New York State's Nursing Home Industry Profit, Losses, Expenditures and Quality

by Cynthia Rudder, Ph.D.
Director
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ERRATA

1. Title Page - Judy Brickman, Member of Board of Directors was inadvertently omitted

2. Page 4 of the Executive Summary - First Bold Statement the figure should read: $486,250 instead of $425,120.

3. Page 27, Table 3, Location and Sponsorship Category - All figures should be dropped down one line

4. Page 30, Location Differences - Last line should read 71 per cent in New York City with a margin of 2.58

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Of course, all mistakes are the responsibility of the author.

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Executive Summary

NEW YORK STATE'S NURSING HOME INDUSTRY PROFITS, LOSES, EXPENDITURES AND QUALITY

Introduction

New York State Spends Most In the Country on Medicaid Residents

We are living in an era of severe fiscal constraints. As health care costs continue to rise, Medicaid expenditures continue to escalate. According to a study by the Federal Reserve Bank in Boston[1], New York spends more Medicaid money per nursing home resident than any other state. In fact, New York's Medicaid payment per resident was found to be more than twice the U.S. average payment. Yet, New York State nursing home providers assert that they are losing money and need higher Medicaid reimbursement. This has caused some heated battles among the state, the providers and the Legislature.

National and state solutions to these rising Medicaid costs have been to cut Medicaid access and services for the poor and to talk of the need to ration care without looking at what Medicaid is already paying for and without looking at the relationship of expenditures to patient care outcomes. Are we getting our money's worth?

Medicaid money going to the nursing home industry continues to grow. In 1991 nursing home providers in New York State received $3.5 billion in Medicaid revenue to care for approximately 82,000 Medicaid nursing home residents. It is estimated that in 1994, providers will receive $4.3 billion.[2] Thus, Medicaid will pay over $50,000 a year for the care of each Medicaid nursing home resident.

New York State's Medicaid Reimbursement System May Encourage Profit Making

New York State's nursing home Medicaid reimbursement system reimburses facilities for the care they provide to Medicaid residents by assigning residents to specific categories or "cases." The state then pays a facility a Medicaid rate based upon the estimated costs of caring for residents in each category. Thus, under this system, Medicaid residents needing more care will bring a higher Medicaid rate.

This system, called Resource Utilization Groups (RUGs), encourages providers to make profits by paying them more for residents who need more care without requiring them to expend monies for appropriate staff and care. Under the RUGs system in New York State, nursing home providers decide how they will use the money

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1 Little, Jane Sneddon, "Public-Private Cost Shifts in Nursing Home Care," New England Economic Review, July/August, 1992, p. 3-14.

2 New York State Department of Health, Bureau of Long Term Care Reimbursement.

they receive. They do not have to use the money to provide care. They may use it to pay for other reimbursable costs under Medicaid such as administrative costs or association dues, or they may keep it as profit.

Consumers Are Concerned that Residents are not Getting Needed Care

Many consumers in New York State have feared that nursing homes have been taking in large amounts of money by admitting heavy care residents without hiring the staff or giving the care needed. Is New York State getting its money's worth for each Medicaid dollar it spends? Are the rates inadequate or unreasonable?

Project Objectives

1. To determine the profitability/loss of nursing homes in New York State.

2. To analyze the differences in the profitability/loss of nursing homes by sponsorship, location and case-mix.

3. To examine the expenditure patterns of nursing homes in New York State by detailing costs related to resident care, staffing and administrative costs.

4. To examine the relationship between the expenditure patterns in New York State and the care needs of residents.

5. To examine the relationship between the expenditure patterns and quality of care.

6. To examine the relationship between profit and loss and quality of care.

Methodology

1. All cost reports submitted to Department of Health by nursing home facilities in 1991, the latest year available, were analyzed.
2. Case-mix indices, a measure of resident care needs, were obtained from the Health Department.
3. Quality and negative outcome data provided by the Department of Health and based on PRIs (Patient Review Instruments) for 1991 were analyzed.

Findings

Profits and Losses

The profitability of the nursing home industry in New York State depends on what type of profit one is looking at: total (includes contributions, endowments, county subsidizing of public facility losses, Medicaid and Medicare reimbursement and private pay rates), operating (includes Medicaid and Medicare reimbursements and private pay rates) or Medicaid rates alone.

* **Sponsorship and location in the state are major determinants of whether a facility is likely to make a profit or lose money.**

Total and Operating Profit

* **When looking at total and operating profits, the nursing home industry in New York State as a whole is financially healthy.**

A majority of the facilities in New York State made a total and an operating profit. With a median margin of 2.92 percent (for every dollar in income, $.029 is kept as profit), 76 percent of the facilities made a total profit (median profit was $167,233) and with a median margin of 1.91, 67 percent of the facilities made an operating profit (median profit was $96,491).

* **Statewide total profit was $182,730,000 and statewide operating profit was $82,336,000.**

* **However, when these profits are looked at in terms of sponsorship and location, a different picture appears.**

In terms of total profit, a majority of proprietaries, voluntaries and publics are making profits.

* **In terms of operating profit, less than one-half of the voluntaries and a little over one-third of the publics are making profits.**

* **Both voluntaries and publics had median losses. The publics fared the worst.** They lost over 26 million dollars on operating revenue, most of which was lost by the downstate publics.

* **Most of the profit is being made by proprietaries, particularly downstate (New York City, Long Island and Northern Metropolitan) proprietaries.**

The proprietaries made 65 percent of all the total profit ($119,383,000). Their median profit was $283,370. Over 93 percent of the downstate proprietaries made a total and operating profit. They had a median operating profit of 6.46 percent. This profit margin is twice that of all the facilities and 7 times that of the downstate voluntaries.

This is a possible, not unlikely scenario: if a downstate proprietary with a profit margin of 6.46 received on average $175 a day for care, it would make a profit of $11.31 per bed per day or $1,031,581 a year for a 250 bed facility.

Medicaid Profit

* **Overall, less than a third of the facilities made a profit on Medicaid alone.**

* **Most of the Medicaid profit was made by the downstate facilities, particularly the downstate proprietaries**

Of the 133 facilities (26 unidentified) making a profit on Medicaid alone:

* 70 were downstate proprietaries
* 13 were upstate proprietaries
* 11 were downstate voluntaries
* 6 were upstate voluntaries
* 7 were upstate publics
* 0 were downstate publics

* **The median annual profit on Medicaid for the downstate proprietaries making a profit on Medicaid was $425,120.** They had a median profit margin of 7.3 percent.

* **The median annual profit from Medicaid rates for the downstate voluntaries making a profit on Medicaid was $425,120.** They had a median profit margin of 5.3 percent.

Two possible, not unlikely scenarios:

if a downstate proprietary with a margin on Medicaid of 8, received a $150 Medicaid rate (the average Medicaid rate in New York City) for a 200 bed facility, it would make $12.00 a day for each Medicaid bed. This becomes $876,000 a year on Medicaid alone.

if one of the 11 downstate voluntary facilities with a margin of 5.3, received a $150 Medicaid rate for a 300 bed facility, it would make on average $7.95 a day for each Medicaid bed or $870,525 a year.

Financial Performance of Facilities Profiting From Medicaid		
LOCATION AND SPONSORSHIP	MEDIAN OPERATING MARGIN ON MEDICAID	MEDIAN OPERATING PROFIT FROM MEDICAID
upstate prop	5.7	$101,703
upstate vol.	3.3	$ 97,590
upstate pub	2.7	$ 72,890
downstate prop	7.3	$486,250
downstate vol	5.3	$425,120
downstate pub	0.0	$ 0
missing	7.9	$397,790

* <u>Voluntaries and Publics Generally in Financial Trouble</u>

Clearly the voluntaries and particularly the publics seem to be facing financial problems. However, it is not clear what the cause of their problems are. Do they need more money to care for their residents or do they need more money because of inefficiency or poor management decisions?

Expenditures

Looking at the expenditures in light of the profits being made by the proprietaries, and in particular the downstate proprietaries, and the losses being incurred by the voluntaries and the publics, **we were distressed to find that:**

* **The proprietaries spent 12 percent less per bed than the voluntaries for direct care staff** and 16 percent less than the publics. This means that a 150 bed proprietary facility might spend $266,700 a year less than a 150 bed voluntary facility for registered nurses (RNs), licensed practical nurses (LPNs) and aides.

* **The downstate proprietaries employed the lowest number of direct care staff per bed and spent 19 percent less per bed than the voluntaries for direct care staff and 34 percent less than the publics.**

* Although the **downstate voluntaries had the highest case-mix index, i.e., their residents had the highest care needs, it's full-time direct care staff per bed was less than the upstate voluntaries with a lower case-mix.** Their full-time direct care staff numbers were the same as the upstate proprietaries, with the lowest case-mix in the state.

* **The voluntaries spent the most money per bed on salaries for management and supervisory positions.** Consumers have long been concerned that voluntary facilities sometimes seem top heavy. Do they really need to spend 21 percent more per bed than the proprietaries and 32 percent more than the publics on management and supervisory positions?

* **The percentage of expenditures and amounts of money spent on activities and social work services is embarrassingly low.** Activities and social work services are of major import to nursing home residents. Only $576 per bed was spent on activities ($1.57 per day per bed) and only $456 was spent on social work services ($1.25 per day per bed). It seems impossible to provide meaningful and varied activities and social work services with so little money.

We were however, pleased to see that:

* **Fiscal and administrative expenses do not take an inordinate amount of the expenditure budget.** Fiscal and administrative services are averaging about 12 percent of operating expenditures.

* **Voluntaries spent the most on food services: 9 percent** more than the proprietaries and 3 percent more than the publics. This is a very important area for nursing home residents. Much of nursing home life revolves around meals. Although we are aware that more expense doesn't necessarily mean better food and service, we are pleased to see that this has been given major importance by the voluntaries.

Relationships Among Profits and Losses, Expenditures and Quality

* **Quality, as defined in this study[4], was not found be related to facility revenue or to facility expenditures.**

* **No relationship was found between quality, as we defined it, and profitability.**

A moderate relationship was found:

* **Intensity of resident care needs related moderately to expenditures.** The more the care needs of its population, the more the facility expended.

Questions for Policy Makers

Does the Medicaid Rate Adequately Cover Care?

Evidence that a majority of the nursing homes in New York State are losing money on Medicaid is not proof that the Medicaid rate is not high enough. Without knowing where revenue is being spent in relation to care outcomes, we do not know if more money is needed. **Are two-thirds of the facilities in New York State losing money because they are expending revenue on necessary care, and therefore need more, or are they spending money in areas we might believe would indicate poor management or are they making financial decisions that are not in the best interest of their residents?**

The state must answer this question in order to protect the state's nursing home residents. For some providers, the rate seems too low. Many nursing homes, particularly voluntaries and public facilities, are losing money. On the other hand, for other providers, the Medicaid rate seems too generous; profit margins on Medicaid for some providers are high.

What are the Business Risks of Operating a Nursing Home?

The nursing home industry in New York State is a substantially low-risk business for a number of reasons: (1) competition is limited; (2) New York State has a high occupancy rate; and (3) most payments are guaranteed.

* **Given the low risks of running a nursing home in New York State, providers should be satisfied with lower profit margins.**

What is a Reasonable Profit?

In order to limit the rapid growth of Medicaid costs, we must look to limiting the amount of profit nursing home facilities can make.

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[4] Low prevalence and low continuance of: psychotropic drugs; restraints; contractures; decline of functioning in eating, toileting and transferring; and incontinence and never taken to the bathroom.

Profit Margins and Return on Equity

High profit margins mean a high return on investments. When an operator wants to build a facility, s/he must put up in cash a minimum of 10 percent of the cost of the project (equity) and an additional 5 percent for working capital. This makes the total cash investment for a 120 bed facility $1,800,000 and for a 250 bed facility $3,750,000.

With a profit margin of 3 percent, close to the median total profit margin found in this study for all the facilities, a facility would make on average $6.00 a day per bed with an average rate of $200 a day. The return on the initial investment in this case would be 15 percent.

Facilities with profit margins of 7 percent, less than the median margin found for downstate proprietaries who profited from Medicaid, would make on average $10.50 a day per bed, with rates of $150 per day. The return on the initial investment would be 26 percent.

In addition, all nursing home operators will actually get back their entire equity through the Medicaid rate over 25 to 40 years. Proprietary facilities also get a return on equity which is interest for the use of the money.

Additional Profit: Owners' Salaries

In addition, this study cites recent Department of Health (DOH)[5] data that indicates that **additional profit is being taken out as salaries for owners and their families.** To the extent that owners are paying more in salaries to themselves or their families than would be reasonable and would be expected to be paid to an outside employee, this additional amount must be considered additional profit. DOH data indicates that in 1991 five downstate proprietary facilities paid its owners and/or family members over $1,000,000 in salaries. In 1992, eight downstate proprietary facilities took between $1,000,000 and $1,975,000 in owner and family salaries.

Is New York State a Prudent Buyer of Nursing Home Care?

*** New York State is not a prudent buyer of nursing home care**

Many people believe that historically we have expended so much in the nursing home industry because we had very strong standards of care that we were paying for. Some policy makers have questioned whether New York State can afford such high standards. However, although we assumed that the high rates of reimbursement were buying better care, we did nothing to make sure that the money we put into the system actually bought better care. We did nothing

[5] Press Release, State Department of Health, Albany, November, 12 1993.

to tie public monies to compliance with standards and did little to support the Department of Health's ability to oversee compliance with care standards.

The results of this study show no relationship among profits and losses, expenditures and quality of care. It seems that facilities which spend more, or who had large profits, had as good or bad quality of care as those who spent less, or had losses.

* **New York State has spent large sums of money without knowing what it was buying.**

How can some policy makers suggest that we can no longer pay for high quality of care when we don't know what kind of care we are buying now? What has our money bought? We do not know.

* **New York State is not a prudent buyer of nursing home care. It spends money without knowing what it is buying and without knowing how to buy what it wants.**

Recommendations

The following recommendations are meant to be viewed together. No one suggestion will deal with all of the issues raised.

* The present study found that although profits were not related to our measures of quality, there were large profits being made on Medicaid monies. Given the rising Medicaid costs, we suggest:

  * **Set a limit on the amount of profit a facility may make on Medicaid alone.** Consider inappropriately high salaries for owners and their families as additional profit.

  * **Require facilities to spend the portion of their rate that is for direct care on the care of their residents or to return the unused portion to the state.**

* The present study found that quality care, as defined by this project, was not related to facility profit or loss, facility revenue or to facility expenditures in specific areas. This raises the question of what the state is buying for its Medicaid dollars. We suggest:

  * **Tie expenditures to deficiencies in care**

    If nursing homes are found to be deficient in any area by the state Department of Health, the state must have the ability to require the facility to expend money in those area found deficient.

  * **Publicly recognize facilities with high quality of care**

* The present study raised the question of whether the Medicaid rate was adequate or too generous. The state must answer this question. We suggest:

* **Conduct studies of facility management.** Identify facilities with low costs and high quality. Gather data on these facilities as well as the facilities with high quality and high profits. Find out how they manage to do so.

* The present study examined expenditures in specific detail. These examinations indicates differences in expenditure patterns among the various sectors of the industry. It also found that many voluntaries and some publics are making a total profit and/or operating profit at the same time they are saying that the Medicaid rate must be raised. We suggest:

* **Strengthen facility accountability of the use of public funds and the state oversight of this accountability.**

    * Finance a state oversight system to periodically report in detail nursing home expenditures.
    * Require uniform reporting on the cost reports so that the state can compare expenditures.
    * Require voluntaries and publics with surpluses to report publicly and to the state how much surplus they have and how they intend to spend this additional money.

* The present study discussed the fact that New York State believes that one of the reasons for the high Medicaid reimbursement rate in New York State is the fact that the state has high standards of care. However, New York State's ability to monitor compliance with these standards has been drastically weakened over the last 6 years. It no longer has the staff or resources to comply with federal mandates or to protect nursing home residents. If we are paying for compliance with high standards, it makes no sense not to have the ability to find out if the facilities are in fact complying. We suggest:

* **Add financial support to the state Department of Health's inspection and enforcement systems.**

* The present study raised questions about the basic tenets of the present system for reimbursing Medicaid nursing home costs. Thus, we suggest:

* **Review the basic tenets of New York State's Reimbursement System**

NEW YORK STATE'S NURSING HOME INDUSTRY PROFITS, LOSSES, EXPENDITURES AND QUALITY

Introduction

New York State Spends Most on Medicaid Residents

We are living in an era of severe fiscal constraints. As health care costs continue to rise, Medicaid expenditures continue to escalate. According to a study by the Federal Reserve Bank in Boston[6], New York spends more Medicaid money per nursing home resident than any other state. In fact, New York's Medicaid payment per resident was found to be more than twice the U.S. average payment. Yet, New York State nursing home providers assert that they are losing money and need higher Medicaid reimbursement to care for their residents who are sicker than they have ever been before. This has caused some heated battles among the state, the providers and the Legislature.

National and state solutions to these rising Medicaid costs have been to cut Medicaid access and services for the poor and to talk of the need to ration care without looking at what Medicaid is already paying for and without looking at the relationship of expenditures to patient care outcomes. Are we getting what we are paying for?

Medicaid money going to the nursing home industry continues to grow. In 1991 nursing home providers in New York State received $3.5 billion in Medicaid revenue to care for approximately 82,000 Medicaid nursing home residents. It is estimated that this number will rise to $4.5 billion in 1994.[7] This means that Medicaid will pay over $50,000 for the care of each Medicaid nursing home resident.

The Boren Amendment Encourages Provider Law Suits

In 1980, the Boren Amendment to the Medicaid statute replaced the requirement that nursing homes be paid on a reasonable cost-related basis with a requirement that states pay nursing homes rates that are "reasonable and adequate to meet the costs 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... "[8] This was to allow states increased flexibility in containing Medicaid costs by developing reimbursement systems that are not cost-based. This has led many states to develop case-mix systems based upon the average estimated costs of caring for residents with different needs.

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[6] Little, Jane Sneddon, "Public-Private Cost Shifts in Nursing Home Care," New England Economic Review, July/August, 1992, p. 3-14.

[7] New York State Department of Health, Bureau of Long Term Care Reimbursement.

[8] Pub. L. No. 96-499, § 962(a) (amending 42 U.S.C. § 1396a (a)(13)(A).

In 1990, the Nursing Home Reform Law, the Omnibus Budget Reconciliation Act (OBRA) of 1987, went into effect. The implementation of OBRA and the cry for additional money to carry out its mandates, has led to an enormous amount of Medicaid reimbursement litigation. Many providers in New York State are now suing, on the grounds that the Medicaid reimbursement they are receive is not "reasonable or adequate." Since the Boren Amendment did not contain criteria for evaluating "reasonable" and "adequate" rates, the courts have been making their own judgements. If New York State loses these suits, additional hundreds of millions of Medicaid dollars will flow into the nursing home industry. Will this have any relation to care?

New York State's Medicaid Reimbursement System May Encourage Profit Making

One of the case-mix systems developed after the Boren Amendment in the 1980s was New York State's Medicaid nursing home reimbursement system. It reimburses facilities for the care they provide to Medicaid residents by assigning residents to specific categories or "cases." Each case has a different case-mix index. A case-mix index describes the severity of care needs. The higher the case-mix, the higher the care needs. Nursing homes assess their residents' resource and staff needs twice a year. Each resident is then assigned to one of 16 different cases. The state then pays a facility a Medicaid rate based upon estimated costs which are in turn based upon previous time and motion studies. These studies were conducted to find out what providing care to residents in each case costs. Thus, under this system, Medicaid residents needing more care should bring a higher Medicaid rate.

This system, called Resource Utilization Groups (RUGs-II), encourages providers to make profits by paying them more for residents who need more care without requiring them to expend the necessary monies for resident care. Under the RUGs system in New York State, nursing home providers may decide how they will use the money they receive. They do not have to use the money to provide care. They may use it to pay for other reimbursable costs under Medicaid such as administrative costs or association dues, or they may keep it as profit.

Consumers Are Concerned that Residents are not Getting the Needed Care

Many consumers in New York State have feared that nursing homes have generated income by admitting heavy care residents without providing appropriate staff or care. Health Department data examining direct care expenditures in nursing homes for the years 1985 to 1988 found no relationship between the rise in care needs and the rise in direct care costs, most of which are staff salaries[9]. Consumers are concerned that this has affected the

[9] Presented to the Fiscal Committee of the New York State Hospital Review and Planning Council (SHRPC) in September, 1991.

quality of care. Is New York State getting its money's worth for each Medicaid dollar it spends? Are the reimbursement rates inadequate or unreasonable?[10]

Need for This Study

This study attempts to examine in detail the profits and losses in the New York State nursing home industry for 1991, the most recent year available for analysis. It attempts to give detailed information on exactly where money is being spent. It attempts to begin to examine the relationships between profit and loss, patterns of expenditures and quality care.

It is hoped that the findings of this report will be used to help state policy makers make decisions about the nursing home Medicaid reimbursement system.

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[10] Many providers say that if care suffers they will face surveillance penalties. However, the surveillance system in New York State has steadily weakened over the last five years. Due to the fiscal crisis, numbers of surveyors have dwindled to such a low point that Federal mandates are no longer being met.

Project Objectives

1. To determine the profitability/loss of nursing homes in New York State for 1991.

2. To analyze the differences in the profitability/loss of nursing homes by sponsorship, location and case-mix.

3. To examine the expenditure patterns of nursing homes in New York State in 1991 by detailing costs related to resident care, staffing and administrative costs.

4. To examine the relationship between the expenditure patterns in New York State and the care needs of residents.

5. To examine the relationship between expenditure patterns and quality care.

6. To examine the relationship between profit and loss and quality care.

7. To examine the relationship between income and quality care.

Methodology

1. All cost reports submitted to Department of Health by nursing home facilities in 1991 were analyzed.

   a. In order to fully understand the cost reports, the project director met with and held telephone conversations with a number of people many times over the course of the project to discuss findings and raise questions. These people, experts in understanding the cost reports, included:

      - owners of nursing homes;
      - accountants representing nursing homes;
      - state Health Department staff involved in setting Medicaid rates for nursing homes;
      - state Health Department staff involved in analyzing the cost reports;
      - lawyers representing nursing home owners;
      - provider statewide and local not-for-profit and for-profit association staff; and
      - nursing home controllers.

   b. All revenue reported was used to determine profits and losses. Since most of the nursing homes received over 95 percent of their patient care revenue from the operation of the nursing home, we did not separate revenue that might have come from the provision of such services as adult day care or long term home health care. Since only 20 percent of the facilities received less than 95 percent of their revenues from the operation of their nursing homes, we did not believe that our findings would be affected by such revenue (see Table 1).

   c. It is possible that figures related to expenditures may not include all expenditures in a specific category. The lack of uniformity in filling out the cost reports may lead to some underreporting. We tried to note this wherever we believed it occurred.

2. Case-mix indices, measures of resident care needs, were obtained from the Health Department.

3. Quality and negative outcome data supplied by the Department of Health and based on PRIs (Patient Review Instruments) for 1991 were analyzed.

   Measuring nursing facility quality is always a difficult task. However, there is some agreement on what constitutes poorer versus better quality. The facility-level resident status measures used in this analysis reflected three different types of events. Some were simple prevalence measures (e.g., the prevalence of contractures) that reflected the proportion of residents experiencing a problem. Others were incidence

measures, such as the number of new restraints, that measured changes over a six-month interval, and some were continuing prevalence such as continuing use of psychotropic drugs over a six-month interval.

a. We requested, under the Freedom of Information Law, a large number of resident outcomes that we believed to be indicators of quality from the nursing home resident assessments conducted during the year 1991 (the latest available and related to the 1991 cost data). We gathered data on prevalence rates, new incident rates and continuing incidence of:

   - catheters
   - urinary tract infection
   - incontinence and not taken to the bathroom
   - psychoactive medications
   - physical restraints
   - dehydration
   - feeding tubes
   - contractures
   - pressure sores
   - status ulcers
   - bedfast
   - fed by hand
   - deterioration in toileting
   - deterioration in eating
   - deterioration in mobility
   - overall deterioration in activities of daily living

b. We decided to use the latest assessment in 1991 for all prevalence data because these outcomes would be expected to be more related to expenditures in the year 1991.

c. We chose to use a number of measures that we felt had good face validity and whose distributions provided enough variation so that differences could be observed between facilities. These numbered 12.

d. The 12 chosen indicators were analyzed using a variety of statistical techniques (e.g., principal components analysis and factor analysis). These techniques allowed us to determine which of the individual quality measures seemed to hold together with other measures to reflect more general dimensions of quality of care.

e. Four additive scales were created from the 12 chosen measures. They are:

   Psychotropic drug use: (1) the percent of residents receiving a psychotropic medication at their second assessment during the year (prevalence); (2) the percent of residents receiving psychotropic medications at their first

assessment of the year who were also receiving psychotropic medications at their second assessment (continuing use); (3) the percent of residents receiving psychotropic medications who did not have a traditional mental health diagnosis or epilepsy (prevalence).

Physical restraint use: (4) the percent of residents physically restrained at their second assessment during the year (prevalence); (5) the percent of residents restrained at their first assessment who were also restrained at their second assessment (continuing use).

ADL (Activities of Daily Living)[11] decline: (6) the percent of residents whose mobility scores worsened from the first to the second assessment; (7) the percent of the residents whose total ADL index score worsened from the first to the second assessment; (8) the percent of residents whose score on eating worsened from the first to the second assessment.

Contractures and toileting: (9) the percent of residents who were incontinent and never taken to the toilet at the time of the second assessment; (10) the percent of residents who needed two people to transfer, were incontinent and never taken to the toilet at the time of their second assessment; (11) the percent of residents with contractures at the time of their second assessment; (12) the percent of residents with a contracture at the first assessment who also had a contracture at the second assessment.

f. Facilities were given quality scores on these scales. All of the 12 original, individual indicators were percentages in which higher values represented worse quality. The measures were divided into two parts at their medians.[12] Those facilities below the median received a value of zero and those above the median received a value of one. The individual measures were then added together with other indicators reflecting the same dimension of quality of care. Thus, a facility's score on each scale directly reflected the number of instances in which that facility had a score worse than that for one-half of all the facilities.

   We did not case-mix adjust our quality measures as our analysis found no relationship between case-mix and our quality scores (see Table 16).

g. All of the reported analyses were first done separately with each of these scales. Then the four scales were added together to create a more global quality measure, and facility scores on this measure were roughly broken into four equal groups (quartiles).

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[11] The activities of daily living index measures the ability to eat, toilet and transfer from bed to chair.

[12] Median means that one-half of the facilities were below this value and one-half were above this value.

h. Each scale was analyzed for its relationship to a number of financial indicators: profit per bed; operating margin; total margin; revenue per bed; expenditures per bed; staff nursing per bed; total nursing costs per bed; and contract (temporary agency) use.

i. Staffing expenditures were analyzed for their relationship to a number of indicators: profit per bed; operating margin; total margin; revenue per bed; and expenditures per bed.

j. Case-mix index was analyzed for its relationship to these indicators plus the quality scales.

k. Each quality result that involved only the relationship between quality and one other measure was also evaluated by looking at the relationships among quality and a number of indicators simultaneously (e.g., ordinary least squares regression). These models included the indicators of sponsorship, location, facility size and case-mix.

FINDINGS

Characteristics of Facilities (Table 1)

Size of the Sample

Although we analyzed the entire 1991 cost tape data released by the State Department of Health, only 543 of 554 free-standing nursing homes had useable data. There was no data on hospital-based facilities. This information is found on hospital cost reports and is not easily available. Due to the impossibility of matching facilities on different data, some of the specific findings are based on fewer facilities. This is noted whenever it occurred.

Sponsorship

Sponsorship of the facilities breaks down as follows:

* 45 percent proprietary (for-profit)
* 36 percent voluntary (not-for-profit)
* 8 percent public (county or government)

Location

The data are divided into seven different regions of New York State:

* 12 percent from the Western area of New York State
* 9 percent were from the Rochester area
* 12 percent were from the Central area
* 11 percent were from the Northeast area
* 11 percent were from the Northern Metropolitan area
* 9 percent were from Long Island
* 25 percent were from New York City.

Case-Mix Index

The severity of care needs of the population of each nursing home is defined by its case-mix index. The higher the facility case-mix, the heavier the care needs of its residents. Based upon information from the 543 facilities:

* 17 percent of the facilities had a case-mix index of less than 1.11
* 24 percent had a case-mix index of from 1.11 to 1.15

* 24 percent had a case-mix index of from 1.16 (the average for all the facilities with data) to 1.21

* 24 percent had a case-mix greater than 1.21.

Case-Mix Index and Sponsorship

* proprietary facilities had a case-mix of 1.15

* voluntaries had a case-mix of 1.17

* publics had a case-mix of 1.16.

Sponsorship and Location

* 20 percent were upstate (Western, Central, Rochester and Northeast) proprietaries

* 25 percent were upstate voluntaries

* 7 percent were upstate publics or government facilities

* 25 percent were downstate (Northern Metropolitan, Long Island and New York City) proprietaries

* 21 percent were downstate voluntaries

* 2 percent were downstate county facilities.

Table 1: Facility Characteristics (N=532-559)

CHARACTERISTIC	PERCENT OF FACILITIES	NUMBER OF FACILITIES
Sponsorship		
Proprietary	45	246
Voluntary	36	197
Public	8	41
missing	11	59
Location		
Western	12	66
Rochester	9	49
Central	12	66
Northeast	11	59
N. Metropolitan	11	57
Long Island	9	51
New York City	25	136
missing	11	59
Case-Mix Index		
less than 1.11	17	91
1.11 to 1.15	24	129
1.16 to 1.21	24	131
greater than 1.21	24	128
missing	12	64
Patient Care Revenues from RHCF		
less than 87%	10	52
87-94%	10	56
95 to 99%	19	99
more than 99%	59	315
missing	2	10
Location and Sponsorship		
upstate proprietary	20	114
upstate voluntary	25	137
upstate public	7	40
downstate proprietary	25	140
downstate voluntary	21	116
downstate public	2	12

Definitions of Profit[13]

The study looked at profitability in a number of ways by determining profit margins and actual profit dollar amounts.

Profit margin is the percent of each dollar of revenue or income retained as a profit.

Total Profit

Total margin and profit looks at the total revenues and the total expenses.

Total revenue includes contributions, endowments, Medicaid reimbursement, Medicare reimbursement[14] and private pay income. Contributions and endowments are primarily found in the voluntary facilities. In the case of public facilities, this will include money given by county legislatures to cut potential losses.

Operating Profit

Operating margin and profit looks at only the nursing home's operating revenues and operating expenses: Medicaid reimbursement, Medicare reimbursement and private pay income.

As almost 80 percent of all the facilities received almost all of their revenue from their nursing home, data on operating revenue and profit does not separate out that small amount which might have come from the operation of other patient care programs. We believe that would not substantially change our findings. Margin is the percent of each dollar of operating revenue retained as a profit.

Medicaid Profit

Medicaid profitability will look at the operating profit on Medicaid revenues only.

Actual dollar amounts listed in the report are pre-tax amounts. However, our profit findings probably underestimate the amount of profit in the industry because we did not take into account other measures of profit that we would expect would only raise our numbers. These are: return on equity; depreciation; related companies and administrative salaries taken by owners and family members to the extent that they are above the rate they would be expected to pay for the work they do.

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13 Voluntaries and publics do not actually make profits. They may, however, have surplus money at the end of the year. This report uses the word "profit" to define both profit for the proprietaries and surpluses for voluntaries and government facilities.

14 Medicare accounts for a very small amount of revenue in nursing homes - less than 5 percent.

Total Profit[15] (see Tables 2 and 3)

Facilities With Data

Most of the facilities are making a profit when total revenue and expenses are considered.

* 76 percent of all the facilities made a profit on total revenues.

* The total profit made by all the facilities was $182,730,000.

* The median annual profit was $167,233

* The total profit margin was 2.92 [16]

Differences Between "Winners" and "Losers"

There were big differences between those facilities that made profits ("winners") and those who lost money ("losers"). Table 4 shows the mean and median profit margins for those facilities with profits and for those with losses.

* The winners had a mean total profit margin of 6.62 and a median total profit margin of 4.99.

* The median profit of winners was $303,337.

* The facilities showing a loss had a negative mean total margin of -5.63 and a negative median total margin of -3.65.

* The median loss of the losers was $182,712.

Sponsorship Differences

Sponsorship was an important factor in making a profit.

Proprietaries

* 89 percent made a total profit.

* Their total profit was $119,383,000.

* Their median profit was $283,370.

* Their median total margin was 5.44, over 4 and one-half times higher than the not-for-profits.

* They made 65 percent of all the total profit made in the state.

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[15] Total profit includes revenue from contributions, endowments, Medicaid, Medicare and private pay rates. In the case of public facilities, this includes money given by country legislatures to offset potential losses.

[16] This means that for every dollar of total income, the facility keeps $.0292 profit.

Voluntaries

* 64 percent made a total profit.

* Their total profit was $33,063,000.

* Their median profit was $77,711.

* Their median total margin was 1.17.

Publics

* 58 percent made a total profit.

* Their total profit was $2,778,000.

* Their median profit was $51,193.

* Their median margin was 1.40.

Location Differences

Over 70 percent of the facilities in most of the regions realized a total profit

* 77 percent of the facilities in Western New York made a profit with a median total margin of 3.04.

* 78 percent of the facilities in the Rochester region made a profit with a total margin of 3.68.

* 73 percent of the facilities in Central New York made a profit with a total margin of 2.62.

* 71 percent of the facilities in the the Northeast made a profit with a total margin of 1.57.

The lowest percentage of facilities making a total profit was in the Northern Metropolitan region

* Only 68 percent of facilities in the Northern Metropolitan region made a profit on total revenue.

* Facilities in the Northern Metropolitan region had the lowest total profit margin in the state: 1.44.

Long Island and New York City had the highest percentage of nursing homes making a total profit.

* 82 percent of the facilities in Long Island made a profit with a margin of 3.56.

* **New York City facilities had the highest total margin of 3.72,** with 81 percent making a profit.

Table 2: Profitability and Facility Characteristics (N=543)

FACILITY CHARACTERISTICS	PROFITABILITY: TOTAL AND OPERATING MARGINS			
	MEDIAN TOTAL MARGIN	FACILITIES WITH TOTAL MARGIN ABOVE ZERO	MEDIAN OPERATING MARGIN	FACILITIES WITH OPERAT. MARGIN ABOVE ZERO
Facilities with Data	2.92	76%	1.91	67%
Sponsorship				
Proprietary	5.44	89%	5.25	87%
Voluntary	1.17	64%	-0.45	46%
Public	1.40	58%	-4.26	35%
missing	3.25	75%	2.54	69%
Location				
Western	3.04	77%	1.98	68%
Rochester	3.68	78%	1.58	63%
Central	2.62	73%	0.92	62%
Northeast	1.57	71%	0.79	58%
N. Metropolitan	1.44	68%	0.61	61%
Long Island	3.56	82%	3.43	75%
New York City	3.72	81%	2.58	71%
missing	3.25	75%	2.54	69%
Case-Mix				
< 1.11	3.47	76%	2.15	73%
1.11 - 1.15	3.32	76%	2.48	68%
1.16 - 1.21	2.82	76%	1.32	61%
> 1.214	2.82	80%	2.13	67%
missing	2.55	70%	2.07	66%
Location and Sponsorship				
upstate prop.	4.29	83%	4.08	80%
upstate volunt..	1.87	68%	.14	51%
upstate public	1.56	67%	-.32	42%
downstate prop.	6.26	95%	6.46	93%
downstate volunt.	.83	49%	-.61	42%
downstate public	-4.65	25%	-19.90	0%

Case-Mix Differences

The facilities with the lowest case-mix had the highest total profit margin, 3.47, with 76 percent of these facilities making a total profit. For both total and operating profit (see below), the facilities with the lowest case-mix had the highest profit. This does not hold true when we looked at profit on Medicaid alone (see below). In addition, when we conducted an analysis looking at a number of the variables together, this relationship does not hold.

Location and Sponsorship

In looking at the interactive effects of region and sponsorship, the regions were grouped into two categories: upstate (Western, Rochester, Central and Northeast) and downstate (Northern Metropolitan, Long Island and New York City).

Downstate

* **Downstate proprietaries had the highest total profit margin in the state: 6.26,** over twice that of all the facilities and 7 times that of the downstate voluntaries.

* 95 percent of the downstate proprietaries made a total profit of $94,442,000 with a median total profit of $414,081. This is 52 percent of the total profit made by the entire sample.

* **Downstate voluntaries had a margin of only .83** with 49 percent making a total profit.

* **Downstate publics fared the worst:** only 25 percent made a total profit and they showed a median negative margin of -4.65, with a median loss of $947,041.

Upstate

* 83 percent of the upstate proprietaries made a total profit with a margin of 4.29.

* 68 percent of the upstate voluntaries made a total profit with a margin of 1.87.

* 67 percent of upstate publics made a profit with a margin of 1.56.

Operating Profit[17] (see Tables 2 and 3)

Facilities With Data

A majority of the facilities made an operating profit.

* 67 percent of all the facilities made an operating profit.

17 Operating profit includes Medicaid, Medicare and private pay rates.

Table 3: Total profit and Facility Characteristics (N=543)

FACILITY CHARACTERISTICS	TOTAL PROFIT	OPERATING PROFIT	MEDIAN TOTAL PROFIT	MEDIAN OPERATING PROFIT
Facilities with Data	182,730,000	82,336,000	167,233	96,491
Sponsorship				
Proprietary	119,383,000	115,590,000	283,370	268,113
Voluntary	33,063,000	-22,756,000	77,711	-30,706
Public	2,778,000	-26,130,000	51,193	-139,918
missing	27,502,000	15,632,000	205,504	96,819
Location				
Western	11,358,000	5,907,000	111,970	73,223
Rochester	10,099,000	4,449,000	124,143	51,847
Central	18,953,000	-3,135,000	80,286	49,387
Northeast	12,117,000	6,148,000	81,530	40,977
N. Metropol.	-187,000	-12,740,000	95,357	45,264
Long Island	23,381,000	12,379,000	324,197	287,729
NY City	79,503,000	53,696,000	443,557	268,753
missing	27,502,000	15,632,000	205,504	96,819
Case-Mix				
< 1.11	57,563,000	29,799,000	98,347	67,607
1.11 - 1.15	35,427,000	22,911,000	171,879	116,951
1.16 -1.21	34,055,000	9,719,000	159,460	60,472
>1.21	55,679,000	27,013,000	233,994	193,184
missing	27,950,000	15,105,000	106,356	82,519
Location and Sponsorship	24,941,000	24,251,000	155,312	150,091
upstate prop.	20,673,000	-6,343,000	77,711	4,618
upstate vol.	6,914,000	-4,539,000	84,390	-31,726
upstate public	94,442,000	91,339,000	414,081	399,668
downstate prop.	12,390,000	-16,410,000	84,403	-90,376
downstate vol.	-4,135,000	-21,590,000	-947,041	-3,332,074
downstate public				

* The total operating profit made by all of the facilities was $82,336,000.

* The median operating profit was $96,491.

* The median operating margin was 1.91.

Differences Between "Winners" and "Losers" (see Table 4)

Here too, there was a great difference between the winners and the losers. Table 4 shows the mean and median profit margins for those facilities with profits and those with losses.

* The winners had a mean operating profit of 5.13 and a median of 3.83.

* The median operating profit of the winners was $287,729.

* The losers had a mean operating margin of -8.46 and a median of -5.62.

* The median operating loss of the losers was $215,628.

Sponsorship Differences

There is very little difference between total profit and operating profit for the for-profits, as they rarely get any additional revenue other than operating revenue.

Proprietary

* 87 percent made an operating profit.

* Their total operating profit was $115,590,00.

* Their median profit was $268,113.

* Their median margin was 5.25.

Voluntaries

* Only 46 percent made an operating profit.

* They lost a total of $22,756,000.

* They had a median loss of $30,706.

* Their median margin was -.45.

Publics

* Only 35 percent made an operating profit.

* The publics lost the most on operating revenue: $26,130,000.

Table 4: Profitability Levels for "Winners and Losers" (N=543)

FINANCIAL INDICATOR	FINANCIAL PERFORMANCE	
	WINNERS (total margin greater than zero)	LOSERS (total margin less than or equal to zero)
TOTAL MARGIN		
MEAN	6.62	-5.63
MEDIAN	4.99	-3.65
MEDIAN TOTAL PROFIT/LOSS	$303,337	-$182,712
OPERATING MARGIN		
MEAN	5.13	-8.46
MEDIAN	3.83	-5.62
MEDIAN OPERATING PROFIT/LOSS	$287,729	-$215,628

* They had a median loss of $139,918.

* They had a median margin of -4.26.

Location Differences

Over 60 percent of the facilities in most of the regions made an operating profit.

The highest operating profit margins are found downstate in Long Island and New York City.

* 68 percent in Western New York with a margin of 1.98

* 63 percent in Rochester with a margin of 1.58

* 62 percent in Central New York with a margin of .92

* 58 percent in Northeast New York with a margin of .79

* 61 percent in Northern Metropolitan with a margin of .61

* 75 percent in Long Island with a margin of 3.43

* 71 percent with a margin of 2.58.

Case-Mix Differences

Similar to total profit, facilities with the lowest case-mix made the most operating profit with a margin of 2.15 and 2.48 (see above discussion).

Location and Sponsorship

Downstate

* **The downstate proprietaries had the highest operating margin in the state: 6.46 with 93 percent making a profit.**

* Total profit for the downstate proprietaries was $91,339,000 with a median profit of $399,668.

* 42 percent of downstate voluntaries made a profit with a negative margin of -.61.

* **The downstate publics fared the worst. No publics made a profit and they had a negative margin of -19.90. They lost $21,590,000 with a median loss of $3,332,074.**

Upstate

* Similar to data found for total profit, upstate proprietaries fared better than upstate voluntaries or publics.

* 80 percent of the upstate proprietaries made an operating profit with a margin of 4.08.

* 51 percent of the upstate voluntaries made a profit with a margin of only .14.

* Upstate publics had a negative margin of -.32. Only 42 percent made an operating profit.

Medicaid Profitability[18]

Facilities With Data (see Table 5)

Only 32 percent of the facilities made a profit on Medicaid revenue only. Since 68 percent of the facilities had losses on Medicaid, the median operating margin was negative: -6.9.

Sponsorship Differences

* 42 percent of the proprietaries made a profit on Medicaid reimbursement.

* 13 percent of the voluntaries made a profit.

* 23 percent of the publics made a profit on Medicaid revenue.[19]

Location Differences (see Table 5)

Only New York City facilities had a positive profit margin on Medicaid revenues (4.0) with 61 percent of New York City facilities making a profit on Medicaid. The next highest percent of facilities making a profit on Medicaid was **Long Island** with 34 percent making a profit. The other regions had percentages ranging from 12 percent to 18 percent.

Case-Mix Differences

Given the incentives of the Medicaid case-mix reimbursement system, it is not surprising that 49 percent of the facilities with the highest case-mix made a profit on Medicaid, with only 24 percent of the facilities with the lowest case-mix making a profit.

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18 Medicaid profit was calculated using total expenditures, percent of resident days that were paid by Medicaid, and total Medicaid revenue. Total expenditures were multiplied by the percent of resident days paid by Medicaid. This provides a reasonable measure of facility expenditures for the care of Medicaid recipients. This value was subtracted from total Medicaid revenues, and any excess was considered profit.

19 1991 was somewhat of an anomaly for the public facilities in terms of profit. That year, no contributions were made to the pension system (later declared illegal) and initial lawsuit settlements started coming in.

Location and Sponsorship

Location and sponsorship had the greatest effect. **The highest percentage of facilities making profits on Medicaid was found among the downstate proprietaries.**

Downstate

* 59 percent of the downstate proprietaries made a profit on Medicaid reimbursement.
* 17 percent of the downstate voluntaries made a profit.
* No downstate public made a profit on Medicaid.

Upstate

* 17 percent of the upstate proprietaries made a profit on Medicaid.
* 8 percent of the upstate voluntaries made a profit on Medicaid.
* 26 percent of the upstate publics made a profit on Medicaid.

Characteristics of Facilities Profiting From Medicaid (see Table 6)

There were 133 facilities profiting from Medicaid:

* 78 percent were proprietaries.
* 16 percent were voluntaries.
* 6 percent were publics.
* 32 percent had the highest case-mix.
* 65 percent of the facilities profiting from Medicaid are proprietaries located downstate.

The median operating profit margins and annual profits of the facilities profiting from Medicaid were high for both the proprietaries and the voluntaries.

Financial Performance of Facilities Profiting from Medicaid (see Table 7)

Downstate

* 70 downstate proprietaries made a median profit on Medicaid of $486,250 with a margin of 7.3, the highest median profit margin on Medicaid.

Table 5: Medicaid Profitability and Facility Characteristics (N=419)

FACILITY CHARACTERISTICS	MEDICAID PROFITABILITY	
	MEDIAN OPERATING MARGIN	PERCENT OF FACILITIES WITH A PROFIT
Facilities with Data	-6.9	32%
Sponsorship		
Proprietary	-2.9	42%
Voluntary	-10.2	13%
Public	-14.8	23%
missing	-3.0	46%
Location		
Western	-12.9	14%
Rochester	-12.8	14%
Central	-8.9	18%
Northeast	-9.9	12%
N. Metropolitan	-11.4	14%
Long Island	-3.9	34%
New York City	4.0	61%
missing	-3.0	46%
Case-Mix		
< 1.11	-8.9	24%
1.11 - 1.15	-8.6	25%
1.16 - 1.21	-5.8	29%
> 1.214	-4.2	49%
missing	-3.0	46%
Location and Sponsorship		
upstate prop.	-9.0	17%
upstate volunt..	-12.3	8%
upstate public	-9.7	26%
downstate prop.	2.2	59%
downstate volunt.	-8.6	17%
downstate public	-32.3	0%

* 11 downstate voluntaries made a median profit of $425,120 with a margin of 5.3.

* No downstate public made a profit on Medicaid.

Upstate

* 13 upstate proprietaries made a median profit of $101,703 with a margin of 5.7.

* 6 upstate voluntaries made a median profit of $97,590 with a margin of 3.3.

* 7 upstate publics made a median profit of $72,890 with a margin of 2.7.

Table 6: Types of Facilities Profiting from Medicaid (N=133)

CHARACTERISTIC	PERCENT OF FACILITIES*	NUMBER OF FACILITIES
Sponsorship		
Proprietary	78	83
Voluntary	16	17
Public	6	7
missing	--	26
Case-Mix Index		
less than 1.11	19	20
1.11 to 1.15	24	25
1.16 to 1.21	26	27
greater than 1.21	32	34
missing	--	27
Location and Sponsorship		
upstate prop.	12	13
upstate volunt..	6	6
upstate public	7	7
downstate prop.	65	70
downstate volunt.	10	11
downstate public	0	0
missing	--	26

* Percentages are based on nonmissing cases.

Table 7: Financial Performance of Facilities Profiting from Medicaid

LOCATION AND SPONSORSHIP	MEDIAN OPERATING MARGIN ON MEDICAID	MEDIAN OPERATING PROFIT FROM MEDICAID
upstate prop.	5.7	$101,703
upstate volunt..	3.3	$ 97,590
upstate public	2.7	$ 72,890
downstate prop.	7.3	$486,250
downstate volunt.	5.3	$425,120
downstate public	0.0	$0
missing	7.9	$397,790

Nursing Home Expenditures

Yearly (1991) operating expenses were looked at in two different ways: as average percent of the yearly operating expenses and as total money spent during 1991 on different areas. It is important to note that percentage of operating expenses must be looked at with the knowledge that a large percentage of a small total expense may translate into less money than a small percentage of a large total expense. However, looking at percentage of operating expenses may give some idea of the priorities set by facilities. Looking at money spent per bed helps to better compare the expenditures. Since the most important factors relating to profits and losses seem to be sponsorship and location, differences in expenditures were looked at by sponsorship and for some expenses, by sponsorship and location.

Expenditures of All the Facilities (see Tables 8 and 10)

* 29 percent ($12,051 per bed) of all the expenditures were spent on direct care staff.

* 5 percent ($2,003 per bed) was spent for RNs.

* 6.55 percent ($2,637 per bed) was spent for LPNs.

* 17.36 percent ($7,411 per bed) was spent for nursing aides.

* About 9 percent ($3,638 per bed) was spent on salaries for management staff.

* 12 percent ($4,271 per bed) was spent on fiscal and administrative services.

* A similar percentage was spent on food service.

* Almost 7 percent was spent on plant operation ($2,574 per bed).

* A little over 4 percent was spent on nursing administration ($1,396 per bed).

* Over 5 percent was spent on housekeeping ($1,947 per bed).

* Over 3 percent was spent on laundry and linen ($1,215 per bed).

* Only 1.53 percent ($576 per bed) was spent on activities.

* Only 1.32 ($456 per bed) was spent on social services.

Sponsorship Differences in Spending as a Percentage of Operating Expenses[20] (see Tables 8 and 9)

Functional Area and Sponsorship

A number of differences were found regarding sponsorship.

* The public facilities had the lowest percentage of their expenses devoted to administrative expenses.
* The publics also had the highest percentage of their expenses devoted to pharmacy costs.
* The voluntaries and the publics spent a higher percentage of their expenses on social service than the for-profits.[21]
* The for-profits spent a higher percentage of their expenses on activities than the not-for-profits.
* The for-profits spent a higher percentage of their expenses on fiscal services (bookkeeping, accountants)

Salaries and Sponsorship

* The public facilities spent only 6.83 percent of their expenses on management and supervision salaries compared to 9.36 percent for the proprietaries and 8.90 for the voluntaries.[22]
* The publics spent the highest percentage on licensed practical nurses and nurse aides (7.27 and 19.89). Given the higher salaries and benefits of staff of public facilities, this is not surprising.
* The voluntary facilities spent the lowest percent of their expenses on aides and orderlies (16.51).

Salaries and Sponsorship and Location

Sponsorship was the overriding factor here. Location did not seem to be as important.

* Here too, upstate and downstate publics spent the least percentage of their expenses on management staff.

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20 The next section, expenditures per bed will show somewhat different findings.

21 It is important to note that this difference may be more than it seems because small facilities tend to use social services for admission services as well. Large facilities may be putting admission expenditures in fiscal and administrative; small facilities may be putting this administrative function in social services.

22 It is possible that some management and supervisory staff is shared with other county facilities and may not show up here.

Table 8: Yearly Operating Expenses by Functional Area and Sponsorship (N=484)

FUNCTIONAL AREA	AVERAGE PERCENT OF OPERATING EXPENSES			
	HOMES WITH DATA	PROPRIET	VOLUNT.	PUBLIC
Fiscal services	3.48	3.75	3.03	3.01
Administrative services	8.66	8.79	8.21	6.70
Plant operation	6.76	7.31	5.63	6.52
Grounds	.10	.09	.12	.11
Laundry and linen	3.07	3.24	3.01	3.68
Housekeeping	5.18	5.09	5.11	5.39
Patient food service	12.10	12.08	11.92	11.72
Nursing Administration	4.24	4.37	4.35	4.06
Activities Program	1.53	1.57	1.42	1.40
Social service	1.32	1.22	1.40	1.46
Dental	.31	.31	.27	.26
Psychiatry	.04	.03	.04	.03
Physical therapy	1.28	1.28	1.36	1.26
Occupational therapy	.58	.56	.66	.45
Speech and hearing therapy	.15	.12	.19	.10
Pharmacy	2.04	1.77	2.10	2.73
SALARIES				
Management and supervision	9.01	9.36	8.90	6.83
Registered nurses	5.13	4.90	5.70	4.95
Licensed practical nurses	6.55	6.87	5.96	7.27
Aides and assistants	17.36	18.25	16.51	19.89

* Upstate and downstate proprietaries spent the highest percentage on management staff.

* Downstate voluntaries spent the highest percentage on registered nurses.

* Upstate and downstate proprietaries and upstate publics spent the highest percentage on licensed practical nurses.

* Downstate, the proprietaries spent the highest percentage for nursing aides.

* Upstate, the publics spent the highest percentage for nursing aides.

Sponsorship and Location Differences Operating Expenses Per Bed[23] (see Table 10)

Functional Area and Sponsorship

* Not only did the publics spend a lower percentage of their expenses on fiscal and administrative services, they also spent fewer actual dollars per bed per year on these services ($3,251 per bed vs. $4,304 for the for-profits and $4,405 for the not-for profits).

* Voluntaries spent the most on food service, 9 percent more than the for-profits ($5,015 per bed vs. $4,562 for the proprietaries and $4,856 for the publics).

* The voluntaries also spent 14 percent more on nursing administration than the publics and 11 percent more than the proprietaries ($1,594 per bed vs. $1,364 for the publics and $1,411 for the proprietaries).

* The publics spent the least on social service, spending 31 percent less than the for-profits and 30 percent less than the not-for-profits ($396 per bed vs. $578 for the proprietaries and $564 for the voluntaries).[24]

* The proprietaries spent more on laundry and linen and plant operation than voluntaries and publics. They spent 20 percent more on laundry and linen and 18 percent more on plant operation than the voluntaries ($1,551 per bed vs. $1,240 per bed and $$2,839 per bed vs. $2,315 per bed).

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[23] This analysis focused on expenditure per bed instead of on expenditure per patient-day. Both are reasonable ways of standardizing the data. However, if we had used patient days, a number of facilities would have been lost due to missing data. This would have made the analysis less meaningful.

[24] It is possible that public facilities use county social workers. Their expense may not show up here.

Table 9: Yearly Salaries as Percent of Expenses by Sponsorship and Location (N=509)

TYPE OF SALARY	PERCENT OF OPERATING EXPENSES			
	Manage	RN	LPN	Aides
Upstate proprietary	9.98	4.81	7.76	18.32
Upstate voluntary	9.12	5.08	7.00	16.31
Upstate public	6.76	4.62	7.76	20.76
Downstate proprietary	8.85	4.97	6.11	18.20
Downstate voluntary	8.69	6.29	4.95	16.71
Downstate public	7.09	6.19	5.24	16.29

Salaries and Sponsorship

It is important to note that expenditures in this area are affected by staff union membership, civil service and benefits and may not mean less or more staff. However, labor costs in New York City are pretty homogeneous among the different providers and thus, sponsorship differences are more meaningful.

The proprietaries spend much less than the voluntaries and the publics on direct care staff.

Since case-mix index is a measure of the severity of resident needs, you would expect a facility with a lower case-mix index to spend less on direct care staff than a facility with a higher case-mix. However, a small case-mix difference should not lead to a large difference in expenditures.

* The proprietaries' case-mix index was only 2 percent less than that of the voluntaries and only 1 percent less than the publics.

* They spent 12 percent less on direct care staff than the voluntaries ($11,472 per bed, vs. $13,050 per bed) and they spent 16 percent less than the publics ($13,703 per bed for the publics).

These analyses did not include expenditures for direct care staff employed by contract (outside agencies). The study did not find much use of such staff. Contract direct care staff is reported in one of two places on the cost reports: the "Total Fees" column or the "Total Contracted Services" column. Using the "Total Fees" column which we believe is a better measure of the expenditures for contract staff because it is not likely to include other contract services, we found that only 239 facilities reported the use of any contract staff. We found that the average expenditure for contract staff for all facilities was just $358 per bed, while the median expenditure was zero. Average contract costs amount to only 3 percent of the median cost of facility staff per bed. Thus, we did not include these expenditures in our Tables. The use of contract direct care staff by downstate proprietaries tended to be more frequent than the other facilities, but was still small. These expenditures averaged $567 a bed or 4 percent of their total direct staff expenditures.

It is possible that some contract direct care expenditures has been reported in the "Total Contracted Services" column on the cost report. However, this column includes other contract services in addition to direct care staff. In any event, when we looked at this column, the findings were similar to those found in the "Total Fees" column.

* **The voluntaries spent the most money on salaries for management and supervisory positions** ($4,206 per bed vs. $3,334 for the proprietaries and $2,849 for the publics). This was 21 percent more than the proprietaries and 32 percent more than the publics.

Table 10: Yearly Operating Expenses per Bed by Functional Area and Sponsorship (N=484)

FUNCTIONAL AREA	MEDIAN OPERATING EXPENSES PER BED			
	FACILITIES WITH DATA	PROPRIET.	VOLUNT.	PUBLIC
Fiscal services	1,235	1,260	1,219	1,073
Administrative services	3,036	3,044	3,186	2,178
Plant operation	2,574	2,839	2,315	2,274
Grounds	0	16	0	0
Laundry and linen	1,215	1,551	1,240	1,430
Housekeeping	1,947	1,903	1,990	2,117
Patient food service	4,623	4,562	5,015	4,856
Nursing Administration	1,396	1,411	1,594	1,364
Activities Program	576	589	562	520
Social service	456	578	564	396
Dental	116	134	89	71
Psychiatry	0	0	0	0
Physical therapy	447	465	456	415
Occupational therapy	175	191	183	72
Speech and hearing therapy	23	26	28	11
Pharmacy	827	764	892	1,001
SALARIES				
Management and supervision	3,638	3,334	4,206	2,849
Registered nurses	2,003	1,803	2,557	2,230
Licensed practical nurses	2,637	2,566	2,698	3,178
Aides and assistants	7,411	7,103	7,795	8,295

Salaries and Sponsorship and Location (see Table 11)

The direct care staff patterns held true for upstate and downstate.

* The upstate proprietaries, with only a 1 percent lower case-mix index, spent 7 percent less on nursing staff than the upstate voluntaries and, with only 2 percent lower case-mix, spent 17 percent less than the upstate publics.

* **The largest differences was found among the downstate proprietaries, the facilities which made the most total profit, operating profit and Medicaid profit.**

* With only a 3 percent lower case-mix, the downstate proprietaries spent 19 percent less on nursing staff than the downstate voluntaries ($13,006 per bed vs. $16,020 per bed) and, with only 2 percent lower case-mix, spent 34 percent less than the downstate publics ($19,765 per bed).[25]

Full-Time Equivalents and Sponsorship and Location

Table 12 looks at numbers of full-time staff per bed. This shows a similar picture. **Generally speaking, voluntaries and publics hired, on a full-time basis, the most RNs, LPNs and aides.** However, only the numbers of aides demonstrated large variance among voluntaries, proprietaries and publics.

* **Downstate proprietaries, hired the lowest number of full-time direct care staff, particularly nurse aides,** per bed in the state.

* With a case-mix of 1.16, equal to upstate publics, 1 or 2 percent higher than upstate proprietaries and voluntaries, 2 to 3 percent lower than downstate voluntaries and publics, downstate proprietaries hired 12 percent fewer full-time aides than the voluntaries and 27 percent less than the publics.

* **Downstate voluntaries, with the highest case-mix index (1.19) hired less full-time direct care staff than the upstate voluntaries with a 3 percent lower case-mix index.** The downstate voluntaries hired the same number of full-time direct care staff as the upstate proprietaries, with the lowest case-mix index (1.14).

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25 When we looked at contract nursing ("Total Fees") we found that the downstate proprietaries spent about 4 percent of its total direct staff expenditures on contract staff. If you add these expenditures, downstate proprietaries spent 14 percent less than the downstate voluntaries.

Table 11: Yearly Salaries Per Bed by Sponsorship and Location (N=509)

Sponsorship/Location	Median Nursing Wages per Bed			Avg CMI
	RN	LPN	Aides	
Facilities with data	2,003	2,637	7,411	1.16
Upstate proprietary	1,535	2,502	6,192	1.14
Upstate voluntary	1,928	2,683	6,413	1.15
Upstate Public	1,798	3,041	7,469	1.16
Downstate proprietary	2,140	2,605	8,261	1.16
Downstate voluntary	3,612	2,749	9,659	1.19
Downstate public	3,697	3,749	12,319	1.18

Table 12: Full-Time Equivalents Per Bed by Sponsorship and Location (N=509)

Sponsorship/Location	Median Nursing Wages per Bed			Avg CMI
	RN	LPN	Aides	
Facilities with data	.06	.11	.41	1.16
Upstate proprietary	.05	.12	.43	1.14
Upstate voluntary	.07	.15	.44	1.15
Upstate Public	.06	.14	.45	1.16
Downstate proprietary	.06	.10	.38	1.16
Downstate voluntary	.08	.09	.43	1.19
Downstate public	.10	.12	.52	1.18

Relationships Among Profits and Losses, Expenditures and Quality[26]

We found almost no relationship to quality for any of the indicators. The quality results involving only quality and one other indicator are largely consistent with the results obtained when looking at the relationships among quality and a number of indicators simultaneously (multivariate analysis).[27] However, those correlations that were marginally significant in the quality tables became insignificant in these analyses. Thus, what seemed to be a significant relationship was not.

Table 13 indicates that there was no relationships found between the quality scores and profitability.

Table 14 indicates a weak relationship between quality and total profit margin. However, when we conducted an analysis by looking at the relationships among quality and a number of other indicators simultaneously, to see if this relationship would hold, the relationship disappears. There is also a positive relationship found between quality and nursing staff cost per bed (facilities with higher quality spend less on nursing costs) but this is a very weak relationship. No other indicators showed any relationship to quality.

Table 15 shows a number of relationships between nursing staff expenditures and revenues per bed and expenditures per bed. These relationships also show high correlations. Thus, facilities with high staffing expenditures also had a high revenue and a high total expenditure per bed.[28]

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[26] Only the analyses of the four category, more general quality measure discussed in the Methodology section are reported here. However, the results are consistent across each of the sub-scales. For ease of display, the variables being correlated with quality (e.g., costs, revenues) were aggregated into four approximately equal groups (quartiles). Since quality data was not available for all facilities, these analyzes are based on cost, staffing, and quality data on roughly 450 facilities.

[27] Often indicators are interrelated. The multivariate analysis is conducted to see if a relationship found when analyzing two of the indicators holds when looking at a number of factors together.

[28] Since the use of contract direct staff might affect quality, we did include a measure in these analyses for contract staff. We performed the analysis of staffing using both "Total Fees" and "Total Contract Services." The results were similar for both. In our Tables, we report the results for the measure constructed the "Total Fees" column because we believe that it is the best representation of contract staffing. "Total Contract Services" is more likely to include services other than nursing. However, no matter which measure we used, our conclusions would be the same. It might be worthwhile in a future study to look at those few facilities which did use contract staff heavily. They were downstate facilities.

Table 16 demonstrates that case-mix has a moderate relationship to expenditures, nursing costs per bed and all nursing costs per bed. Facilities with higher case-mix, spend more money on nursing costs. This table also indicates that there is no relationship between case-mix and: quality; profit per bed; operating margin; or total margin.[29]

[29] A variety of analyses surrounding facility size were carried out. No significant relationship was found between size and revenues per bed, expenses per bed, profit or quality.

Table 13: Quality and Profitability (N=445)

Quartile in Quality	Quartile in Profitability ($ per bed)				TOTAL
	Lowest	Second	Third	Highest	
Best	16.8% 17	20.7 % 24	15.8% 19	15.7% 17	17.2% 77
Mod. Good	26.7% 27	28.5% 33	25.8% 31	31.5% 34	28.1% 125
Mod. Poor	20.8% 21	26.7% 31	31.2% 38	28.7% 31	27.2% 121
Poorest	35.6% 36	24.1% 28	26.7% 32	24.1% 26	27.4% 122
TOTAL	100% 101	100% 116	100% 120	100% 108	100% 445

Probability of Chi-Square = .561 Phi Coefficient = 0.131

Table 14: Summary of Relationships Between Quality and Other Indicators*

Indicator Correlated with Poor Quality	Probability of Chi-Square	Phi Coefficient	Number of cases
Profit per Bed	.56	.13	445
Operating Margin	.26	.16	445
Total Margin	.05	.19	446
Revenue per Bed	.08	.19	445
Expenditures per Bed	.20	.17	445
Staff Nursing Cost per Bed	.03	.21	433
Total Nursing Costs per Bed	.11	.18	433
Contract Nurse Use	.79	.05	433

*Entries in the Phi Coefficient column are the correlation coefficients based on the contingency tables used to evaluate these relationships. Entries in the Probability of Chi-square column are the probabilities of the Chi-squares associated with the contingency tables used to examine these relationships.

Table 15: Staffing Measures and Financial Indicators*

Indicator Correlated with Staffing	Staff Nursing Expenditures		Use of Contract Staff		Total Nursing Expenditures	
	Phi	Sig.	Phi	Sig.	Phi	Sig.
Profit per Bed	.16	.13	.11	.11	.14	.33
Operating Margin	.16	.16	.10	.16	.16	.16
Total Margin	.19	.03	.10	.16	.17	.10
Revenue per Bed	.81	.00	.09	.21	.86	.00
Expenditures per Bed	.86	.00	.11	.12	.89	.00

*Entries in the Phi columns are the Phi coefficients based on the contingency tables used to evaluate these relationships. Entries in the Sig. columns are the probabilities of the Chi-squares associated with the contingency tables.

Table 16: Facility Case-Mix and Other Indicators*

Indicator Correlated with Staffing	Case-Mix	
	Phi	Sig.
Profit per Bed	.09	.91
Operating Margin	.11	.75
Total Margin	.10	.86
Revenue per Bed	.34	.00
Expenditures per Bed	.32	.00
Staff Nursing costs per bed	.24	.00
All Nursing Costs per bed	.24	.00
Quality of care	.16	.22

*Entries in the Phi columns are the Phi coefficients based on the contingency tables used to evaluate these relationships. Entries in the Sig. columns are the probabilities of the Chi-squares associated with the contingency tables.

Discussion

Profits and Losses

When looking at total and operating profitability, the nursing home industry in New York State as a whole is financially healthy.

A majority of the facilities in New York State made a total and an operating profit. With a margin of 2.92, 76 percent of the facilities made a total profit (median profit of $167,233) and with a margin of 1.91, 67 percent of the facilities made an operating profit (median profit of $96,491).

However, when these profits are looked at in terms of sponsorship and location, a different picture appears. In terms of total profit, a majority of proprietaries, voluntaries and publics are making profits. But, in terms of operating profit, less than one-half of the voluntaries and a little over one-third of the publics are making profits. Both voluntaries and publics had median losses. The publics fared the worst. They lost over 26 million dollars on operating revenue.

The public facilities have long been the place of "last resort" for those residents who had no other place to go. Publics have often admitted residents other nursing homes have refused. Their survival is crucial.

Most of the profit is being made by downstate proprietaries. Over 93 percent made a total and operating profit. They had a median operating profit of 6.46.

This is a possible, not unlikely scenario: if a downstate proprietary with a profit margin of 6.46 received $175 a day for care, it would make a profit of $11.31 per bed per day or $1,031,581 a year for a 250 bed facility.30

Medicaid profits show similar numbers. Overall, less than a third of the facilities made a profit on Medicaid alone. However, most of the profit was made by the downstate facilities, particularly the downstate proprietaries. Sixty-one of the New York City facilities made a profit on Medicaid alone.

Of the 133 facilities making a profit on Medicaid alone:

* 70 were downstate proprietaries
* 13 were upstate proprietaries
* 11 were downstate voluntaries
* 6 were upstate voluntaries
* 7 were upstate publics
* 0 were downstate publics

30 In the next chapter, profit margins are explained in terms of profit per day per bed, annual profit and return on investment.

Clearly the voluntaries and particularly the publics seem to be facing financial problems. However, it is not clear what the cause of their problems are. This will be discussed in more detail in the next chapter.

Additional Profit: Salaries of Owners and Their Families

This study looked only at profit margins. We did not look at return on equity31, related companies and administrative Recently32, New York State released information on the salaries of owners and their families for 172 proprietary facilities. These salaries are expenses and are thus deducted before listing profits. The data indicates that additional total and operating profits may be found in some of these salaries.33

To the extent that owners are paying more in salaries to themselves or their families than would be reasonable and would be expected to be paid to an outside employee, this additional amount must be considered additional profit.

In 1991, 5 facilities, all in downstate New York, the location making the most profit without counting salaries, (3 in New York City, 1 in Long Island and 1 in Northern Metropolitan) paid its owners and/or families over $1,000,000 in salary. Salaries ranged from 1,000,000 to $1,300,000. In 1992, 8 facilities, all in downstate New York (6 in New York City, 1 in Long Island and 1 in Northern Metropolitan) paid salaries of between $1,000,000 and $1,975,000. The other salaries ranged from $1,025 to $935,924. Thus, it seems as if the profit made by downstate proprietaries is even more than indicated in this report.

This issue must be more carefully investigated. In order to see how much of these salaries are really additional profit, it is important to find out what jobs are being paid for, how many hours the owners are working and what reasonable compensation would be. In addition, salaries of not-for-profit and public facilities must also be looked at. Although such salaries can only be reimbursed up to a cap by Medicaid, to the extent that such salaries are not reasonable, they must also be considered additional total and operating profit. This study does indicate that the voluntaries spend more on management and supervisory salaries than the proprietaries or the publics (see expenditure findings).

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31 Return on equity is much more difficult to gather because it demands a general and consistent valuation of assets. We felt that we could trust the profit margins to be more comparable.

32 Press Release, State Department of Health, Albany, November 12, 1993.

33 There are caps on what Medicaid will reimburse for management salaries.

Public Facility Profit

Although the data indicates that many publics are making profits, it is important to realize that some of the profit shown by the publics are direct tax-based support from their local governments, often given to offset potential losses. In addition, as noted earlier, 1991 was an anomaly for the public facilities. That year, no contributions were made to the pension system (later declared illegal) and initial lawsuit settlements started coming in. Even so, the total profit shown by the 41 facilities was only $2,778,000. The median total profit was only $51,193. The operating profit shows a loss of $26,130,000.

The Disparate Treatment of Homes In New York City and Upstate New York

In a Boren Amendment lawsuit, a number of upstate providers allege that the state is paying homes in New York City more than their costs of caring for Medicaid residents.34 They assert that the reason lies in the state's method for reimbursing labor costs.

Wage Equalization Factor (WEF)

When the state went to a reimbursement system that pays average costs of care, it had to account for unequal labor costs in order to find the "real" average cost. Such costs could then be compared. The WEF is intended to neutralize significant wage differences between regions in New York State. WEF recognizes that the price of labor is similar in different regions with wide variations between upstate and downstate regions and between rural and urban areas upstate. It attempts to avoid penalizing facilities in high labor cost areas relative to facilities in low labor cost areas. The state is divided into 16 regions for rate setting purposes. Each home's reimbursement is adjusted by comparing facility actual wage costs (costs in the base year of 1983) to wage costs of other facilities in its region and across the state. If the facility is in a region with higher than average wage costs, it receives a higher reimbursement rate, whereas a facility in a region with below average wage costs receives a lower rate.

All regions, except for New York City, have a maximum ("cap") and a minimum ("base") amount they can receive. Outside of New York City, a facility receives what they spend unless it spends more than the maximum or less than the minimum. If it is above the "cap," it receives the maximum amount; if they are below the "base," they receive the minimum. Because the state believed that there is a greater homogeneity among wages in New York City than elsewhere (most wages were about the same), New York City was not

34 State of New York Supreme Court Appellate Division - Third Department, Lakeshore Nursing Home and Others vs. Axelrod and Others, March 12, 1992.

given a cap or base. Every facility in New York City is paid at the mean of all the wages in New York City. The upstate facilities believe that New York City facilities are getting more money than they spend while upstate facilities often lose money. These providers also argue that high WEF regions drive up wages in low WEF regions which do not get the benefit of the higher adjustments.

Trend Factor

All rates are based upon actual 1983 costs trended forward. Upstate providers believe that New York City facilities are receiving more in wage expenditure reimbursement than they actually spend. The upstate facilities maintain that New York City facilities signed a labor contract in 1983 that increases wages they must pay at a lower percent than the trend factor figured in for the rates. Because they were paid the full trend factor rather than their actual increases, upstate providers believe that downstate facilities receive much more than upstate facilities.

This needs more careful study. Combined with a less full-time hands-on-staff found in the downstate proprietaries, those making the most profit, this clearly becomes a care issue as well as a financial issue.

Expenditures

The study demonstrates where different types of facilities are spending their revenue.

Looking at the expenditures in light of the profits being made by the proprietaries (in particular the downstate proprietaries), and the losses being incurred by the voluntaries and the publics, we were distressed to find that:

1. The proprietaries spent 12 percent less per bed than the voluntaries for direct care staff and 16 percent less than the publics.

2. The downstate proprietaries hired the lowest number of direct care staff per bed and spent 19 percent less per bed than the voluntaries for direct care staff and 34 percent less than the publics.

3. Although the downstate voluntaries had the highest case-mix index, i.e., their residents had the highest care needs, it's full-time direct care staff per bed was less than the upstate voluntaries with a lower case-mix index. In fact, their full-time direct care staff numbers were the same as the upstate proprietaries, which had the lowest case-mix index in the state.

4. The voluntaries spent the most money per bed on salaries for management and supervisory positions. Consumers have long been concerned that voluntary facilities sometimes seem top heavy. Do they really need to spend 21 percent more per bed than the proprietaries and 32 percent more than the publics on management and supervisory personnel?35

5. The percentage of expenditures and amounts of money spent on activities and social work services is embarrassingly low. Activities and social work services are of major import to nursing home residents. Only $576 per bed was spent on activities ($1.57 per day per bed) and only $456 was spent on social work services ($1.25 per day per bed). It seems impossible to provide meaningful and varied activities and social work services with so little money.

We were however, pleased to see that:

1. Fiscal and administrative expenses do not take an inordinate amount of the expenditure budget. Fiscal and administrative services are averaging about 12 percent of operating expenditures.

2. Voluntaries spent the most on food services: 9 percent more than the proprietaries and 3 percent more than the publics. This is a very important area for nursing home residents. Much of nursing home life revolves around meals. Although we are aware that more expense doesn't necessarily mean better food and service, we are pleased to see that this has been given major importance by the voluntaries.

Profit/Loss, Expenditures and Quality

Quality, as defined in this study was found not to be related to facility profit or loss, facility revenue or to facility expenditures in specific areas.

The question arises: What is New York State buying for its 4.3 billion dollars in Medicaid reimbursement to the nursing facilities?

No relationship was found between quality, as we defined it, and profitability.

Some weak to moderate relationships were found:

Facilities with high staffing expenditures also had a high revenue and a high total expenditure per bed.

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35 A number of nursing home residents and relatives employ private aides or companions because they believe that the facility is not hiring enough staff. It would be worthwhile to look into this issue in future studies.

Case-mix had a moderate relationship to expenditures.

This study did not examine quality of life in relation to the many indicators discussed in this report. Measuring quality of life is even more difficult than measuring quality of care. It is possible, however, that some of these indicators might be related to quality of life. The state should begin to collect data on quality of life as well as quality of care.

Questions for Policy Makers

Does the Medicaid Rate Adequately Cover Care?

Boren Amendment Lawsuits

> "Medicaid coverage for poor Americans seeking health care coverage resembles the last lifeboat for passengers on the Titanic: it is not nearly large enough to accommodate even half of those in need."36

Gordon Bonnyman, a Staff Attorney with Legal Services of Middle Tennessee, lays out the fight that the poor are now having with care providers suing under the Boren Amendment.

> "Medicaid policy involves a zero-sum game among poor patients, the health care industry, and state government. One player gains only at the expense of another...In other words, an on-going struggle is taking place between the poor and the health care industry to determine who keeps a seat in the Medicaid lifeboat."

Nursing Home providers in New York State have begun to sue the state Department of Health under the Boren Amendment. Although some of these providers are making total or operating profits, they explain that they are not making profits on the Medicaid rate; they are raising private pay rates. They believe that the base year of the state's Medicaid reimbursement must be changed; 1983, the current base year, is too old. They also argue that the trend factor used to update the 1983 costs is too low. They question the WEF adjustment. They believe that the Medicaid rate is not reasonable or adequate; the rate does not meet the standard of the Boren Amendment.

Unfortunately, there is no specific criteria in the Boren Amendment to evaluate rates which are "reasonable" and "adequate". If the providers are successful in their litigation, New York State may be liable for hundreds of millions of Medicaid dollars. If what Gordon Bonnyman says is true, it is crucial for New York State to be able to answer the question of whether the Medicaid rate is "reasonable" and "adequate" in a way that will be convincing to the courts.

Medicaid Rates Must Be Adequate to Enhance Access and Quality

In addition, the state must answer this question in order to protect the state's nursing home residents. For some providers, the rate seems too low. Many nursing homes, particularly voluntaries and public facilities, are losing money. The publics,

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36 Bonnyman, Gordon. "Deciding Who Swims with the Sharks: Boren Amendment Litigation," Clearinghouse Review, July, 1992, pgs. 302 -305.

in particular, care for the patients rejected by most of the other facilities, such as Medicaid patients and low-paying patients. The state cannot lose these facilities because county legislatures no longer want to cover losses. The public homes must survive. On the other hand, for other providers, the Medicaid rate seems too generous; profit margins on Medicaid for some providers are high.

How will this question be answered? Simply demonstrating loss is not enough. The results of this study demonstrate that only 32 percent of the facilities are making a profit on the Medicaid rates. This includes 42 percent of the proprietaries; 13 percent of the voluntaries and 23 percent of the publics.

Evidence that a majority of the nursing homes in New York State are losing money on Medicaid is not proof that the Medicaid rate is not high enough. Without knowing where revenue is being spent in relation to care outcomes, we do not know if more money is needed. Are two-thirds of the facilities in New York State losing money on Medicaid because they are expending revenue on necessary care, and therefore need more, or are they spending money in areas that would indicate poor management or are they making financial decisions that are not in the best interest of the residents? Are they spending money "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.."?

If the Medicaid rate is inadequate in certain circumstances, rates must be changed relative to the problems found. The state must take the initiative to answer this question. It is dangerous to leave this decision in the hands of the judicial system by answering this question only in relation to the litigation. The courts may declare an entire reimbursement system inadequate without ever looking at the questions of access or quality in relation to the rate. They may declare the entire system invalid when the issue may relate to only specific issues or facilities.

In order to answer this question properly, future study must look carefully into how facilities which deliver good care, break even or make a profit on Medicaid manage to do so. Why does the rate seem adequate for some but not others? Studies must examine management styles, reimbursement system issues and facility financial decisions. Is the rate too generous in certain cases? Are losses due more to mismanagement than to inadequacy of the rate? The state must answer this question for itself and change the way it calculates its rates if necessary.

What are the Business Risks of Operating a Nursing Home?

The nursing home industry sells an important product: care for the frail elderly and disabled and others in need of institutionalized medical and social care. Most nursing homes, whether for-profit, not-for-profit or public institutions, operate

as businesses; they are all concerned about the bottom line. For-profit facilities try to make profits; not-for-profit and public facilities try to break even, or to create a surplus of funds.

The nursing home industry is a substantially low-risk business, particularly in New York State, for a number of reasons: (1) competition is limited; (2) New York State has a high occupancy rate; and (3) most payments are guaranteed.

Competition is Limited

While the ratio of number of beds per 1000 people aged 65 and older in the United States is 53.1, the ratio for New York State is 44.7. While the ratio of number of beds per 1000 people aged 85 and older in the United States is 501.7, the ratio in New York State is 382.2.37 A new publication, State Data Book on Long Term Care Program and Market Characteristics[38], analyzed the supply of nursing home beds in New York State. It found that both state officials and, their own analysis, pointed up the undersupply of beds.

High Occupancy Rate

New York State nursing homes have had a 99 percent occupancy rate39. This is ensures a steady income.

Most Payments Guaranteed

Medicaid pays for 80 to 85 percent of the beds in New York State. Thus, nursing home providers are assured of selling 80 to 85 percent of its product just by opening its doors.

Generally speaking, the demand for nursing home beds far exceeds the supply; many nursing homes need do no more than open its doors for customers to appear. This is a seller's market. In addition, providers have the right to accept who they want; this acceptance is often based upon maximizing income. They want to admit those who pay privately or whose Medicaid reimbursement is high.

Many providers believe that there are many risks in doing business in New York State. They are concerned that the fact that Medicaid does pay for so many of their beds causes problems. They are very dependent on the state which, at times, lags payments, cuts rates

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37 Du Nah, R. Jr., Keo de Wit, S., Harrington, C., Swan. B., Bednay, B. State Data Book on Long Term Care Program and Market Characteristics, Department of Social and Behavioral Sciences and the Institute for Health and Aging, University of Calif.; San Francisco, November, 1993.

38 Ibid.

39 Ibid.

and is way behind on calculating accurate rates. Thus, they believe that they must have other resources to handle potential cash flow problems. In addition, if facilities are losing money on Medicaid alone, as 68 percent are, they look toward the private pay market for their profits. Thus, any fluctuation in the occupancy rates immediately affects profits. Although the occupancy rate in New York State has been extremely high, some providers are concerned that there have been some changes over the last few years that may cause problems. It is unclear what is causing this issue and whether it is an issue that will soon resolve itself. Before one accepts these arguments, it is important to look historically at what the state has done in the past in terms of lagging payments and cutting rates. The state has, in fact, lagged payments and has been late in calculating timely rates. However, providers are assured that the rates will be paid. These actions may cause cash flow problems, but will not lower revenue. The money that the state has taken out of the system over the years has not been substantial.40

What is a Reasonable Profit/Should There be Caps on Profits?

In order to limit the rapid growth of Medicaid costs, we need to look to limiting the amount of profit nursing home facilities can make. This study found quite a variety of profit margins depending upon sponsorship and location in the state. Thus, a median range of positive total profit margins was found from a high of 6.26 to a low of .83. Looking at those facilities that made a profit on Medicaid alone (32 percent of the facilities), downstate proprietary facilities were found making a median operating profit on Medicaid income alone of 7.3 percent.

Studies in Other States

What do profit margins mean? What is a reasonable profit margin? Although it is difficult to compare the findings of this study with other financial analyses, as methods of research may differ, an examination of other states' findings are interesting.

In its study, Minnesota's Office of the Auditor attempted to determine whether the state's nursing homes' financial performance was adequate. They agree, that at a minimum, facilities must at least break even, but it was hard to say how much more was necessary or desirable. The answer, they believe depends on the facility's mission, state policy, degree of business risk and

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40 When this happens, providers sue the state. See State of New York Supreme Court Appellate Division - Third Department, New York State Health Facilities Association, Inc., and its members, et al vs. Axelrod and others, July 13, 1993.

community standards.41 Some not-for-profit Minnesota owners said they would be satisfied with any positive total margin. The for-profits believed that a 5 to 6 percent was desirable. In its study, Wisconsin's Legislative Audit Bureau found total margins (after corporate taxes; total margins in this report are before taxes) for the proprietaries averaging 3.3 to 4.1 percent and for the not-for-profits 2.4 to 3.7 percent. The publics lost 8.4 percent. The Wisconsin researchers determined that a total profit margin of 3 to 4 percent could be considered reasonable in 1988 because it meant a profit on average of $1.84 per resident per day.42

What Do the Profit Margins in this Report Mean?

Tables 17 and 18 give some examples of what different profit margins mean in terms of profit per bed per day, total yearly profits and return on an operator's investment. Table 17 gives sample numbers for a 120 bed facility, the average size upstate and Table 18 gives sample numbers for a 250 bed facility, the average size downstate. Each table assumes a cost of $100,000 a bed to build.

When an operator wants to build a facility, s/he must put up in cash a minimum of 10 percent of the cost of the project (equity). For a 120 bed facility that means $1,200,000. For a 250 bed facility that means $2,500,000. In addition, the operator is required to have an additional 5 percent in cash for working capital for the period when the facility first opens. This makes the total cash investment for a 120 bed facility $1,800,000 and for a 250 bed facility $3,750,000.43

Tables 17 and 18 demonstrate how profit margin relates to daily profit per bed, annual profit and return on the operator's cash investment (equity and working capital).

For example, if a facility with a profit margin of 1 percent, which is close to the total profit margins for the voluntaries and the publics in this study, received a rate of $100 a day (the average Medicaid rate upstate), the operator would make on average $1.00 per day per bed. If this facility had 120 beds, it would make an annual profit of $43,80044; if it had 250 beds, it would

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41 Office of the Legislative Auditor, Program Evaluation Division, Nursing Homes: A Financial Review, State of Minnesota, January, 1991.[23] Legislative Audit Bureau, A Review of Nursing Home Reimbursement Formula (Madison, Wisconsin: September, 1988).

42 Legislative Audit Bureau. A Review of Nursing Home Reimbursement Formula (Madison, Wisconsin: September, 1988).

43 Sometimes the operator shares the equity responsibility and shares the profits with a real estate developer. This scenario may be slightly different.

44 In addition, as discussed earlier, the profit does not include the "profit" generated by salaries of owners and their families and voluntary and public managing and supervisory staff to the extent that they are unreasonable and above the going rate.

make an annual profit of $91,250. The return on the operator's investment would be 3 percent.[45]

A facility with a profit margin of 2 percent, close to the operating margin of all the facilities and a little less than the profit margin of the downstate proprietaries who profited from Medicaid alone, would make on average a daily profit of $3.00 per bed with a rate of $150 a day (average Medicaid rate downstate). With 120 beds, the facility would make $131,400 a year; with 250 beds, $273,750. The return on investment would be 7 percent.

With a profit margin of 3 percent, close to the total profit margin of all the facilities, a facility would make on average $6.00 a day per bed with an average rate of $200 a day. The return on investment in this case would be 15 percent.

The upstate proprietaries had profit margins over 4 percent. Tables 17 and 18 demonstrate that facilities with profit margins of 4 percent, charging or receiving rates of $150 a day, would also make a profit on average of $6.00 per day per bed.

The proprietaries in general had profit margins of over 5 percent and the median profit margin of the downstate voluntaries profiting from Medicaid was also over 5 percent. The tables indicate that these facilities would have profits on average $10.00 per day per bed, charging or receiving $200 a day. For such a 120 bed facility, the annual profit would be $438,000; for such a 250 bed facility, the annual profit would be $912,500. The return on investment would be 24 percent.

If a facility had a profit margin of 6 percent, close to the median total and operating margins for the downstate proprietaries, it would make on average $9.00 per day per bed, with a rate of $150 a day. A 120 bed facility would make an annual profit of $394,200; a 250 bed facility would make $821,250. The investment return would be 22 percent.

Finally, facilities with profit margins of 7 percent, less than the median margin found for downstate proprietaries who profited from Medicaid, would make on average $10.50 a day per bed, with rates of $150 per day. Facilities with 120 beds would make $459,900 a year; facilities with 250 would make $958,125. The return on investment would be 26 percent.

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45 Operators will also be getting back the entire equity portion of the cash investment through the Medicaid rates as well. Voluntaries will get their equity back in about 25 years through depreciation and the proprietaries will get their equity back in about 40 years through an additional amount in the Medicaid rate. In addition, proprietaries also get a return on equity in the rate. This is interest (based upon the interest of a 30 year Treasury Note) for the use of the money. Voluntaries do not get a return on equity.

Table 17: Illustrating Profits in a 120 Bed Facility

Profit Margin	Daily Income Per Bed	Profit Per bed	Profit Per Year	Annual Return on Investment
1 percent	$ 100	$ 1.00	$ 43,800	3 percent
	150	1.50	65,700	4 percent
	200	2.00	87,600	5 percent
2 percent	$ 100	$ 2.00	87,600	5 percent
	150	3.00	131,400	7 percent
	200	4.00	175,200	10 percent
3 percent	$ 100	$ 3.00	131,400	7 percent
	150	4.50	197,100	11 percent
	200	6.00	262,800	15 percent
4 percent	$ 100	$ 4.00	175,200	10 percent
	150	6.00	262,800	15 percent
	200	8.00	350,400	20 percent
5 percent	$ 100	$ 5.00	219,000	12 percent
	150	7.50	328,500	18 percent
	200	10.00	438,000	24 percent
6 percent	$ 100	$ 6.00	262,800	15 percent
	150	9.00	394,200	22 percent
	200	12.00	525,600	29 percent
7 percent	$ 100	$ 7.00	306,600	17 percent
	150	10.50	459,900	26 percent
	200	14.00	613,200	34 percent

The tables indicate other possible profits with higher or lower rates. The tables do not give examples of profit margins above 7, but one-half of the downstate proprietary facilities making a profit on Medicaid had profit margins above 7, thus demonstrating even higher profits and returns on investment.

In an era of fiscal constraints, where, in an effort to cut health care and Medicaid costs, policy makers cut services to the poor, do providers have the right to make unlimited profit on private pay rates and/or Medicaid rates alone? To raise their profits, providers can charge private pay residents any rate they like. High private pay rates clearly affect Medicaid rates. High private pay rates force people to apply for Medicaid much more quickly. Their savings do not go far. Are private pay rates subsidizing Medicaid rates? Or are they subsidizing profits and/or poor management decisions?

Should a Public Utility Framework for the Nursing Home Industry be Considered?

The concept of a public utility is an interesting one. The nursing home industry is a heavily regulated industry, at least on paper. If done well, the public utility framework offers the opportunity for better public oversight of adequacy of rates, provision and quality of services and reasonableness of profits.

Should Voluntaries and Publics Be Making Profits (Surplus)?

Although voluntaries and public facilities do not actually make a profit, they can keep surpluses. Those facilities making such surpluses are amassing a discretionary pool of funds that the facility can spend in any way it sees fit. They can spend it on any number of things: furnishings for administrative offices; resident care; resident activities; public relations; dues to their associations; and litigation against the state. At the same time they are lobbying the Legislature and the Governor for more Medicaid money. They are in reality usurping the right of the public, through its elected representatives, to decide how to spend public monies by urging more money where money might not be needed.

It is important to realize however, that often these facilities raise outside funds for crucial projects that will better the nursing home residents' care and life. Such activities should not be discouraged. However, providers do need to be held accountable to policy makers and the public for the expenditure of the discretionary pools of money they amass.

Should Medicaid Rates Be Tied to Actual Expenditures

This study indicates that not enough money is being spent in the areas of activities and social services. In addition, there are

Table 18: Illustrating Profits in a 250 Bed Facility

Profit Margin	Daily Income Per Bed	Profit Per bed	Profit Per Year	Annual Return on Investment
1 percent	$ 100	$ 1.00	$ 91,250	3 percent
	150	1.50	136,875	4 percent
	200	2.00	182,500	5 percent
2 percent	$ 100	$ 2.00	182,500	5 percent
	150	3.00	273,750	7 percent
	200	4.00	386,000	10 percent
3 percent	$ 100	$ 3.00	273,750	7 percent
	150	4.50	410,625	11 percent
	200	6.00	547,500	15 percent
4 percent	$ 100	$ 4.00	365,000	10 percent
	150	6.00	547,500	15 percent
	200	8.00	730,000	20 percent
5 percent	$ 100	$ 5.00	456,250	12 percent
	150	7.50	684,375	18 percent
	200	10.00	912,500	24 percent
6 percent	$ 100	$ 6.00	547,500	15 percent
	150	9.00	821,250	22 percent
	200	12.00	1,095,000	29 percent
7 percent	$ 100	$ 7.00	638,750	17 percent
	150	10.50	958,125	26 percent
	200	14.00	1,277,500	34 percent

differences in expenditures for direct care staff. Should facilities be required to spend some specific portion of their reimbursement in these areas?

What are the Relationships Among Profits, Losses, Expenditures and Quality

Profits and losses and expenditures cannot be looked at in isolation. Looking at profits and losses without looking at where money is going (expenditures) and how this relates to quality is meaningless. Health care policy makers cannot decide whether to add or subtract money from the nursing home system based upon profits and losses alone. In the same vein, efficiency cannot be defined only in terms of costs. It makes no sense to label a facility that has low expenditures efficient without looking at quality.

Is New York State a Prudent Buyer of Nursing Home Care?

The federal government requires each state to demonstrate that it is acting as a prudent buyer of nursing home services.46

Medicaid will pay $4.3 billion for care for Medicaid residents in New York State's nursing homes. This is about $50,000 for each resident. Many people believe that historically we have expended so much in the nursing home industry because we were paying for very strong standards of care. Providers have long argued that higher standards of care must be accompanied by higher Medicaid reimbursement and argue that if Medicaid rates drop or do not rise, care will suffer. Some policy makers have questioned whether New York State can afford such high standards. However, although we assumed that the high rates of reimbursement were buying better care, we did nothing to make sure that the money we put into the system actually bought better care. We did nothing to tie public monies to compliance with standards and did little to support the Department of Health's ability to oversee compliance with care standards.

The results of this study show no relationship among profits, expenditures and quality of care. It seems that facilities which spend more, or who had large profits, had as good or bad quality of care as those who spent less, or had losses.

New York State has spent large sums of money without knowing what it was buying. How can some policy makers suggest that we can no longer pay for high quality of care when we don't know what kind of care we are buying now? What will our $4.3 billion buy? We do not know.

New York State is not a prudent buyer of nursing home care. It spends money without knowing what it is buying and without knowing how to buy what it wants.

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46 Department of Human Services, Methods and Standards for Determining Payment rates for Services Provided by Skilled Nursing and Intermediate Facilities. Transmittal IM-90-01 (March, 1990).

Recommendations

The following recommendations are meant to be viewed together. No one suggestion will deal with all of the issues raised.

* The present study found that although profits were not related to our measures of quality, there were large profits being made on Medicaid monies. Given the rising Medicaid costs, we suggest:

  * **Set a limit on the amount of profit a facility may make on Medicaid alone.** Consider inappropriately high salaries for owners and their families as additional profit.

  * **Require facilities to spend the portion of their rate that is for direct care on the care of their residents or to return the unused portion to the state.**

* The present study found that quality care, as defined by this project, was not related to facility profit or loss, facility revenue or to facility expenditures in specific areas. This raises the question of what the state is buying for its Medicaid dollars. We suggest:

  * **Tie expenditures to deficiencies in care**

    If nursing homes are found to be deficient in any area by the state Department of Health, the state must have the ability to require the facility to expend money in those area found deficient.

  * **Publicly recognize facilities with high quality of care**

* The present study raised the question of whether the Medicaid rate was adequate or too generous. The state must answer this question. We suggest:

  * **Conduct studies of facility management.** Identify facilities with low costs and high quality. Gather data on these facilities as well as the facilities with high quality and high profits. Find out how they manage to do so.

* The present study examined expenditures in specific detail. These examinations indicates differences in expenditure patterns among the various sectors of the industry. It also found that many voluntaries and some publics are making a total profit and/or operating profit at the same time they are saying that the Medicaid rate must be raised. We suggest:

  * **Strengthen facility accountability of the use of public funds and the state oversight of this accountability.**

    * Finance a state oversight system to periodically report in detail nursing home expenditures.

* Require uniform reporting on the cost reports so that the state can compare expenditures.

* Require voluntaries and publics with surpluses to report publicly and to the state how much surplus they have and how they intend to spend this additional money.

* The present study discussed the fact that New York State believes that one of the reasons for the high Medicaid reimbursement rate in New York State is the fact that the state has high standards of care. However, New York State's ability to monitor compliance with these standards has been drastically weakened over the last 6 years. It no longer has the staff or resources to comply with federal mandates or to protect nursing home residents. If we are paying for compliance with high standards, it makes no sense not to have the ability to find out if the facilities are in fact complying. We suggest:

  * **Add financial support to the state Department of Health's inspection and enforcement systems.**

* The present study raised questions about the basic tenets of the present system for reimbursing Medicaid nursing home costs. Thus, we suggest:

  * **Review the basic tenets of New York State's Reimbursement System**

    Is the WEF equitable? Are the trend factors too high for some and too low for others?

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