated that between 50 and 75% of the required paperwork was redundant; 224 of these nurses estimated that only 25-50% of the paperwork was needed to ensure quality of care; 228 said the time they spent doing paperwork diminished resident care; more than half indicated that they received conflicting information from the regulatory agencies at least quarterly.

The problem was multifaceted and due in large part to the multiple agencies involved in the regulation of these issues. While each of the agencies involved (Bureau of Medical Services, Case Mix Demonstration Project, The Muskie Institute, BEAS, Department of Health and Human Services) had a legitimate need for the information requested, none knew what the others were requesting. The result was confusing to providers and regulators alike Gathering and documenting the same information in multiple formats was counterproductive and costly. At a time when residents were much more in need of time and services from Registered Nurses they were receiving less attention and their medical records were receiving more.

Results of the questionnaire were conveyed to Senator Harriman who then submitted to the Maine Legislature a bill designed to reduce the amount of paperwork required. The bill did not pass in both houses and an appeal was made to the Legislative Council which endorsed it unanimously! The Human Resources Committee subsequently heard testimony on this bill and in the end directed that a Task Force be created to address the issue of excessive documentation requirements in nursing facilities. Appointments to the Task Force were completed by the middle of May (see attached list of appointees and Department Representatives) and the group met for the first time on May 29, 1996. As directed by the Legislature a chair was elected by the nurse members of the Task Force. The members agreed to meet every other week and did so until the final meeting on January 9. 1997.

GOALS AND OBJECTIVES

The goal of the Legislative Task Force on Paperwork Reduction was to "study the needs of the patient and family, the nursing and professional staff of the nursing facility, the department and other interested parties .....(and).. shall search for methods of meeting the legitimate needs of all parties in the most efficient , efficacious and collaborative manner possible". [1]

It quickly became apparent that the first objective was to clarify the issue for members of the Task Force. It is fair to say that all members learned a great deal about the workings of all the other entities involved. Once members had a clearer sense of perspective we began the process of determining further objectives. We acknowledged the fact that there were some issues over which we had no control due to federal mandates. There was also acknowledgment of some confusion on the part of providers as to what was a requirement and what was facility practice.

We reviewed documentation requirements by the various regulatory agencies and recommended or implemented changes that will provide documentation to:

* assure and validate high quality resident care
* assist in a method for determining medical eligibility
* demonstrate compliance with State and Federal Regulations.

It was a very complicated process. While the Task Force was meeting. other regulatory changes were taking place, and major changes anticipated with the adoption of the federally mandated resident assessment form (MDS 2.0). We were mindful throughout the process that we must consider the current regulatory framework, as well as the anticipated Federal requirements which had no date certain for becoming effective in the State of Maine.

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[1] LD 1689 Maine State Legislature

ACCOMPLISHMENTS

Throughout the work of the Task Force, members remained committed to working collaboratively and to understanding the issues from all aspects. As a result we were able to make many changes that will be beneficial to all parties. It is our collective view that regulatory bodies, providers, taxpayers, and, most importantly, the residents for whom we provide services, will benefit from the work we have done. We believe that this work was necessary and the process a good one. The process speaks to cooperation, collaboration and joint problem solving in the long term care arena. As the system continues to change at a rapid pace, it would seem to be a model that could be duplicated in our continued search for an efficient, efficacious and humane health care system. The refinement of this effort could be the beginning of a CQI model across the continuum of care.

Through the work of this Task Force the following changes were made in documentation requirements:

Principles of Reimbursement

Many issues that are regulated by Licensing and Certification were duplicated in the Principles of Reimbursement for Nursing Facilities. This required facility staff to review multiple documents in order to remain in regulatory compliance. In addition, each time one of these areas changed multiple documents had to go through the costly rule making process. All areas of duplication have now been removed from the Principles of Reimbursement.

Unresolved conditions report

This is a summary report of ongoing clinical issues compiled from the resident assessments (MDS+) sent to the Muskie Institute each month. Any identified errors, including typographical errors, required re-accomplishment of the entire resident assessment. Working with High Tech Software, the Task Force requested the ability to track such issues before transmission to the Muskie Institute. This has been accomplished and will save resources for both providers and the Muskie Institute.

Schedule for completion of the Resident Assessment (MDS+)

Maine was not following the national schedule for the completion of the resident assessment (MDS+), but rather required them to be completed on a more frequent basis. The major reason for this was that Maine is a Case Mix reimbursement state. The Task Force determined that there was no compelling financial reason to continue completing multiple assessments for each resident and that requirement was changed. Maine now follows the national assessment schedule.

MDS+ as a sole source of information

The information located on a resident assessment (MDS+) has been required to be validated in other areas of the resident record in order to be considered "true". Task force members have agreed that the initial MDS+ should not require validation of ALL information in the record as this information can be obtained from the resident, family, or other care providers. Subsequent MDS+s would require more areas of validation.

Triggers and RAPS

RAPS (resident assessment protocols) "are problem oriented frameworks for additional assessment based on problem identification items (triggered conditions)."[2]There are currently 18 identified RAPs with an additional four under development. They are , in practice, a detailed recipe for care planning.

There has been much concern and confusion over what the requirements are for "working" the RAPs. Most facilities have adopted lengthy , commercially available forms in an effort to address issues that have arisen at time of survey relative to whether or not the RAPs have been "worked" Licensing and Certification has respond to this issue via Task Force discussions. It will now be acceptable for the interdisciplinary team to write a summary statement indicating why the decision to proceed or not proceed with care planning was made. There is no regulatory requirement for the use of any particular form or format.

Survey issues

Facilities have been required to transfer data from facility staffing schedules to a state specified form , which was a lengthy, time consuming and redundant process. Licensing and Certification has now agreed that copies of facility schedules will be accepted.

There were other survey issues that we were unable to resolve because they are Federal requirements. Several of the Task Force Members are participating in a Federal work group that is attempting to re-design some of the very issues that we have raised in Maine (paperwork requirements for short stay admissions, federal forms at survey, data gathering at survey, etc.). Other issues that are federal requirements (medication review, monthly progress notes) were also outside of the scope of our work.

Care Planning

Care plans remain lengthy and poorly utilized by many team members.. The Task Force recommends a care plan format that is usable and meaningful to all team members. . In that spirit we have developed a format that is being tested in the pilot project discussed

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[2] Long Term Care Resident Assessment Instrument User's Manual version 2.0 October 1995 page 4-1

below. The format being tested has the potential to significantly reduce duplication and redundant documentation It is the concept that is endorsed by this Task Force pending final results of the pilot program. Facilities would have the option of adopting the concept at that time.

The Pilot Demonstration Project

The Task Force members have agreed in concept to a new mechanism for documenting and validating resident care that meets the goals and objectives of this project. Three facilities (Southridge Living Center in Biddeford, Auburn Nursing Home in Auburn, and The Barron Center in Portland) are currently piloting the system. The pilot will be in progress from January 1 until March 31, 1997. All levels of nursing home beds are involved and all regulatory bodies will continue to work together on this . At the successful conclusion of the project all interested parties will be offered the opportunity to learn the new concept. Early reports from the participating facilities indicate that it is working well. This new way of dealing with documentation should be effective, efficient and easily used by all.

RECOMMENDATIONS

The Members of the Task Force on Paperwork Reduction in Nursing Facilities believe that the work they have done was necessary and will have a positive effect on consumers. The reduction in duplicative paperwork will allow us to spend our time and resources in a more cost effective and rational manner. The collaborative work that providers and regulators have done has increased our ability to see the larger issues and make recommendations for improvements at all levels of the system. The individual changes that were made and will continue to be made as a result of our work are, of course, important. We believe strongly that the more far reaching accomplishment was in the process of collaborating and joint problem solving. All parties were in the same room at the same time discussing issues that effected all of our consumers. We developed a mutual understanding of the bigger issues. We have learned a great deal about all areas of health care regulation.

The issues that lead to the creation of this Task Force are not going to disappear unless there are changes in the way we communicate and collaborate in the field of health care. If we can improve services and reduce duplication of effort surely we will be conserving resources that are scarce. All members of the Task Force are committed to cost effective high quality care in the most appropriate setting for our consumers. We believe that the efforts of the Task Force should continue in some way. Extending this effort across the continuum could assist emerging areas of the health care system in avoiding the same problems that we have begun to resolve.

We respectfully suggest that the work of this Task Force could be the basis of something larger. Health care providers and regulators working together to identify and solve problems would be a more CQI/TQM approach than the inspection model we currently have .We would ask that the Task Force continue for one year for purposes of developing a CQI/TQM model to problem solve across the continuum of care. Given the success of this Task Force we would request that providers and regulators continue to work together on this project.

TASK FORCE ON PAPERWORK REDUCTION IN NURSING FACILITIES
MEMBERS

Appointed by the President of the Senate:

Debra Fournier, RN,C Vice Chair
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Gorham, Maine 04038

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Brunswick, Maine 04011

Nancy Mattis, RN
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Portland, Maine 04103

Appointed by the Speaker of the House

Claire Brannigan, RN
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Elected as Chair
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Appointed by the Commissioner of Human Services

Brenda Gallant
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Muskie Institute
Center for Health Policy
P.O. Box 9300
Portland, Maine 04104-9300

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*Replaced Shelly Lezer who relocated to Pennslyvania

APPENDIX CC

Agreement of the Department of Human Services and the Maine Health Care Association, January 30, 1998

MEMORANDUM OF AGREEMENT

Joint Committee to Study the Viability of Maine Nursing Facilities

Maine Department of Human Services
And
Maine Health Care Association

Background

In 1993, public policy for long-term care undertook a new direction. The so-called "Med 94 legislation," put into place policies which supported consumer choice in long-term care and encouraged the delivery of Medicaid-funded care in the most appropriate environment. In general, the intent of the legislation was to shift public funding for long-term care from high cost nursing home care to lower cost community-based health care. This new policy followed nearly a decade of public policy that encouraged expansion of nursing home beds.

The Med 94 legislation and its accompanying rules raised the medical eligibility standards for admission to nursing homes, thus encouraging delivery of services in a home setting or institutional settings less restrictive than nursing facilities. Nursing facilities were urged to convert some of their beds to residential care beds, and were allowed to bank a certain number of NF beds. The policy, in fact, reduced nursing facilities occupancy rates—from 96% in 1993, to 86% in 1997, and significantly shifted public funds to home health care services. The number of nursing home beds, however, was not reduced to the level desired by the state. Consequently, the nursing home industry experienced a precipitous fall in financial stability.

In September 1997, the Commissioner, Maine Department of Human Services (DHS), and the President, Maine Health Care Association (MHCA), agreed to enter into a formal discussion of the problems attending the downsizing of nursing facilities, and, if possible, to define mutually agreeable strategies to address the problems.

Purposes/Goals

DHS Commissioner Concannon and MHCA President Orestis committed a team of key staff[1] to enter into a series of five meetings across the Fall, 1997. The discussion group was charged with deriving a common understanding of the problem, articulating a set of solution criteria, identifying options for resolving the identified problem, and establishing a set of agreed upon recommendations.

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[1] DHS: Kevin Concannon, Commissioner; Christine Gianopoulos, BEAS; Cathy Cobb, BEAS; John Bouchard, Div. of Audit; Christopher Nolan, BMS; MHCA: John Orestis, President; Paula Valente, Executive Vice President; John Pelletier, Member; Michael McNeil, CPA, Consultant

Findings

Problem Definition: The discussion group generally agreed that the challenge was to find a way to "right size the number of nursing home beds, while attending to the economic and social impact on owners, employees and communities." The focus of the problem to be resolved was articulated as follows: *Financially viable nursing facilities that provide top quality care in the financial, geographic and social context of Maine.*

The financial viability of the nursing home industry is further challenged by certain emerging and interrelated influences. The group identified five factors significantly affecting the financial viability of nursing homes over the next five years: *number of beds and distribution; hospital restructuring; management capability of NFs; certificate of need; consumer preferences.*

Criteria for Solutions: In the process of brainstorming possible strategies to address the problem the group posed nine criteria for evaluating strategies:

1. Feasible—can we do it;
2. High leverage—affects multiple factors;
3. Affordable;
4. Safety—protects the consumer;
5. Politically sellable/can communicate;
6. Consumer impact—increases personal control and responsibility;
7. Impact on competition;
8. Less capital intensive; and
9. Fair and equitable.

Strategies – Brainstorming: The group identified the following fourteen possible strategies:

1. State-sponsored buy out of obsolete facilities;
2. Incentives for entrepreneurial providers;
3. Create single long-term care bed license; eliminate Med 96; case mix payment reflect the changed case mix; use standard assessment tool as part of standardized payment;
4. Bed/Occupancy/Cost analysis by component—data base for entire continuum of care;
5. Highest/best use of facility;
6. Separate vouchers for housing and services based on case mix across the continuum;
7. Contract with providers on number of beds or capitated system;
8. State commitment to training/retraining providers, regulators, consumers, public;
9. Comprehensive plan for geographic locale (county);
10. "Managed care" on regional approach through capitation and need planning;
11. CON process maintain competition;
12. Free enterprise approach;
13. Change financial system to social insurance model; and

14. Institute an outcome compliance approach.

The group noted that certain of these strategies are impractical, some are long-term and others short-term strategies, and that they need to be considered in light of current realities; bed occupancy rates have remained high in certain areas; over bedding persists in at least another eight areas (Portland, Lewiston, Augusta, Bar Harbor, Pittsfield, Caribou, Fort Kent, and Norway); decline in financial viability of NF persists (with some facilities being unable to meet their loan covenants).

Recommendations

Following analysis and deliberation of the strategies by two subcommittees, a series of recommendations were adopted by the two parties.

The DHS and MHCA will work together to:

1. Develop the industry's management capacity to enable the industry to:

    - Promote entrepreneurial, economically viable alternative uses for existing physical and human resources, so that the industry can better serve the changing needs of consumers;
    - Address the broader human resource needs, in order to create a stable, professional workforce. This would include efforts to improve the supply and availability of labor, training of staff, adequacy of pay and the development of professional career opportunities for long-term care health workers—all of which are critical to maintaining quality care and the financial viability of the industry.

    Lead Agency: Maine Health Care Association will develop an action plan. The DHS will collaborate with MHCA by providing appropriate state resources to support the plan.

    Time Line: MHCA in consultation with DHS will develop an action plan by February 1998.

2. Extend the initial classification period from 30 to at least 90 days in order to allow sufficient time to establish a clear picture of the resident's needs.

    - Exception would be individuals eligible for Medicaid within community. They are limited to 30 days unless they apply for NF eligibility.

    Lead Agency: Department of Human Services/BEAS initiated a practice change in November 1997.

3. Revise existing licensing rules to achieve simplicity and consistency across various long-term care services. Eliminate requirements that are not critical to consumer health and safety. Establish a single, long-term care license for providers who offer

multiple services, e.g. nursing facility, residential and home health, in order to encourage the development of integrated services.

Lead Agency: The Department of Human Services, in consultation with the Maine Health Care Association, will conduct the review and propose rule changes as appropriate.

Time Line: Complete by December 1998.

4. Seek to amend and broaden existing legislation which allows nursing facilities to provide home health under limited circumstances.

   Lead Agency: The Maine Health Care Association.

   Time Line: MHCA will draft legislation for introduction and consideration during the current session of the 118th Legislature.

5. Design a demonstration project with a small number of facilities (<6) to allow multi-level facilities to "flex" beds in order to accommodate the needs of residents.

   Lead Agency: The Department of Human Services will seek the authority for such a demonstration project. The DHS, in consultation with the MHCA, will design the project and identify potential demonstration sites.

   Time Line: Complete by December 1998.

6. Modify existing policies and rules to facilitate reduction in licensed Nursing Facility beds and stabilize the financial status of Nursing Facilities, by:

   a. providing for the non-applicability of depreciation recapture if depreciable assets are sold to a purchaser who will not use the assets for a health care service for which future Medicare, Medicaid, or state payments will be received.

      Lead Agency: Department of Human Services will modify Principles of Reimbursement.

      Time Line: Include at next revision of Principles.

   b. changing the minimum occupancy requirements from 97% to 95% for use in the preparation of pro forma cost reports for the establishment of revised nursing facility and residential care rates for conversion projects.

      Lead Agency: Department of Human Services will modify Principles of Reimbursement.

      Time Line: Include at next revision of Principles.

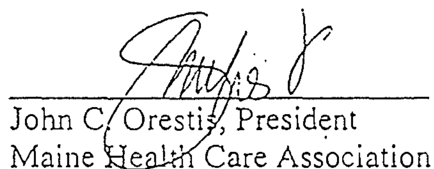
c. recognizing a portion of the acquisition cost for the rights to a nursing facility license in the fixed cost component of a purchaser's Medicaid rate for those situations where the purchaser acquires the entire existing nursing facility license of a provider and delicenses all or a significant portion (at least 50%) of the beds associated with that license.

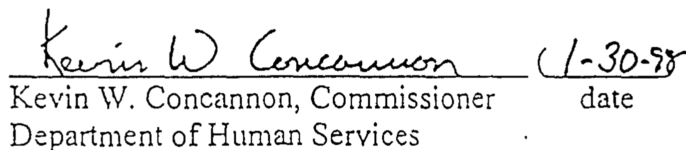
Lead Agency: Department of Human Services will amend the Principles of Reimbursement.

Time Line: Include at next revision of Principles.

7. DHS and MHCA agree to meet quarterly to review progress of implementing these recommendations.

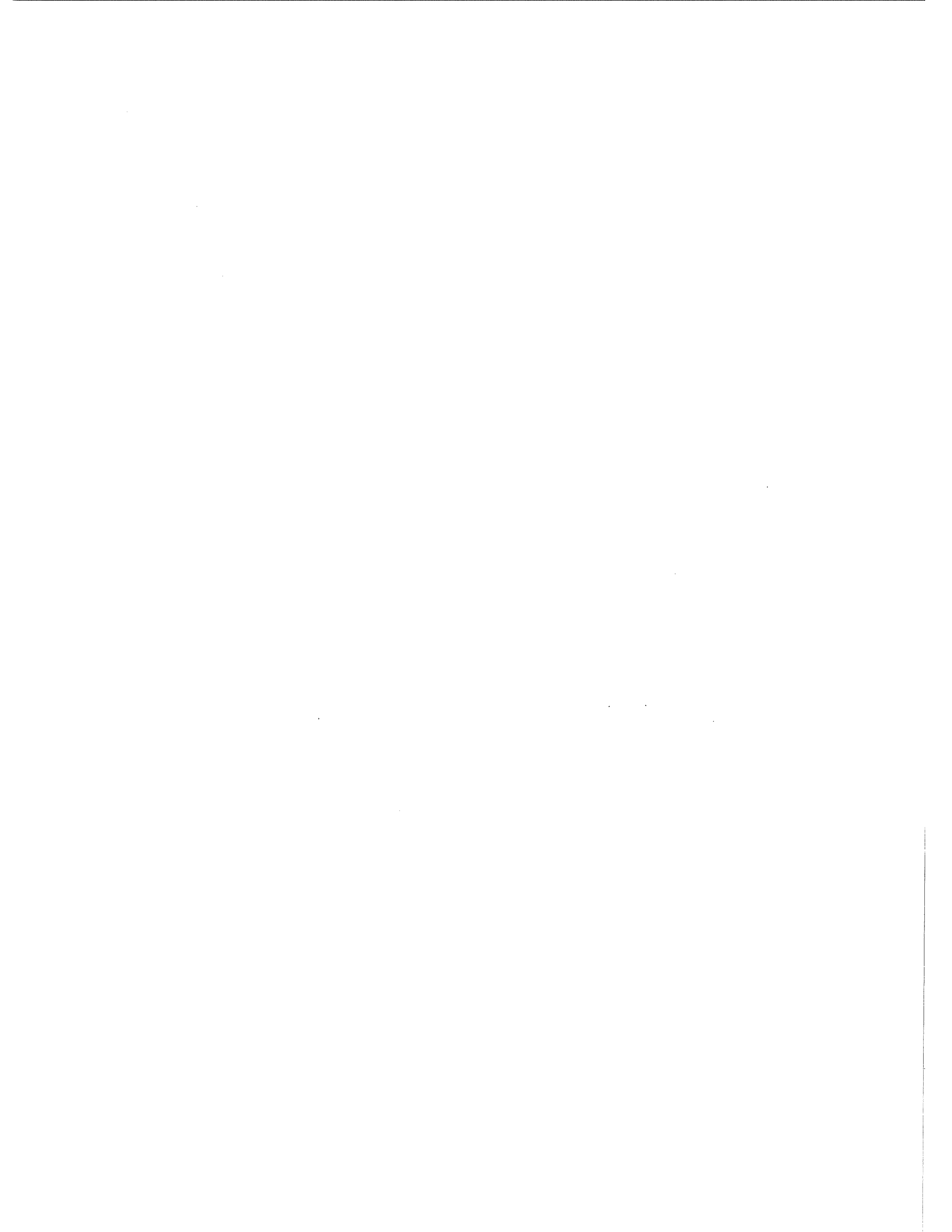
AGREED TO BY THE UNDERSIGNED PARTIES:





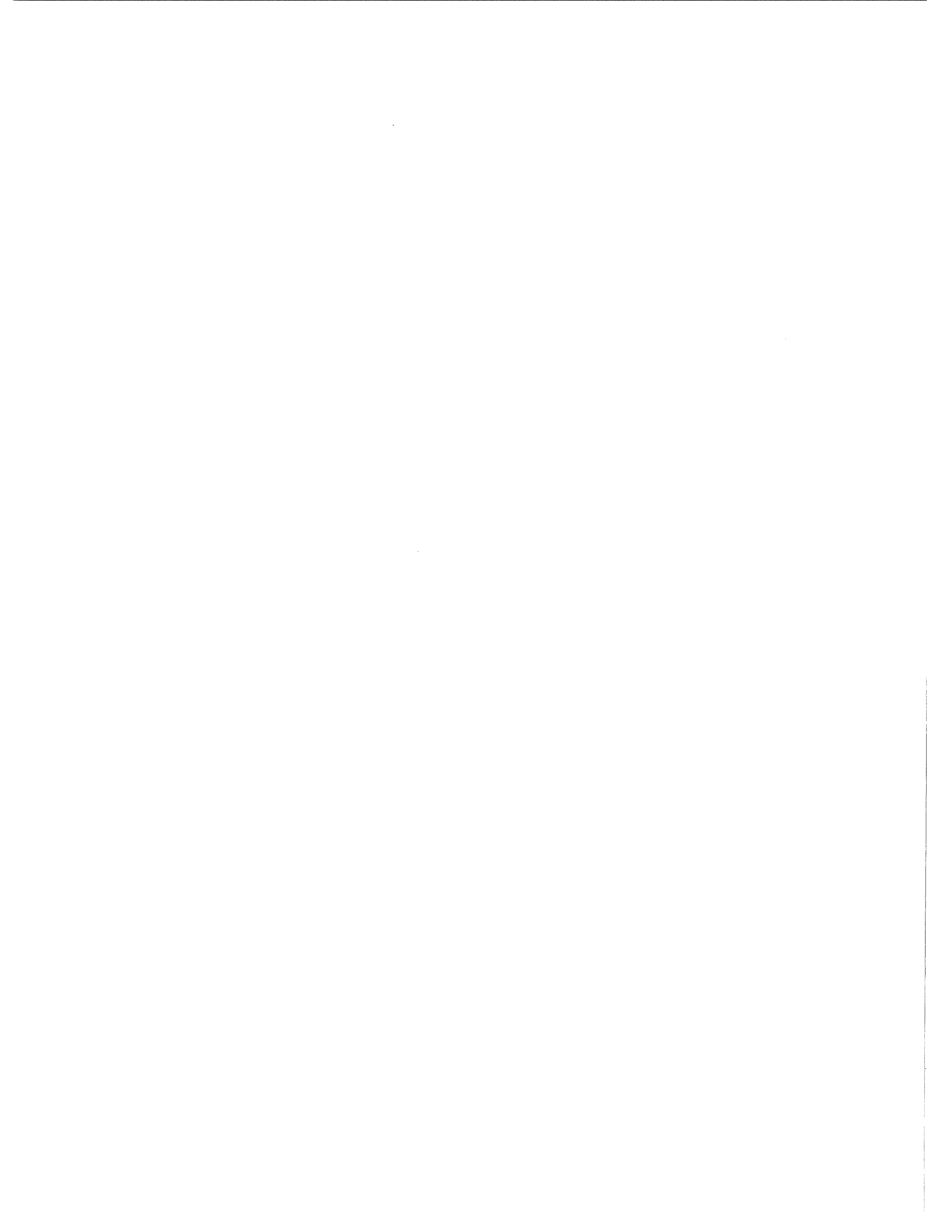
John C. Orestis, President — 1/30/98 (date)
Maine Health Care Association

Kevin W. Concannon, Commissioner — 1-30-98 (date)
Department of Human Services



APPENDIX DD

Petition to the Commission to Examine Rate Setting and the Financing of Maine's Long-term Care facilities



PETITION TO THE COMMISSION TO EXAMINE RATE SETTING AND THE FINANCING OF LONG TERM CARE FACILITIES

We, the undersigned, family caregivers of loved ones in nursing homes in Maine, are pleased to know of the Commission's work. Our long-standing distress about the quality of care provided and the constant frustration we have endured in our efforts to improve conditions in our own back yards prompts us to place this Petition before you and for the record.

Given your wide-ranging charge, we assume you have already heard from numerous consumers voicing similar concerns to ours. We wish to add to their voices and outline the barest minimum improvements in the system which should be the heart of your report.

Preliminary information from the Long Term Care Steering Committee's recent consumer survey shows four major areas most in need of immediate improvement.

1. Staffing. Too few and often with too little training and supervision.
2. Lack of staff means there is no time to provide tender loving care, almost as important as physical attention.
3. Food. Little or no attention to individual preferences.
4. Lack of security and care for safety and well-being of residents in Alzheimer's units.

There are many more issues we could bring to your attention if only more time were available or we had had more advanced notice of your important work.

We have come to the conclusion, reluctantly, that consumers have little to lose under present arrangements and much to gain in the future if your report addresses these core issues. Hence our determination to play a new and enhanced role in the future in all major policy matters relating to the care of our family members, as well as young and disabled people who suffer under the present system.

November 12, 1998

APPENDIX EE

Two letters to the Commission to Examine Rate Setting and the Financing of Maine's Long-term Care Facilities and
One Letter to a Nursing Facility Administrator Delivered with the Petition that is Appendix DD

Dear Sir:

The Care at Parkview was quite poor due to Lack of help, especially Night shift "3-11" One girl used to work all alone taking care of 15 to 16 patients. Lately they have 2 for 3-11 shift.

Most people in residential still Need a Lot of care. My Mother if Left alone to care for herself, does a poor Job of it. I have seen quite a Few Messes. that I'm sure wouldn't happen if They had more help.

Anita Caslanquay

PO Box 157
Madison, Maine 04950

Hilton Power
5 Atwood Lane
Brunswick, ME 04011-3407

Dear Hilton Power:

Our mother has been a resident at Parkview Nursing Center for 2 ½ years. During this time we have noticed a decline in the level of care she receives, increasing turnover in staff and a decrease in the activities provided.

The personnel who provide direct care are concerned, caring individuals. They are trying to provide more than basic care but are unable to because of limitations in staffing set up by the administration.

We are providing you with a few examples of situations in which complaints were made about the care being provided at Parkview:

I visited Mom on a Sat. afternoon and arrived to find her and another resident wet with urine to the knees. I was upset by the situation and both residents were promptly changed and cleaned when I notified the charge nurse. Since the nurse couldn't tell me how this could have happened, I wrote to the Administrator. I was informed that "agency" people were on duty that day. In answer to my comments about the staff being short-handed he remarked that the requirements for staff to patient ratio were being met.

Mom's Care Meeting was held on Aug. 5 Th., it was decided to make changes in her meal time arrangements. She would be moved to a feeding table with fewer distractions so that she might be more apt to feed herself. If not then help would be available. One and one half months later, the changes had not been implemented. The acting DON admitted that she was responsible for not following up. When Mom was moved to this table, we noted that the table was too high for even an average sized person to eat at comfortably. It has been lowered but not enough. Mom is a small person.

Recently, my sister was informed that Mom had choked on her "ill-fitting" dentures and that it was unsafe to have them in at night. We later learned that the situation was exaggerated and at no time was she in danger. Arrangements were made to have a dentist evaluate the fit of Mom's dentures and he has determined that they fit fine.

I am enclosing a copy of my original letter to Parkview Administrator.

Sincerely,

Rose Marie St. Peter

PO Box 157
Madison, Me. 04950
Aug 9, 1998

Administrator
Parkview Nursing and Rehab. Ctr.
Livermore Falls, Me. 04254

Dear Skip,

I am Rose Marie ~~St. Peter~~, Loretta Roy's daughter and am writing to apprise you of a situation I found when I visited her on Sat. Aug. 8 th.

I arrived at 2:15 P.M. and found mother sitting in her wheelchair wet to the knees in urine. There were no aides in the area so I informed the charge nurse, Sally. She immediately took Mom to the bathroom and washed & changed her. She commented that it was no wonder that she was wet because there was no incontinence pad on Mom. Neither Sally nor Jackie

were able to explain how this happened since they didn't know who or when she had last been taken to the toilet. Mom is unable to give any information about this but she knew what condition she was in and was upset about it.

She was not the only patient in this condition. Daniel was wet and needed help. I informed Jackie of this when I noticed. It was taken care of right away also.

I sincerely hope that this was an isolated incident. But please know that I am very upset and have shared this with other patient's visitors. These family members all voiced concerns with what they perceive as a decline in the level of care at Parkview.

I usually visit on Saturday mornings and know that the 2 aides on duty work very hard to give very basic care. I have noticed that they now are

responsible for handing out snacks that were given out by the dietary dept. This added task shortens the time they can spend feeding snack to patients unable to feed themselves. I'm sure that this is only one example of them being expected to do more with less. At some point this places pateints at risk. These aides have precious, little time left for a smile or a kind word or a touch on the arm or shoulder that's not involved with basic care.

My sister and I have agreed to visit at less regular times than we have been. We hope never to have to write you with a complaint of this sort again

Sincerely

Rose Marie St Peter

P.S. Phone: 696-5514 c̄ questions if any.
p̄ 6 p.m