Comparative reports of hospital administrative services for extended care facilities and nursing homes

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MEDICARE created a new name for some nursing homes—Extended Care Facility. The term "ECF" is defined in the law as an institution that has in effect a transfer agreement with one or more hospitals and in addition—

- is primarily engaged in providing to inpatients (a) skilled nursing care and related services for patients who require continuing medical or nursing care, or (b) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

- has policies developed by professional personnel, including doctors and nurses, to govern the skilled nursing care and related medical or other services provided;

- has a physician, registered professional nurse, or a medical staff responsible for the execution of such policies;

- has a requirement that the health care of every patient must be under the supervision of a physician, and provides for having a physician available in case of a medical emergency;

- maintains clinical records on all patients;

- provides twenty-four hour nursing service sufficient to meet the nursing needs indicated in the professionally developed policies mentioned and has at least one registered nurse employed full time;

- provides appropriate methods and procedures for dispensing and administering drugs and biologicals;

- has in effect a utilization review plan;
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• if locally required, is licensed or approved by the agency responsible as meeting the standards established; and

• meets any other conditions relating to the health and safety of individuals who are furnished services in such institutions or relating to the physical facilities thereof as the secretary may find necessary.

Additional conditions of participation concerning administrative management and nursing, dietary, restorative, and social services have been required by federal regulation.

ECFs are subject to the basic requirements that all medical services prescribed by the physician will be provided, that the same charges for the same services will be applied to medicare and non-medicare patients alike, and that the patients can only be charged for coinsurance and non-covered services. Cost reporting forms and accounting rules have been issued for use in making an annual settlement based upon reasonable costs. ECFs participating in the medicare program became something quite different from a nursing home.

NURSING HOMES

Federal assistance to the states in paying medical expenses of the needy unemployed began in 1933, but did not include institutional care. The 1950 amendments to the Social Security Act provided for "Vendor Payments"—direct payments by the states to the provider or supplier of health care, but because the federal share of money was not increased, few states participated. Changes in federal participation in medical costs were made in 1956 and 1958, and by 1960 most of the states provided medical vendor payments for persons in the categorical assistance programs—old-age assistance, blind, disabled, and aid to families with dependent children. Under the Kerr-Mills bill of 1960 Medical Assistance for the Aged, each state determined the extent of its participation in the new health programs and the amount of the recipient's income or resources that would first be applied in payment for the care provided. Supplemental payments by relatives for nursing home care were permitted, and in many states still are permitted.

The nursing home industry growth seems to be directly related to the improved federal funding of state medical programs. The American Nursing Home Association's booklet "Nursing Home Fact Book" shows this growth to be as follows:
The high standards of staffing, services, and physical facilities required of ECFs under medicare, of skilled nursing homes under medicaid, and tougher local licensing requirements have caused many of the older, smaller homes to close or to become a room and board facility. At January 1, 1968, the A.N.H.A. report shows 12,912 homes—239 fewer than in 1966—but 707,184 beds, an average number of 54 beds per home.

The 1967 amendments to the Social Security Act provided for still another classification of nursing homes—intermediate care. In Colorado, a skilled nursing home is required to employ a registered nurse to head the department of nursing service and to have nursing staff sufficient to provide at least two hours of nursing care per patient per 24-hour period. An intermediate home is only required to employ a RN or LPN full time and to have sufficient supplemental staff to assure that the patient’s doctor’s orders are carried out on a twenty-four hour basis. The differences in required staffing patterns result in a very substantial difference in payroll costs.

Before the Social Security Act was amended to provide for intermediate care, federal matching funds were not available for institutional care that was more than room and board but less than skilled nursing-home care. If a state classified a needy person as in need of skilled nursing-home care, it could receive unlimited matching federal funds, but if the state said that person needed other institutional care, only the standard old-age assistance matching cash, up to $75 a month on the average, was available. The Department of Health, Education and Welfare advised the Senate Finance Committee considering the amendments that as many as 50 per cent of the assistance recipients were not, in fact, in need of skilled nursing-home care. The Senate Finance Committee reported that it believed intermediate care could be obtained for these people at costs of $150 to $200 a month instead of the more than $300 being paid for skilled nursing-home care.
When a state enters into the Title XIX program, it must cause every assisted patient in nursing homes to be classified by his physician as requiring skilled or intermediate care. The nursing homes must also assess their classification as skilled or intermediate; some cannot recruit the necessary nurses and will have to be classified as intermediate care homes.

**REIMBURSEMENT SYSTEMS**

ECFs in the Title XVIII program are paid reasonable cost determined from a cost-report form. A provider reimbursement manual contains specific regulations on allowable costs, and the conditions of participation allow charges to the patient only for coinsurance, personal-comfort items, and a part of the private room charge when not medically necessary. There is also the problem of retroactive denial of eligibility if the patient's condition was such that extended care was not necessary.

This reimbursement mechanism does not apply to Title XIX. Many state welfare programs are funded on a fixed budget and avoid retroactive adjustments. Colorado must account for its payments to nursing homes on a specific-patient basis by county of original residence. A retroactive adjustment following the close of the year is considered an administrative impossibility. The states have been allowed to determine their own basis for payment, and I think the majority of states negotiate flat rates of payments for all homes, although some classify homes by hours of nursing service provided, number of services available, condition of the facility, or by ambulatory and bedfast patients. Each of the ninety-two counties in Indiana negotiates its own rate. Some states set rates that have little relation to cost and permit relative supplementation. As of January 1, 1968, the American Nursing Home Association reported that thirty-one states did not permit supplemental payments. At that time, however, Arizona paid $125 a month and permitted supplementation up to a maximum of $600; Kentucky paid $466.50 and permitted supplementation up to "full cost"; Utah paid $250 and permitted supplementation up to "reasonable cost" by relatives only; and Iowa paid $318 and permitted additional payments only for oxygen and physical therapy.

Colorado provides prescription drugs on a vendor payment to the dispensing drug store. A nursing home, therefore, does not have any drug costs for welfare recipients, and if drug revenue and expense are found in
the accounting records, the expense is assumed to pertain to private pay or ECF patients and is excluded from costs for welfare. Medical supplies have been a problem. Although the daily rate determined from reporting costs was supposed to include cost of medical supplies, revenue from the sale of supplies was applied to the extent of the related cost, resulting in no cost for medical supplies. This problem has now been resolved, and the daily rate is all-inclusive except for private room differential and personal-comfort items. Since payment is cost related, no supplementation is allowed.

A nursing-home patient should be either very rich or very poor. Private-pay patients are charged standard rates for room and board, but very likely will also pay levels-of-care charges, such as $30 a month for incontinency, hand-feeding, close supervision, if necessary, and other such items, or all of them in combination. Charges of $600 to $900 a month for years and years of custodial care would deplete almost anyone's resources.

Uniform charges as a requirement of medicare was not well understood in 1967 and 1968 by ECF administrators. We have seen additional charges of $3 to $5 a day for the sole reason that the person was a medicare patient and probably was very sick and required additional nursing care. This was somewhat similar to the levels-of-care charges that were permitted initially, but the ECFs had overlooked the same charge for the same service to all-patients-alike theory. This billing practice made ratio of charges to charges applied to cost (R.C.C.A.C) settlement method very attractive because of the heavy weighting to medicare, but in such situations it is not permitted.

Many ECFs failed to record revenue when earned, and accounted for revenue on a cash basis. If the welfare rate of payment was less than standard charges, the discount should have been recorded as a deduction from full revenue or the R.C.C.A.C. concept is not usable.

COMPARATIVE REPORTS

Most nursing homes are proprietary. Although several charts of accounts and accounting books are available, the industry has been slow in striving for uniformity in accounting. Owners of nursing homes are entitled to use the income tax elections and all other business operating techniques or devices their attorneys and accountants can suggest. Oper-
ating a nursing home for a legitimate profit does not adversely affect quality of care provided. The big-volume purchasers of nursing home care today, however, are state governments. The Barr Committee on Hospital Effectiveness recommended that reimbursement to health care institutions having third party service contracts be based upon rates negotiated and agreed to annually. It also recommended that each institution be required to prepare each year a detailed budget of income and expenses and a plan for services and operations, and that the states and H. E. W. develop a national standardized administrative reporting system designed to meet the needs of third-party payors and institutional managements. The report stated that improved management performance can be produced by making comparative data on management performance visible throughout the community and suggested co-ordinating the proposed reporting service with Hospital Administrative Services.

I have long been a supporter of the Comparative Reports for hospitals and of the cost allocation systems for medicare by all providers. I am uneasy, however, about a comparative report that includes nonprofit and proprietary institutions and compares at once all classes of nursing homes—ECF, skilled care, intermediate care, convalescent centers, and long-term units of hospitals. In an early year, four Colorado ECFs were in the comparative reporting service: One was the ECF unit of a large nonprofit medical center; the second was a proprietary institution licensed three ways—as a convalescent hospital, ECF, and nursing home; the third was a proprietary nursing home qualified as an ECF, but which also had room and board residents, used cash-basis accounting, and had all the credit cards useful for entertaining; and the fourth was a tax supported institution in a small, mountain town.

By design, skilled and intermediate-care nursing homes are not comparable. A sixty-bed skilled-care home in Colorado has to provide 840 hours of nursing care each week, including a RN or LPN on each shift, while an intermediate home of the same size need provide only 168 hours of nursing care and employ either an RN or LPN full time. This is one-fifth the requirement of skilled care.

Each type of nursing home can be compared, I think, with others of the same classification, but a set of rules or guidelines is needed that can be applied to the preparation of financial and statistical reports submitted to third-party payors for the purpose of arriving at reasonable costs
that are fair and equitable for all parties concerned and are free of de­
liberate financial manipulation.

A conversion of accounting figures through use of a schedule like
the Medicare A-5 adjustment sheet would be helpful.

I have attended meetings with Nebraska and Indiana welfare offi­
cials who regarded reimbursement rates for nursing homes as their big­
gest headache. I think Hospital Administrative Services could provide
welfare officials with a very useful report, if comparability could be ob­
tained, to be used for paying on a cost basis or for negotiating rates.

**Operating Expense**

Nursing homes operated as partnerships or proprietorships often do
not include compensation to working owners among expenses. A compar­
able value for services of owners, and of members of religious orders not
fully compensated, should be included in operating expenses. Compara­
bale value, in the instance of hospitals, does not exceed amounts
paid other employees for similar work.

Salaries paid to working stockholders or their relatives similarly
should not exceed amounts paid other employees for the same or similar
work. Higher salaries may, of course, be paid to such persons, but adjust­
ments downward should be made within the cost report. In a study of
nursing-home costs made by the state of Washington for the year 1959,
an amount of $9.40 per bed (for capacity) per month to a maximum of
100 beds was determined to be fair for the administrator's salary. The
amount of $10 a month per licensed bed with a monthly minimum of
$750 and maximum of $1,500 has been accepted in Colorado. Salaries
paid non-working officers should not survive in the cost report.

Accelerated methods of computing depreciation of buildings and
equipment are frequently used. These methods result in expenses greater
than normal in early years, with a tapering-off to a point after which the
expense is less than normal. Cost-reimbursement systems for hospitals
under the federal programs allow accelerated depreciation methods, but
several Blue Cross plans and state welfare departments provide for com­
putation of depreciation in equal, annual amounts over the expected life
of the property. A chart of estimated lives by specific items of equipment
is provided by the American Hospital Association in its publication
"Uniform Chart of Accounts and Definitions for Hospitals," and this chart should be applicable in most instances for nursing homes.

Particular consideration must be given to amounts paid as rent whenever the lessor also has a financial interest in the nursing home operation. Frequently, the leasing arrangement is a necessary financing device for the nursing home. Leases, however, are often related in years and amounts to the mortgage-payment schedule accepted by the owner, resulting in inclusion in operating expenses of the full cost of the leased property in a period of years usually less than the expected property life (15 to 20 year loan on a building versus expected life of 40 to 50 years). Leases are sometimes used as a means of withdrawing profits and, in these instances, can inflate operating expenses. Control over rent expense can be exerted by adopting a maximum property expense per bed, related to bed capacity.

Certain expenses are excluded from operating expenses in cost reports on the theory that the expenses are not necessary for care of welfare patients or are of a nature that the state would not ordinarily incur. Suggested exclusions are:

- Provision for income taxes
- Promotion
- Travel and entertainment, other than for professional association meetings and direct operations of the home (entertainment of physicians and country club dues and fees are examples of intended exclusions)
- Part-time officers' salaries
- Fees paid board of directors
- Expenses related to services or supplies for which reimbursement is received from other welfare programs such as prescriptions paid for by the department (or by relatives)
- Interest paid to stockholders of amounts in excess of interest amounts payable at commercial rates
- Bad debts, discounts, and allowances (to be accounted for as a reduction of income)
- Donations
- Expenses of non-nursing home facilities
**Operating Income**

Income or receipts should be sufficiently classified in the accounts to reflect gross revenue from routine service (room and board), special services, expense recoveries, and services of a miscellaneous nature. The following items frequently recorded in gross income should be set out separately for application, in the cost report, as a reduction of a related operating expense:

- Purchase discounts (if recorded)
- Revenue from telephone service
- Revenue from employee and guest meals
- Rental of rooms to employees
- Revenue from supplies sold employees and others, except patients
- Interest or investment income earned on funds borrowed and on which interest is paid
- Beauty and barber shop income and recorded receipts for patients personal purchases if expenses are recorded
- Laundry receipts, sale of scrap, expense refunds, rebates on purchases, and any other income items that should be offset against expense accounts

**Other Items**

It is impossible to foresee all items that may now or in the future be an expense of a nature that may be considered non-patient related, and a general reservation should be made concerning unusual expenses that occur so infrequently that they warrant only specific consideration or agreement.

In the event that reimbursement is to be made to each nursing home on the basis of its costs, consideration should be given to the following:

- Should there be an adjustment of costs for under-utilization of bed capacity?
- How should reimbursement be made for nursing homes in operation less than one year where there may be cost distortion due to atypical costs during first year of operation?
- Should depreciation be funded?
COST ALLOCATION STUDIES

Extended Care Facilities that plan to participate in the Medicare Hospital Insurance Program should consider the implications of the law's provisions concerning "reasonable costs"; specifically, that the regulations shall "take into account both direct and indirect costs of providers of services in order that, under the methods of determining costs, the costs with respect to individuals covered by the insurance program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs." Further, no payment may be made under the plan if the expenses incurred are for custodial care. Cost allocation studies are required of ECFs operated by hospitals, and of ECFs accepting patients after their hospital discharge and providing them continuing skilled nursing care, which also provide intermediate or custodial care for other patients. Cost-allocation studies are not difficult to make, but must be based upon accurate statistical data. Unless routine gathering of all necessary statistics has been planned for, the statistics may not be available when needed.

SUMMARY

Accountants will agree that the primary purpose of a nursing home is to provide the degree of service required by its patients and not just to maintain records for the auditors. Nursing homes are economic enterprises, however, generally organized for profit. Good accounting records, accurate statistics, and the application of statistics to financial statements assist the accounting functions in the management processes of planning and maintaining control over operations in order to make enough profit to stay in business.