1994

Nursing homes; Consulting services practice aid, 94-2

American Institute of Certified Public Accountants. Management Consulting Services Division

AICPA

CONSULTING SERVICES
PRACTICE AID 94-2

Industry Consulting

Nursing Homes

Management Consulting Services Division

AMERICAN

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ACCOUNTANTS

NOTICE TO READERS

This practice aid is designed as educational and reference material for Institute members and others who provide consulting services as defined in the Statement on Standards for Consulting Services (SSCS) issued by the AICPA. It does not establish standards or preferred practices. However, since the services described in this series of practice aids are consulting services, the standards in the SSCS should be applied to them as appropriate.

Various members of the 1992–1993 AICPA MCS Technical and Industry Consulting Practices Subcommittee were involved in the preparation of this practice aid. The members of the subcommittee are listed below.

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PREFACE

This practice aid is one in a series providing practitioners with information about a particular industry, its typical consulting services engagement opportunities, and additional information on the sources of industry and technical engagements. The practice aid's purpose is to assist practitioners in identifying pertinent issues as well as the resources needed for engagements involving a particular industry.

Although these practice aids often deal with aspects of consulting services knowledge in the context of a structured consulting engagement, they are also intended to be useful to practitioners who provide advice on the same subjects in the form of a consultation. Consulting services are defined in the Statement on Standards for Consulting Services (SSCS) issued by the AICPA's Management Consulting Services (MCS) Division.

This series of Industry Consulting Practice Aids should be particularly helpful to practitioners who are considering (a) offering initial or additional consulting services to clients in an industry, (b) offering consulting services to clients who are entering or considering entry into the industry, (c) expanding their practice by marketing services to potential clients in the industry, and (d) undertaking a cooperative engagement by arranging for an industry specialist from outside the firm to assist a client. For readers employed in the industry, Industry Consulting Practice Aids may be useful in providing advice to management.

These practice aids do not purport to include everything that a practitioner needs to know to become expert in providing services to that industry. Current conditions in an industry may vary from those at the time the practice aid was developed.

CONTENTS

84/100 NURSING HOMES

84/105 SCOPE OF THIS PRACTICE AID

.01 The primary purpose of this practice aid is to describe the nursing home industry, discuss current industry trends, identify critical operational issues in nursing homes, and assist the practitioner in identifying and delivering consulting services that can be provided to nursing home clients.

.02 This practice aid also discusses Medicare and Medicaid reimbursement for nursing home services. This discussion is intended to provide general information, not all the specific exceptions and alternatives available under these programs. Additional information is available to the practitioner in the sources listed in appendix 84/A. In this practice aid, the terms *patient* and *resident* are used somewhat interchangeably.

.03 Although this practice aid focuses on nursing homes, the matters discussed may also apply to retirement communities, personal care homes, and other health care providers insofar as their operations are similar to those of nursing homes.

84/110 INDUSTRY PROFILE

Definition of the Industry

.01 *Nursing home* is a generic term for several types of long-term care facilities serving the elderly population. In fact, many nursing homes provide short-term care as well as long-term care. Although most persons served may be classified as elderly, these facilities also provide substantial amounts of restorative care for residents other than the elderly. These restorative services may consist of physical therapy, speech therapy, occupational therapy, or similar services.

.02 Nursing homes usually fall into one of the following categories:

a. Skilled-nursing facility (SNF)
b. Intermediate-care facility (ICF)
c. Extended-care facility (ECF)
d. Intermediate-care facility for the mentally retarded (ICF/MR)
e. Multiple-service facility

.03 In February 1992, the U.S. Department of Health and Human Services eliminated the distinction between SNFs and ICFs when it ruled that the federal standards for participation in the Medicare and Medicaid programs are the same for both types of facilities. However, the nursing home industry still distinguishes between facilities providing skilled patient nursing care and those not providing skilled care. Accordingly, this practice aid makes a distinction between skilled nursing and intermediate care facilities.

.04 Skilled-Nursing Facilities. An SNF provides skilled nursing care and related services to patients who require medical, nursing, or rehabilitation services. In an SNF, the health care of every patient is under the supervision of a physician who is available to furnish medical care in an emergency. In addition, SNFs provide twenty-four hour nursing service and generally have at least one registered nurse on duty at all times. The objective of SNF services is to restore the patient, to the maximum extent possible, to the health status that preceded the present illness or injury.

.05 Services provided to patients in SNFs may be covered by third-party insurance carriers, Medicaid, or Medicare if they have been ordered by a physician and meet contractual conditions.

.06 An SNF is generally more costly to operate than an ICF or ECF because of the costs associated with the twenty-four hour registered nursing coverage and expensive supplies. Supplies associated with the skilled care of a patient include special feeding formulas, dressing changes, which often are required continuously, and special equipment, such as feeding pumps and oxygen concentrators.

.07 Intermediate-Care Facilities. ICFs generally provide maintenance care rather than skilled nursing care. Some ICFs, however, provide extensive rehabilitation services, such as physical, speech, and occupational therapy.

.08 Generally, each state mandates the level of staffing for ICFs. Usually, a registered nurse is on duty eight hours per day and licensed practical nurses supervise patient care during the remainder of the day. ICFs generally do not provide twenty-four hour skilled nursing care and therefore cannot meet the needs of certain patients.

.09 The primary goal of most ICFs is to maintain residents at their existing level of functioning. This maintenance care does not entitle ICFs to participate in Medicare reimbusement. However, Medicaid reimbursement of ICFs is extensive.

.10 Extended-Care Facilities. At one time, an *extended-care facility* was defined as a skilled-nursing facility that qualified for Medicare participation. In 1972, the Medicare laws were amended to include the more generic term *skilled-nursing facility*. Currently, the term *extended-care facility* is used in certain circles to describe a personal care facility, which assists residents in activities of daily living, such as bathing, toileting, grooming, and eating. An ECF generally does not retain full-time therapists or nursing staff, but contracts for these services as needed.

.11 Intermediate-Care Facilities for the Mentally Retarded. ICFs/MR are intended to meet the unique requirements of mentally retarded residents. These facilities generally accommodate fewer residents than either ICFs or SNFs because of the extent of the personal attention required

by the mentally retarded residents. These factors—staff-intensive personal care and the fixed income of a small patient pool—mean that ICFs/MR generally incur high operating costs on a per-patient day basis.

.12 **Multiple-Service Facilities.** Many nursing homes have designated part of the facility for skilled nursing care and other parts for a different patient population. For example, a 120-bed facility may consist of 90 intermediate care beds and 30 skilled nursing care beds.

.13 The multiple service facility is quite common. The arrangement allows the facility to staff each component of the nursing home differently, thereby holding down staffing costs in the intermediate-care portion while meeting registered nurse staffing requirements in the skilled nursing portion of the facility. Nursing homes providing both skilled nursing and other levels of care in the same facility without separation of patients may be required to staff the entire facility as if it were an SNF because of Medicare and state requirements.

Related Industries

.14 The nursing home industry shares many characteristics with hospitals, hotels and motels, and retirement communities. Accordingly, some of the information provided in this practice aid may be useful to the practitioner in serving these types of clients. Many elements of their operations, however, are quite different from those of nursing homes. Furthermore, the ownership characteristics, marketing approaches, services provided, and business cycles may differ substantially from those described in this practice aid. This practice aid is not intended to cover these related industries.

Standard Industrial Classification Code

.15 The Standard Industrial Classification (SIC) system categorizes industries by type of economic activity. Its purposes are to facilitate the collection, tabulation, presentation, and analysis of data relating to industries and to promote uniformity and comparability in the presentation of statistical data describing the economy. The SIC is used by agencies of the United States Government that collect or publish data about particular industries. It is also widely used by state agencies, trade associations, private businesses, and other organizations including publishers of industry reference books such as Robert Morris Associates and Dun and Bradstreet. The SIC Code for the nursing home industry is 8050.

Historical Information

.16 Since the 1960s, the number of residents in nursing homes has more than doubled. The following factors have contributed to the growth in nursing home utilization:

- An increase in the aged population

- Lack of involvement by family members in the care of elderly relatives
- Implementation of Medicare coverage of skilled nursing care
- An emphasis on the early discharge of hospital patients to alternative health-care settings
- Expansion of Medicaid coverage for intermediate care and extended care (personal care) services

.17 The nursing home industry was once dominated by not-for-profit and religious organizations that were tax-exempt. This domination declined because many of these organizations were unable to obtain and maintain appropriate levels of capital and because the nursing home industry became attractive to proprietors seeking to profit from their investments.

.18 The domination of proprietors was encouraged by the advent of the Medicare and Medicaid programs, which today pay more than half the costs of nursing home care. The general increase in demand for nursing home services has also contributed to the increase in the number of homes operated by proprietors.

.19 During the 1980s, many facilities were constructed by owners who hoped to profit from the demand for nursing home services by an ever-increasing population of the aged. However, these owners did not wish to operate the facilities. They created a demand for companies to manage the facilities for a fee, which could be based on patient days, a flat amount per period, a percentage of income, or some combination thereof. These companies assured investors that maximum financial revenues would be secured, costs would be held down, and regulatory requirements would be met.

.20 However, many absentee owners entered the industry for the short term. Consequently, many of these facilities were acquired by large corporations. These corporations currently dominate the industry, creating substantial chains of nursing home facilities. They are able to bring professional management and efficient operations to the industry.

Government Reimbursement Programs

.21 Most nursing home revenues comes from the Medicare and Medicaid programs. The nursing home expenditures reimbursed by these government programs are growing at a substantial rate. The government response to rising health care costs has generally been to limit reimbursements and shift a greater portion of the costs to the Medicare or Medicaid beneficiary.

.22 The Medicare program, which is federally funded, covers the skilled nursing services provided to eligible individuals. To participate in the Medicare program, an SNF must adhere to Medicare conditions. The practitioner can obtain information regarding these conditions and other standards of performance from the Health Care Finance Adminstration (HCFA) or the industry association in the particular state (these associations are listed in appendix 84/A). To participate in the Medicaid program, which is the state-administered program for serving the

medical needs of the financially indigent, the nursing home must meet the same standards developed by the Medicare program.

.23 Most states have developed licensing requirements that are more stringent than the standards established by the Medicare and Medicaid programs. The standards set by each state are related to its administration of the Medicaid program; however, each state also imposes other requirements to better control the quality of the nursing home services being rendered.

.24 The states are responsible for conducting a system of audits and inspections to ensure that nursing homes comply with the state requirements and the Medicare and Medicaid conditions of participation. Accordingly, failure of the nursing home to comply with all applicable standards could mean loss of state and federal funding, and possibly closure.

.25 Medicare. The Medicare program was enacted in 1965 as Title XVIII of the Social Security Act and became effective July 1, 1966. It is a nationwide health insurance program for people age 65 and over, people eligible for social security disability payments for more than two years, and certain workers and their dependents who need a kidney transplant or dialysis treatments. Medicare coverage is available to insured individuals without regard to income. Moneys from payroll taxes and premiums are deposited in special trust funds for use in meeting the expenses incurred by the insured.

.26 The program includes two separate but coordinated programs: hospital (Part A) and supplementary medical insurance (Part B). These two insurance programs provide different benefits and also represent separate governmental funds. Part A funds are accumulated from payroll taxes imposed on both employers and employees. Part B funds are allocated from general tax revenues of the federal government and premiums paid by those over 65 years for supplemental health coverage.

.27 *Medicare Part A.* The Medicare health insurance program provides payments under Part A (from the social security fund) to qualified participating hospitals for expenses incurred by Medicare beneficiaries as inpatients. A patient at an SNF is considered to be an inpatient according to the definition used for Medicare Part A payments. Accordingly, Medicare beneficiaries admitted to an SNF for covered skilled services are entitled to Medicare Part A coverage, provided that they had been a patient in a hospital for no less than three days prior to their admission to the SNF.

.28 The Medicare program pays the SNF directly for services provided to Medicare beneficiaries. Payments are generally made monthly and are based on rates determined through a retrospective cost-based system. Such rates are based on an annual cost report filed by the nursing home. The cost report is used to determine the average cost per day incurred by the facility which, when multiplied by the number of Medicare patient days, determines the final Medicare liability for the year to the nursing home. The nursing home is paid only for costs incurred to render services; no payment representing a profit is made to the nursing home. The patient is responsible for only deductibles and coinsurances, which are continually revised.

.29 Part A Medicare reimbursement is available to Medicare-participating SNFs rendering covered services to Medicare beneficiaries. An SNF not electing to participate in the Medicare

program is not eligible for payment from Medicare Part A. In addition, noncovered services, such as custodial or personal care, are ineligible for Medicare payment regardless of where they are rendered. SNFs, ICFs, and ICFs/MR are ineligible to receive Medicare Part A payments.

.30 *Medicare Part B.* Medicare Part B generally provides payments for outpatient, or nonresident, services. However, nursing home patients who do not receive skilled nursing care may be eligible for Part B reimbursement for drugs and biologicals (which cannot be self-administered), durable medical equipment for certain restorative services, such as physical therapy, occupational therapy, speech therapy, and certain other services provided at the nursing home.

.31 These Part B services are reimbursed to an SNF based on the cost reports filed by the facility. Deductibles and coinsurance amounts for Part B are different from those imposed on Part A covered services but are the patient's only liability.

.32 An intermediate care facility that has entered into an agreement with its Medicare program for Part B services may provide the above-mentioned services and be paid according to a fee schedule.

.33 *Medicaid.* Medicaid programs represent the most significant funding source of nursing home services in the United States. The Medicaid program is federally aided, but is state operated and administered. The program provides medical benefits to certain low-income individuals under Title XIX of the Social Security Act. Subject to broad federal guidelines, states determine the program benefits, eligibility requirements, rates of payments to providers, and methods of administering the program.

.34 Skilled nursing care, intermediate nursing care, extended nursing care, and intermediate nursing care for the mentally retarded are all services covered by the Medicaid program. Medicaid reimbursement policies vary from state to state.

Reimbursement Methodologies

.35 Although the Medicare program is a federal program, the reimbursement principles may vary from locale to locale. For Medicaid reimbursement to nursing homes, most states use one of three methods to make payments: prospective payments based on costs, retrospective payments based on costs, or prospective rate setting.

.36 Prospective Payments Based on Costs. A reimbursement methodology that is prospective based on costs requires each nursing home to report annually or semiannually to the state the costs incurred to render services. The state then uses these cost reports to set rates for an ensuing period. The rates set represent the amount to which the nursing home is entitled for services rendered to Medicaid-eligible residents.

.37 The prospective rates may be specific to the facility or may be based on the experience of all nursing homes reporting or groups of nursing homes classified according to size or designation (SNF, ICF, SNF/ICF).

.38 Retrospective Payments Based on Costs. When a nursing home is reimbursed retrospectively, it receives interim payments subject to reconciliation with its actual costs. The nursing home submits a cost report that provides the basis for determining whether the facility has been overpaid or underpaid for services rendered to Medicaid patients. The cost report also serves as the basis for determining the amount of interim payments for the upcoming period prior to the next retrospective settlement.

.39 Other Prospective Rate-Setting Methods. Various other prospective rate-setting methods are being tested throughout the U.S. These methods are similar in that the nursing homes are paid an amount of money based on flat rates established by the state or on the amount of care required by specific types of residents. These methods generally have no retrospective elements. The amount paid the facility is not based on costs incurred but on other factors, and the payment is final.

.40 A nursing home may be eligible for a simplified prospective reimbursement system if its services to Medicare patients are minimal. The nursing home is paid a flat amount per patient day for routine services during the year. A simplified filing at year end determines the new rate for the ensuing year. With this simplified process, no major settlements are made at year end because only the costs incurred for ancillary services could cause a settlement.

.41 Evaluating third-party reimbursements for the nursing home client involves the following elements:

a. Understanding the reimbursement methodology being employed by Medicare, Medicaid, or other third-party payer

b. Reviewing the nursing home's operations and internal cost accumulations to identify potential reclassifications of cost

c. Reviewing the statistical accumulations used by the nursing home in preparing the cost report (for example, dietary needs, laundry pounds, square footage)

d. Preparing "what if...?" scenarios and sample cost reports to test available cost and statistical alternatives

Current Trends

.42 The demand for services offered by nursing homes continues to increase because of the needs of a growing elderly population, the lack of in-home care givers, and government pressures to provide health care services in the least restrictive setting.

.43 Payments to nursing homes represent the single greatest Medicaid expenditure in most states. As more nursing home beds become available, Medicaid expenditures increase. Accordingly, many states, despite their recognition of the need for nursing home beds, have limited the number of new beds to be made available to the public. Some states have completely halted the construction of nursing home beds, other than replacement facilities.

.44 Cost reduction and reimbursement control and limitation are constant goals of both federal and state governments. These pressures create the need for nursing homes to maintain effective cost management processes.

.45 Simultaneous with the need to control costs, nursing homes are confronted with stringent standards established by federal and state governments. Many of these requirements are the result of renewed public awareness of quality-of-life issues for the elderly. This public awareness results partly from revelations of instances of cruelty, neglect, and inadequate conditions for nursing home residents. As uncommon as these conditions may be, they provide a rationale for government intervention.

.46 A significant concern of the nursing home industry is the inability to recruit and retain qualified health care professionals, which is due to a general shortage of these individuals and keen competition for those available.

.47 Other trends in the nursing home industry significant to the practitioner include the following:

- The number of available nursing home beds is not expected to match the increase in need. Financial pressures on federal and state governments, as well as third-party insurers, are expected to cause an expansion in programs providing alternatives to nursing home care, such as adult day care, congregate living residential facilities, and in-home care.

- The increasing financial burden on the federal and state governments for health-care services may result in more of the financial obligation being shifted to the patient. This shift should encourage nursing homes to ensure that their billing and collection procedures are efficient and effective.

- Many hospitals, especially those in rural areas, are converting acute care beds to alternative uses such as nursing home care. This is due to an inability to secure nursing home beds for discharged patients in need of such care and the need to utilize present hospital facilities.

- Professional staff shortages are not expected to abate in the short-term future.

Impact of Technology

.48 Two broad areas of technology have had an impact on the nursing home industry: medical technology and computer technology. The effects have been both indirect and direct. Medical technology has enabled hospitals to treat patients more quickly and discharge them earlier than in past years. As a result, many patients are being discharged to nursing homes for follow-up care of their illnesses or injuries.

.49 Computer technology has had a direct impact on nursing homes. Procedures that once were done manually have been automated. Computers are used to price services and produce bills based on care rendered, time requirements and diagnosis, and to process financial

transactions. Computers are also used to document patient needs assessments, prepare and revise care plans, evaluate drug interactions, and maintain patient charts.

Capital Requirements

.50 Nursing homes require capital for land, building, equipment, and furnishings. Working capital is also required for inventory and the financing of patient receivables.

.51 Most nursing homes were constructed or acquired by proceeds of debt obligations. In fact, many nursing homes constructed prior to 1986 were financed through the issuance of tax-exempt bonds by local governments or other bond-issuing authorities. This method of financing the physical plant was attractive because the lower interest rates were tax-exempt and owners were not personally liable for the debt in certain situations.

.52 Laws governing tax-exempt debt issues have changed significantly. Although tax-exempt facilities (501 c(3) organizations) can still issue tax-exempt bonds, the financing of proprietary facilities is done through banks and other conventional sources and is not tax exempt. However, if proprietary facilities have tax exempt bonds outstanding, they are permitted to refinance them with a new issue that would still be tax exempt.

.53 The amount of working capital required by a nursing home depends largely on the extent to which it relies on governmental programs. Nursing homes with a significant number of private-paying patients have less need to finance working capital than those dependent on third-party programs because a private-paying patient generally pays at the beginning of the month for one month's room charges. Commercial third-party payers, as well as Medicare and Medicaid intermediaries, often pay the room charge between thirty and ninety days after the end of the month during which services were rendered.

Competition

.54 Competition is intense among nursing homes for residents who can pay their own bills without relying on the Medicaid program. Many facilities employ a marketing person to help attract such residents. They offer well-designed tours of the facility, produce attractive brochures, advertise the facility in the proper markets, and engage in other marketing activities familiar to the commercial world.

.55 In states with low numbers of nursing home beds, there is little competition among facilities for other than private-paying residents. This is because Medicaid residents are waiting to fill the empty beds as they become available. However, in states with excess nursing home beds, competition exists for all residents. Even though the Medicaid payment may be less than that of a private-paying resident, some daily payment is better than none.

.56 Some hospitals have converted acute care beds to nursing care beds, thereby creating additional competition for the nursing home industry.

Charges for Services

.57 Some facilities, especially tax-exempt governmental providers, use an all-inclusive rate that incorporates the charges for room and board with other charges, such as supplies and prescription drugs. However, the current trend is to use a charge structure more directly related to the service rendered to residents. Under this method, charges could be generated for therapy services, medical supplies, prescriptions and nonprescription drugs, oxygen, medical appliances, and so forth. Additionally, nursing homes generally charge separately for substantial amounts of personal services, such as barber and beauty shop treatments and television in a patient's room.

.58 Nursing homes that provide skilled nursing services to Medicare program beneficiaries can be reimbursed on the basis of actual services rendered if they maintain appropriate cost and charge information. This charge structure is usually more advantageous than an all-inclusive rate structure.

84/115 TYPICAL MAJOR DAY-TO-DAY ACTIVITIES

.01 The major day-to-day activities in nursing homes are associated with providing housing, nursing, and restorative services, maintaining medical records, maintaining physical facilities, providing daily living activities such as dietary and laundry services, and administering the services and operations.

Nursing Services

.02 Nursing services are those services provided to maintain or improve the physical condition and capabilities of the residents. These services are generally performed by employees of the nursing home. The nursing department usually includes a director of nursing and a staff of registered nurses, licensed practical nurses, and aides.

.03 Facilities that participate in the Medicare and Medicaid programs must comply with certain regulations concerning nurse staffing, such as the availability of registered nurses, the availability of licensed practical nurses, and the numbers of nursing personnel based on the size of the facility.

.04 Nursing homes frequently use personnel agencies to meet their short-term needs when regular employees are on vacation, are ill, or are unavailable for other reasons.

Restorative Services

.05 Restorative services include physical therapy, speech therapy, occupational therapy, and related programs intended to maintain or improve the resident's functional capability. Nursing homes may hire employees for these services, especially physical therapists, if the size of the facility and number of residents justify maintaining these skills full time. Most nursing homes, however, cannot justify employing full-time personnel to provide restorative services. Therefore,

they usually contract with an agency to pay for these services as rendered.

Medical Records

.06 The medical records activities of a nursing home, especially those participating in the Medicare and Medicaid programs, are extensive. Government regulations require substantial documentation regarding resident needs and the provision of services to meet those needs.

.07 The medical records function of a nursing home involves many people including:

- A medical director, generally contracted
- Medical records technicians
- Consulting professionals, such as pharmacists and utilization review committees, which are responsible for reviewing resident needs

.08 As health care reform proceeds, more and more services will be provided by outside parties. This external control will further increase the need for documentation regarding the need for service and outcome achievement.

Physical Facilities

.09 The physical facilities of a nursing home are quite extensive and include offices, patient rooms, social areas such as the dining room, and kitchen and laundry facilities. The maintenance and housekeeping functions are generally performed by employed staff; however, major facility projects such as roof repair and similar items are acquired as needed by the facility.

Daily Living Activities

.10 The nursing home is the permanent residence for most patients. Accordingly, a substantial number of daily living activities are conducted by the nursing home. These include meal preparation, laundry services, social functions such as church services, outings, and birthday parties, and other activities depending on the population served by the facility.

Administration

.11 The administration of the facility consists primarily of business office personnel, secretarial staff, and the administrator. The size of the facility dictates the extent of administrative staff needed. Facilities of 120 beds or more generally employ an assistant administrator. Additionally, the desire to attract private-paying patients has caused many facilities to employ full-time admission personnel who also provide public relations and marketing services.

84/120 AREAS OF BUSINESS RISK

.01 Nursing homes are exposed to a variety of risks by the nature of the operations conducted. Some of the risks to which they are most often exposed are associated with professional liability, government reimbursement, recruitment and retention of personnel, and public perception.

Professional Liability

.02 Nursing homes are exposed to risk associated with malpractice claims in which the claimant asserts that the home failed to meet professional standards relating to quality of care. Most nursing homes are insured for such losses. Most supervisory employees, registered nurses, and licensed practical nurses also carry personal professional liability insurance.

Government Reimbursement

.03 Nursing homes that participate in Medicare or Medicaid programs are reimbursed according to methods established by federal and state regulators. These methods are under constant scrutiny by government bodies seeking to curtail expenditures. Any change might have a negative impact on the nursing home. Further, nursing homes that fail to meet government standards may be denied reimbusement or barred from participation in Medicare or Medicaid.

.04 The Medicare and Medicaid programs have the right to conduct audits of the nursing home's filed cost reports. These audits could result in the disallowance of certain costs and the repayment of funds to these programs.

Recruitment and Retention of Health Care Personnel

.05 Federal and state mandated staffing patterns, coupled with a lack of qualified nursing personnel, cause the nursing home difficulty in recruitment and retention. Offering competitive wage and employee benefits is the key to the nursing home's ability to recruit and retain nursing personnel. The nursing home competes for personnel not only with other nursing homes, but also with hospitals and other health care providers.

Public Perception

.06 The public's perception of the quality of the nursing home's physical plant and resident care will influence the financial success of the nursing home. Private-paying residents can generally obtain admission to the nursing home of their choice. Accordingly, to attract private-paying patients, a nursing home needs to be perceived by the public as providing high quality care in a well-maintained facility.

84/125 PERFORMANCE MEASURES

.01 Performance measures for the nursing home industry are well defined. Information for comparing a facility's performance with that of other facilities is available from state nursing home associations and the American College of Health Care Administrators.

.02 The performance measures described in the following paragraphs are useful for comparing a nursing home's performance with that of other facilities. Such comparisons require considering differences among facilities that are due to state, region, and classification of facility. For example, due to staffing, an ICF may experience lower nursing costs than does a skilled care facility. Resident needs and acuity must also be considered in comparisons between facilities. For example, a nursing home with numerous incontinent residents may need more staffing than a facility with few, if any, incontinent residents. Similarly, a nursing home that uses disposable diapers may have a greater nursing supply cost than a facility using cloth diapers. The facility using cloth diapers, however, may incur greater laundry costs because of the need to reprocess the cloth diapers.

Utilization

.03 Utilization performance measures are used to evaluate the utilization of facilities. These measures are important for self-assessment as well as for comparison with other facilities. Utilization performance measures include the following:

- *Facility occupancy rate*, determined by dividing the number of actual patient days by the number of possible patient days. For example, a sixty-bed nursing home could have 21,900 patient days (60 × 365). If it actually had 18,500 patient days, its occupancy rate would be 84 percent (18,500 ÷ 21,900). The occupancy rate is influenced by the amount of time that elapses between a discharge and a new admission.

- *Treatments per patient day*, calculated by dividing the number of restorative treatments by patient days. This measure reflects the utilization of such restorative services as physical therapy. For example, a facility with 3,900 physical therapy treatments and 18,500 patient days would have .21 physical therapy treatments per patient day.

- *Patient mix*, calculated by dividing the patient days for each payer by the total patient days. For example, a nursing home with 18,500 patient days which comprise 12,000 Medicaid days, 2,000 Medicare days, and 4,500 private-payer days would have the following patient mix:

Medicaid	65 percent
Medicare	11 percent
Private-payers	24 percent

.04 Since varying amounts of revenue are generated from different payer sources, such data provides the nursing home with important information concerning its ability to generate profits.

Revenues

.05 Nursing homes can only generate revenues from residents. Accordingly, the nursing home must maximize revenues from residents without jeopardizing its competitive status with other nursing homes. Revenue measures are important for assessing the facility's capabilities to achieve revenue maximization and for comparing revenues with that of other facilities. The revenues measured include:

- *Revenue per patient day*, determined by dividing total patient revenue by total patient days (billed patient days). For example, a nursing home with total patient revenue of $1,554,000 and total patient days of 18,500 would have revenue per patient day of $84.

- *Revenue per patient day by payer*, calculated by dividing the total patient revenue from a particular payer by the total patient days billed to that payer. For example, a nursing home with Medicaid revenue of $780,000 and 12,000 Medicaid patient days would have Medicaid revenue per patient day of $65.

- *Restorative revenue per patient day*, determined by dividing the total restorative revenue by the total patient days. For example, a nursing home with restorative revenue of $38,000 and 18,500 patient days would have restorative revenue of $2.05 per patient day.

- *Net revenue per patient day*, calculated by dividing total patient revenue less contractual adjustments, bad debts, and charity allowances by the total patient days. For example, a nursing home with $1,554,000 of total patient revenue, $35,000 of contractual adjustments, $12,000 of bad debts, $4,000 of charity allowances, and 18,500 patient days would have a net revenue per patient day of $81.24. For financial reporting purposes, bad debts must be treated as an expense rather than a contra revenue item.

Expenses

.06 Labor costs represent the single greatest expense of the nursing home. It is common for salary and wage costs, including employee benefits, to represent 70 percent of a nursing home's total expenses. The management of labor in a nursing home is a substantial activity.

.07 Personnel management in a nursing home is generally performed by the administrator or assistant administrator, although some larger facilities may have a separate personnel director. Directors of nursing, dietary, and housekeeping services generally supervise the scheduling and other daily activities of these personnel. A large percentage of nursing home personnel—kitchen, laundry, maintenance, and housekeeping-workers—are unskilled and earn small salaries.

.08 Nursing supplies, medical supplies, oxygen, foodstuffs, linens, housekeeping and maintenance supplies, activity supplies, and similar items also represent expenses for a nursing home.

However, some items, such as nonprescription and prescription drugs, can also be a source of revenue when charged directly to patients.

.09 Material and supply controls are important in controlling nursing home costs. It is common for nursing homes to group similar supplies together for purposes of maintenance and inventory control. For example, foodstuffs would be controlled by dietary supervisors, nursing and medical supplies by the nursing supervisor, and other supplies by a central stores function.

.10 The expense performance measures most commonly used by nursing homes are expenses per patient day. These are determined by dividing the total and the departmental costs by the number of occupied beds (patient days). The costs per patient day by department provide the nursing home with data that can be used to compare the same periods of different years.

.11 The following expense performance measures are also useful:

- *Dietary food costs per meal*, which is the cost of food divided by the total number of meals. Nursing homes that often serve meals to visitors and employees must include these meals to obtain accurate costs.

- *Total dietary costs per meal*, which is the total dietary costs divided by the total meals served.

- *Laundry costs per pound*, which is the total laundry costs divided by the pounds of laundry (linens weighed prior to cleaning). Most nursing homes weigh their laundry because soiled pounds of laundry can be used to allocate laundry costs on the Medicare cost report. This expense measure could be important in evaluating the costs and benefits of using outside laundry services, which generally charge commercial customers on a per-pound basis.

- *Utility cost per square foot*, which is the total utility cost divided by internal facility square footage.

- *Salary cost per hour*, either in total or by department, is calculated by dividing total salary costs by the total hours worked. Salary costs can also be measured on a per-patient-day basis. The high salary costs in a nursing home and the need to utilize lower paid personnel give importance to salary-related performance measures.

- *Inventory to cost of use*, which is calculated by dividing the inventory by the cost of use. For example, a nursing home with a dietary inventory of $12,000 and annual dietary food costs of $64,750 would have a ratio of .19. Multiplying .19 by 365 days indicates that 69.35 days of food supplies are carried in inventory. Similar evaluations could be made for other consumed supplies.

Operations

.12 Operating criteria are important to the nursing home. These criteria relate to the quality of the food, cleanliness of the facility, and documentation of resident needs. Nursing homes participating in Medicare or Medicaid programs are subject to official inspections of their compliance with federal and state standards. These standards and inspections continually reinforce the need for operational criteria.

84/130 TYPICAL CONSULTING ENGAGEMENT OPPORTUNITIES

.01 Practitioners can provide a variety of services to nursing home clients, whether the facilities are new or established. Consulting services in the nursing home industry require analysis of financial and service indicators, and attention to detail. The practitioner can aid clients in collecting and analyzing the data needed to understand cost control, financial control, third-party reimbursements, and business in general. Engagements that are particular to nursing homes and other health care providers include—

- Establishing a resident personal fund accounting and reporting system.
- Providing third-party reimbursement evaluations.
- Preparing third-party cost reports.

Establishing a Resident Personal Fund Accounting and Reporting System

.02 The Nursing Home Reform provisions under Subtitle C of the Omnibus Budget Reconciliation Act of 1987 (OBRA) require that facilities participating in Medicare and Medicaid programs manage and account for each resident's personal funds if authorized to do so by the resident (or the resident's legal representative). Substantial opportunity exists for practitioners to assist nursing home clients in meeting this requirement. In as much as the patient is to have access to personal funds at all times, the practitioner could assist the nursing home to comply with the regulations yet maintain acceptable internal controls.

.03 The regulations prescribe that, upon receiving a resident's written authorization, the facility must hold, safeguard, manage, and account for the resident's personal funds under a system that meets the following requirements:

- Each resident's funds must be fully and separately accounted for in accordance with generally accepted accounting principles (GAAP).
- A resident's funds may not be commingled with the funds of the facility or a nonresident.
- Upon request, each resident (or the resident's legal representative) must be provided with an individual financial record of all transactions involving the resident's funds.

- A resident's funds in excess of $50 must be deposited in an interest-bearing account that credits all interest accrued to the resident.

- A resident's funds of $50 or less must be deposited in a petty cash fund or a non-interest-bearing account. The regulations do not prohibit placement of these funds in an interest-bearing account. The regulations are intended to allow nursing homes some flexibility in managing funds under $50 and to ensure residents' access to their funds.

- Each resident's funds, together with a financial accounting, must be promptly conveyed upon the resident's death to the individual administering the resident's estate.

- Each resident who receives Medicaid benefits must be notified (1) when the resident's funds are $200 less than the supplemental security income (SSI) resource limits for one person specified in Section 1611 (a)(3)(B) of the Social Security Act (currently $2,000), and (2) that the resident may lose eligibility for Medicaid or SSI if the amount of the resident's funds, in addition to the value of the resident's nonexempt resources, reach the SSI resource limit for one person.

- The facility may not charge the resident's personal account for any item or service for which payment is made under Medicaid or Medicare.

.04 In addition to the preceding, each facility must ensure the security of the resident's funds by either purchasing a surety bond or by otherwise providing assurance satisfactory to the Secretary of the U.S. Department of Health and Human Services that the funds are secure.

.05 Nursing homes must also establish appropriate accounting policies and procedures to address the handling of residents' funds. These policies and procedures, and their functioning, are subject to review by the state certification unit that periodically determines whether the nursing home is complying with federal standards.

.06 The objective of designing and implementing a system for resident personal fund accounting and reporting is to establish procedures for—

- Obtaining and maintaining resident authorization for managing personal funds.

- Documenting deposits to individual resident accounts and for adequate filing of the documents.

- Withdrawing funds from resident accounts, including documenting the withdrawals and filing the documentation.

- Handling of resident funds, including interest allocations, bank account reconciliations, and transfers of funds between the bank accounts used for resident funds.

- Issuing periodic statements to residents or their legal guardians.

- Ensuring compliance with other resident notification requirements.

- Providing a final accounting of funds upon the death or discharge of a resident.

.07 The accounting for patients' personal funds can be performed with manual or computerized systems. The practitioner should review the client's existing computer system to determine whether it would be practical to add software specifically designed for patient trust fund accounting.

.08 A well-organized system of handling resident personal funds can be a very effective marketing tool for securing private-paying residents.

Providing Third-Party Reimbursement Evaluations

.09 Medicare Reimbursement. Nursing homes often look to outside accountants for assistance in addressing Medicare and Medicaid reimbursement-related issues. Although Medicare is a national program, nursing homes are reimbursed based on customary local charges for services rendered. Practitioners serving the industry are expected to be very familiar with these reimbursement principles. Information can be obtained from the sources listed in appendix 84/A.

.10 Medicaid Reimbursement. Medicaid reimbursements to nursing homes are generally computed by each state in one of three ways: prospective payments based on costs, retrospective payments based on costs, or other prospective rate setting. There are variations among these methodologies; however, such variations need to be addressed state by state.

.11 An evaluation of a facility's methods for calculating costs for third-party reimbursement can provide the following benefits to the client:

- Classifying costs to gain optimal reimbursement
- Recognizing costs in a more timely fashion to hasten reimbursement
- Reducing costs
- Reclassifying costs in areas in which the costs are inappropriately classified
- Assessing the impact of reimbursement on the client's plans for the future to assist in decision making

Preparing Third-Party Cost Reports

.12 The practitioner can assist the client in preparing cost reports for submission to third-party payers. An understanding of cost reporting requirements is necessary for meeting the client's needs. In addition, the practitioner can assist the client with analysis of the cost report submissions, which includes: comparing costs with the reimbursement amounts received or to be received, and identifying cost reimbursement alternatives that would improve reimbursement through better costing, redistribution of costs, or accounting procedures.

.13 Many nursing homes have contracts with third-party payers that allow renegotiation of certain terms of the contract. These are common with nursing homes serving veterans or residents covered by some third-party insurance carriers, but not Medicare and Medicaid. In these situations, the nursing home may engage the practitioner to recommend changes in the contract. Contract provisions that could be negotiated could concern the range of services rendered to the residents, the manner in which costs are reimbursed, or the contracted rate paid for services.

.14 To assist the practitioner in carrying out such engagements, checklists are provided in appendix 84/C.

Other Consulting Services

.15 In addition to the services highlighted in the preceding sections of this practice aid, a nursing home client may also request the following services:

- Formalization of property and equipment records to provide necessary tax, bookkeeping, and Medicare and Medicaid information
- Assistance with potential mergers or acquisitions, including valuation services
- Formalization of accounting policy and procedures
- Evaluation and modification of employee benefit programs
- Assistance with equipment lease-buy decisions
- Formalization of billing procedures, including credit and collection policies
- Evaluation of patient fee schedules
- Assessment of the financial feasibility of facility or program expansion
- Development of special reports required by debt instrument

APPENDIX 84/A

SELECTED SOURCES OF NURSING HOME INFORMATION

Many sources of information are available to help the practitioner provide services to nursing homes. They include the following:

National Associations

American Association of Homes for the Aging
901 E. Street, NW
Suite 500
Washington, DC 20004
(202) 783-2242

American College of Health
Care Administrators
325 S. Patrick Street
Alexandria, VA 22314
(703) 549-5822

American Health Care Association (AHCA)
1201 L Street, NW
Washington, DC 20005-4014
(202) 898-2857

Healthcare Financial Management
Association
Two Westbrook Corporate Center
Suite 700
Westchester, IL 60154
(800) 424-4301

State Associations of For-Profit Nursing Homes

Alabama Nursing Home Association
4156 Carmichael Road
Montgomergy, AL 36106
(205) 271-6214

Alaska State Hospital and
Nursing Home Association
319 Seward Street, Suite 11
Juneau, AK 99801
(907) 586-1790

Arizona Health Care Association
1817 N. Third Street, Suite 200
Phoenix, AZ 85004-1557
(602) 258-8996

Arkansas Health Care Association
Little Rock, AR 72201
(501) 374-4422

California Association of Health Facilities
1251 Beacon Boulevard
W. Sacramento, CA 95691-3461
(916) 371-4700

Colorado Health Care Association
1600 Sherman Street, Suite 1000
Denver, CO 80203
(303) 861-8228

Connecticut Association of Health Care
Facilities
131 New London Turnpike, Suite 18
Glastonbury, CT 06033
(203) 659-0391

Delaware Health Care Facilities
Association
1013 Centre Road, Suite 101
Wilmington, DE 19805
(302) 633-7864

District of Columbia Health
Care Association
1001 Connecticut Avenue, NW, Suite 900
Washington, DC 20036
(202) 835-1488

Florida Health Care Association
P.O. Box 1459
Tallahassee, FL 32302-1459
(904) 224-3907

Georgia Health Care Association
3735 Memorial Drive
P.O. Box 36349
Decatur, GA 30032
(404) 284-8700

LTC and Mental Health Services
Health Care Association of Hawaii
922 Ward Avenue, Suite 430
Honolulu, HI 96814
(808) 521-8961

Idaho Health Care Association
802 W. Bannock, Suite 304
Box 2623
Boise, ID 83701
(208) 343-9735

Illinois Health Care Association
1029 S. 4th Street
Springfield, IL 62703
(217) 528-6455

Indiana Health Care Association
One North Capitol, Suite 1115
Indianapolis, IN 46024
(317) 636-6406

Iowa Health Care Association
950 12th Street
Des Moines, IA 50309
(515) 282-0666

Kansas Health Care Association
221 Southwest 33rd Street
Topeka, KS 66611
(913) 267-6003

Kentucky Association of Health
Care Facilities
9403 Mill Brook Road
Louisville, KY 40223

Louisiana Health Care Association
7921 Picardy Avenue
Baton Rouge, LA 70809
(504) 769-3705

Maine Health Care Association
303 State Street
Augusta, ME 04330
(207) 623-1148

Health Care Facilities Association
of Maryland
229 Hanover Street
Annapolis, MD 21401
(301) 269-1390

Massachusetts Federation of Nursing
Homes, Inc.
990 Washington Street
Suite 207 South
Dedham, MA 02026
(617) 326-8967

Health Care Association
of Michigan
7413 Westshire Drive
Lansing, MI 48917
(517) 627-1561

Care Providers of Minnesota
Suite 200
2850 Metro Drive
Minneapolis, MN 55425
(612) 854-2844

Mississippi Health Care Association
114 Marketridge Drive
Lakeover 220 Business Park
Jackson, MS 39213
(601) 956-3472

Missouri Health Care Association
236 Metro Drive
Jefferson City, MO 65109
(314) 893-2060

Montana Health Care Association
36 S. Last Chance Gulch
Helena, MT 59601
(406) 443-2876

Nebraska Health Care Association
3100 "O" Street, Suite 7
Lincoln, NE 68510
(402) 435-3551

Nevada Health Care Association
P.O. Box 3226
Carson, NV 89702
(702) 885-1006

New Hampshire Health Care Association
125 Airport Road
Concord, NH 03301
(603) 225-4346

New Jersey Association of Health Care Facilities
2131 Route 33
Trenton, NJ 08690
(609) 890-8700

New Mexico Health Care Association
1021 Eubank NE, Suite D
Albuquerque, NM 87112
(505) 296-0021

New York State Health Facilities Association
111 Washington Avenue, Suite 700
Albany, NY 12210-2213
(518) 462-4800

North Carolina Health Care Facilities Association
5109 Bur Oak Circle
Raleigh, NC 27612
(919) 782-3827

North Dakota Long Term Care Association
120 W. Thayer Avenue
Bismarck, ND 58501
(701) 222-0660

Ohio Health Care Association
50 Northwoods Boulevard
Worthington, OH 43235
(614) 436-4154

Oklahoma Nursing Home Association
5801 N. Broadway, Suite 500
Oklahoma City, OK 73118
(405) 848-8338

Oregon Health Care Association
5895 72nd Avenue, Suite 250
Portland, OR 97224
(503) 225-0900

Pennsylvania Health Care Association
2400 Park Drive
Harrisburg, PA 17110
(717) 657-4902

Rhode Island Health Care Association
144 Bignall Street
Warwick, RI 02888
(401) 785-9530

South Carolina Health Care
Association
1706 Senate Street
Columbia, SC 29201
(803) 256-2681

Tennessee Health Care Association
P.O. Box 100129
Nashville, TN 37224
(615) 834-6520

Utah Health Care Association
4190 S. Highland Drive, Suite 113
Salt Lake City, UT 84123
(801) 262-9181

Virginia Health Care Association
2112 W. Laburnum Avenue, Suite 206
Richmond, VA 23227
(804) 353-9101

West Virginia Health Care
Association
#8 Capital Street, Suite 700
Charleston, WV 25301
(304) 346-4575

Wyoming Health Care Association
P.O. Box 2390
Cheyenne, WY 82003
(307) 635-2175

South Dakota Health Care
Association
804 North Western Avenue
Sioux Falls, SD 57104-2098
(605) 339-2071

Texas Health Care Association
P.O. Box 4554
Austin, TX 78765
(512) 458-1257

Vermont Health Care Association
2 Moonlight Terrace
Montpelier, VT 05602-9504
(802) 229-5700

Washington Health Care Association
2120 State Avenue, NE
Olympia, WA 98506
(206) 352-3304

Wisconsin Association
of Nursing Homes
14 S. Carroll Street, Suite 200
Madison, WI 53703
(608) 257-0125

State Associations of Not-for-Profit Nursing Homes

Alabama Association of Homes for the Aging
c/o Methodist Homes for Aging
1424 Montclair Road
Birmingham, AL 35210
(205) 951-2442

California Association of Homes
for the Aging
7311 Greenhaven Drive, Suite 175
Sacramento, CA 95831
(916) 392-5111

Arizona Association of Homes
for the Aging
340 East Palm Lane, Suite 310
Phoenix, AZ 85004
(602) 253-6171

Colorado Association of Homes
& Services for the Aging
Colorado State Bank Building
1600 Broadway, Suite 1680
Denver, CO 80202-4916
(303) 837-8834

Connecticut Association of Not-for-Profit Providers for the Aging
Westview Office Park, Bldg. 2
850 North Main Street Extension
Wallingford, CT 06492
(203) 269-7443

Delaware Association of Nonprofit Homes for the Aging
c/o Peninsula United Methodist Homes, Inc.
13 Centre Road, Suite 101
Wilmington, DE 19805
(302) 633-7864

Florida Association of Homes for the Aging
1018 Thomasville Road, Suite 200Y
Tallahassee, FL 32303
(904) 222-3562

Georgia Association of Homes and Services for the Aging
1687 Tullie Circle, NE, Suite 120
Atlanta, GA 30329-2316
(404) 728-0223

Illinois Association of Homes for the Aging
911 North Elm Street, Suite 228
Hinsdale, IL 60521
(708) 325-6170

Indiana Association of Homes for the Aging, Inc.
9011 North Meridian Street, Suite 208
Indianapolis, IN 46260
(317) 581-1115

Iowa Association of Homes for the Aging
Oakmoor II
4685 Merle Hay Road, Suite 101
Des Moines, IA 50322
(515) 270-1198

Kansas Association of Homes for the Aging
700 SW Harrison Street, Suite 1106
Topeka, KS 66603-3759
(913) 233-7443

Kentucky Association of Homes for the Aging
1244 South Fourth Street
Louisville, KY 40203
(502) 635-6468

Louisiana Association of Homes and Services for the Aging
10538 Kentshire Court, Suite 4
Baton Rouge, LA 70810
(504) 766-9955

Maryland Association of Nonprofit Homes for the Aging
10270 Old Columbia Road, Suite 125
Columbia, MD 21046
(410) 381-1176

Association of Massachusetts Homes for the Aging, Inc.
45 Bromfield Street
Boston, MA 02108
(617) 423-0718

Michigan Non-Profit Homes Association, Inc.
1423 Keystone, Suite 210
Lansing, MI 48911-4039
(517) 393-0500

Minnesota Association of Homes for the Aging
2221 University Avenue, SE, Suite 425
Minneapolis, MN 55414
(612) 331-5571

Missouri Association of Homes for the Aging
P.O. Box 190430
St. Louis, MO 63119-9998
(314) 353-9050

Montana Association of Homes for the Aging
c/o Horizon Lodge
701 South Wisconsin
Conrad, MT 59425
(406) 278-3233

Nebraska Assocation of Homes for the Aging
Suite 203, The Mayfair
625 South 14th Street
Lincoln, NE 68508
(402) 434-5681

New York Association of Homes
& Services for the Aging
194 Washington Avenue, 4th Floor
Albany, NY 12210
(518) 449-2707

Northern New England Association of Homes
& Services for the Aging
c/o Taylor Home
435 Union Avenue
Laconia, NH 03246
(603) 524-5600

Oregon Association of Homes for the Aging
7360 South West Hunziker Street
Suite 207
Tigard, OR 97223
(503) 684-3788

Rhode Island Association of Facilities
for the Aging
210 Cahir Street
Providence, RI 02903
(401) 453-0040

South Dakota Association of Homes for the Aging
c/o Management Service Partners
225 South Minnesota Avenue, LL
P.O. Box 639
Sioux Falls, SD 57101-0639
(605) 331-2927

Texas Association of Homes for the Aging
2205 Hancock Drive
Austin, TX 78756
(512) 467-2242

New Jersey Association of
Non-Profit Homes for the Aging
760 Alexander Road, CN-1
Princeton, NJ 08543
(609) 452-1161

North Carolina Association of
Nonprofit Homes for the Aging
The Presbyterian Home of High Point
201 Greensboro Road, Box 500
High Point, NC 27260-3434
(919) 883-9111

Association of Ohio Philanthropic
Homes & Housing for Aging
855 South Wall Street
Columbus, OH 43206-1921
(614) 444-2882

Pennsylvania Association of
Non-Profit Homes for the Aging
Executive Park West, Suite 409
4720 Old Gettyburg Road
Mechanicsburg, PA 17055-8419
(717) 763-5724

South Carolina Association of
Nonprofit Homes for the Aging
c/o Greenwood Methodist Home
1110 Marshall Road
P.O. Box 1203
Greenwood, SC 29646
(803) 227-7231

Tennessee Association of Homes
for the Aging
3500 Greenwood Drive
Hermitage, TN 37076
(615) 885-6883

Virginia Association of Non-Profit
Homes for the Aging
Innslake Place Building
4401 Dominion Blvd., Suite 200
Glen Allen, VA 23060
(804) 965-5500

Washington Association of Homes for the Aging
444 NE Ravena Boulevard, Suite 109
Seattle, WA 98115
(206) 526-8450

Wisconsin Association of Homes
& Services for the Aging
204 South Hamilton Street
Madison, WI 53703
(608) 255-7060

Quality Health Care Foundation of Wyoming
P.O. Box 3050
Cheyenne, WY 82003
(307) 637-7575

Additional Sources

AICPA CPE Seminars

Information about the following courses can be obtained from local state societies of CPAs or from the AICPA at 800-862-4272.

Preparing the Medicare Cost Report for Skilled Nursing Facilities
Level: Basic
Length: One day
Recommended CPE Credit: Eight hours

Understanding Medicare Reimbursement for Skilled Nursing Facilities
Level: Intermediate
Length: One day
Recommended CPE Credit: Eight hours

AICPA CPE Self-Study Courses
To order, call 800-862-4272

Introduction to Long-Term Care
Level: Basic
Format: Text
Recommended CPE Credit: Six hours

Principles of Medicare Reimbursement
Level: Basic
Format: Text
Recommended CPE Credit: Fifteen hours

AICPA Publications
To order, call 800-862-4272

The practitioner may find the following AICPA publications helpful in conducting engagements for nursing home clients:

Small Business Consulting Practice Aids

Identifying Client Problems: A Diagnostic Review Technique

Developing a Budget

Technical Consulting Practice Aids

Automating Small and Medium-Sized Businesses in Selected Industries

Preparing Financial Models

Mergers, Acquisitions, and Sales

Practice Administration Aids

Written Communication of Results in MAS Engagements

Communicating With Clients About MAS Engagement Understandings

APPENDIX 84/B

ILLUSTRATIVE NURSING HOME COST EVALUATION — PER-DAY BASIS: ABC HEALTH CARE LIMITED PARTNERSHIP

The development of meaningful internal financial information for nursing homes requires the use of patient-day cost information. This appendix presents an illustration of how patient-day information can be presented to facilitate management in monitoring costs incurred to provide resident services.

Exhibit 84B-1

ABC Health Care Limited Partnership
Detail Statement of Expenses
Six Months Ended June 30, 199X

	Total Expense	*Per Resident Day*
Nursing		
Registered Nurse salaries	$ 16,107	$ 1.50
Licensed practical nurses salaries	64,416	6.00
Aides salaries	88,582	8.25
Director of Nursing (DON) salaries	12,387	1.15
Assistant DON salaries	4,065	.38
Drugs	10,486	.98
Nursing supplies	6,014	.56
Medical supplies	2,304	.22
Disposable diapers	10,434	.97
Oxygen	23	-
Aides training, other	417	.04
	$ 215,235	$ 20.05
Dietary		
Salaries	$ 36, 878	$ 3.44
Supplies	3,493	.33
Food	43,911	4.09
Consultant fee	1,439	.12
	$ 85,721	$ 7.98
Laundry		
Salaries	$ 10,048	$ .94
Linen	926	.09
Supplies	2,223	.20
Purchased services	15	-
	$ 13,212	$ 1.23
Housekeeping		
Salaries	$ 19,042	$ 1.77
Supplies	6,691	.63
	$ 25,733	$ 2.40
Maintenance		
Salaries	$ 8,885	$ .83
Supplies	2,153	.20
Painting and gardening	680	.06
Purchased services	8,750	.82
Repairs and maintenance	2,904	.27
	$ 23,372	$ 2.18

ABC Health Care Limited Partnership
Detail Statement of Expenses
Six Months Ended June 30, 199X (Continued)

	Total Expense	*Per Resident Day*
Employee Benefits		
FICA	$ 24,861	$ 2.32
State unemployment	13,556	1.26
Federal unemployment	2,450	.23
Workers' compensation	12,230	1.14
Health insurance	15,558	1.45
Other benefits	405	.03
	$ 69,090	$ 6.43
Utilities		
Gas	$ 5,355	$ .50
Electricity	10,594	.99
Water	1,219	.11
Sewer	1,907	.18
Garbage	1,624	.15
Fire service	156	.02
Television cable	1,069	.09
	$ 21,924	$ 2.04
Taxes and Insurance		
Business franchise tax	$ 50	$
Real estate tax	6,434	.60
Personal property tax	10,474	.98
Business and occupation tax	5,014	.47
Property insurance	7,060	.65
	$ 29,032	$ 2.70
Interest		
Working capital	$ 7,542	$ .70
Building	113,326	10.56
	$ 120,868	$ 11.26
Depreciation and Amortization		
Depreciation	$ 45,082	$ 4.20
Amortization	12,975	1.22
	$ 58,057	$ 5.42

(continued)

ABC Health Care Limited Partnership
Detail Statement of Expenses
Six Months Ended June 30, 199X (Continued)

	Total Expense	*Per Resident Day*
Administration		
Salaries	$ 27,200	$ 2.53
Management fees	18,253	1.70
Advertising	2,632	.25
Telephone	3,610	.34
Dues and subscriptions	1,482	.14
Equipment rental	3,429	.32
Office supplies	2,501	.24
Printing	881	.08
Postage	412	.04
Bank charges	63	-
Licenses	160	.01
Accounting	35,183	3.28
Legal	6,237	.58
Other professional fees	942	.09
Mileage, travel, and meals	3,870	.36
Education and seminars	2,242	.21
Public relations	154	.01
Copier	528	.05
Administration cost, health insurance	266	.03
Contributions	60	-
	$110,105	$ 10.26
Medical Records		
Salaries	$ 8,972	$ .84
Consultant fee, medical director	5,400	.50
Consultant fee, medical records	1,436	.13
Utilization review fees	2,500	.23
Supplies	857	.08
Consultant fee, pharmacist	598	.06
	$ 19,763	$ 1.84
Activities		
Salaries	$ 14,595	$ 1.36
Supplies	1,235	.11
	$ 15,830	$ 1.47
Restorative		
Salaries	$ 13,813	$ 1.29
Consultant fee, physician services	600	.06
Consultant fee, physical therapy	10,410	.96
Supplies	3	
	$ 24,826	$ 2.31

Exhibit 84B-2

ABC Health Care Limited Partnership
Detail Statement of Operating Income and Expenses
Six Months Ended June 30, 199X

	Year To Date	*Per Resident Day*	*Medicaid Rate Per Day*
Resident Days	10,736		
Operating Income			
Resident services	$849,898	$79.16	
Less contractuals, bad debts, and refunds	89,092	8.30	
	760,806	70.86	
Other operating income	3,957	.37	
	764,763	71.23	
Operating Expenses			
Nursing	215,235	20.05	$19.77
Dietary	85,721	7.98	6.81
Laundry	13,212	1.23	1.42
Housekeeping	25,733	2.40	2.12
Maintenance	23,372	2.18	1.46
Administration	110,105	10.26	9.02
Medical records	19,763	1.84	1.57
Activities	15,830	1.47	1.71
Restorative	24,826	2.31	2.29
Employee benefits	69,090	6.43	5.00
Utilities	21,924	2.04	1.74
Taxes and insurance	29,032	2.70	1.07
Interest	120,868	11.26	-
Depreciation and amortization	58,057	5.42	9.68
	832,768	77.57	63.66
Excess of operating expenses over operating income	$(68,005)	$(6.34)	
Add-on (Efficiency and other)			5.02
Total Medicaid rate			$68.68

Exhibit 84B-3

ABC Health Care Limited Partnership
Detail Statement of Income
Six Months Ended June 30, 199X

	Year To Date Actual	*Year To Date Budget*	*Year To Date Variance*
Operating Income			
Resident services	$849,898	$744,660	$105,238
Less contractuals, bad debts, and refunds	89,092		(89,092)
	760,806	744,660	16,146
Other operating income	3,957	3,000	957
	764,763	747,660	17,103
Operating Expenses			
Nursing	215,235	212,190	(3,045)
Dietary	85,721	78,834	(6,887)
Laundry	13,212	13,728	516
Housekeeping	25,733	20,508	(5,225)
Maintenance	23,372	20,682	(2,690)
Administration	110,105	81,006	(29,099)
Medical records	19,763	13,122	(6,641)
Activities	15,830	16,002	172
Restorative	24,826	18,654	(6,172)
Employee benefits	69,090	68,892	(198)
Utilities	21,924	24,024	2,100
Taxes and insurance	29,032	17,286	(11,746)
Interest	120,868	122,100	1,232
Depreciation and amortization	58,057	56,718	(1,339)
	832,768	763,746	(69,022)
Net loss from operations	(68,005)	(16,086)	(51,919)
Other Income			
Interest and dividends	5,279		5,279
Computer reimbursement, State	11,995		11,995
Other	55		55
	17,329		17,329
Net Loss	$(50,676)	$(16,086)	$(34,590)

APPENDIX 84/C

ILLUSTRATIVE CHECKLISTS FOR COMPILATION OF COST REPORTS AND ENGAGEMENTS

Exhibit 84C-1

Checklist for Partner's Review of Compilation of Cost Reports

Client:_____ **Balance Sheet Date:**_____

	Done By	*Not Applicable*	*Date*
1. The Technical Review, if applicable, is attached, and I have reviewed it. I understand the questions raised and am satisfied with their disposition.	_____	_____	_____
2. The client file copy of the report is attached, and I have read it.	_____	_____	_____
3. The cost report appears to be appropriate in form and free from obvious material errors in application of reimbursement principles.	_____	_____	_____
4. Our report is appropriate for the circumstances.	_____	_____	_____

5. Notes for next period:

_____

_____

_____

6. In my absence, I authorize _____ to clear all open review notes and sign the report.

_____

_____

_____

7. Partner signing the report should complete the following:

   I am authorized to sign the accountant's report and have cleared all open review notes.

   Partner's name _____ Date signed _____

Exhibit 84C-2

Checklist for Technical Review of Compilation of Cost Reports

Client _____ **Balance Sheet Date** _____

Type of Service _____

Technical Reviewer _____ **Date** _____

	Done by	*Not Applicable*	*Date*
1. Review workpapers, working trial balance, and other file materials. Clear points with preparer.	_____	_____	_____
2. Review the accountant's report for appropriateness and consistency with firm guidelines.	_____	_____	_____
3. Determine that all supplemental schedules have been included and are appropriately referenced to the various worksheets of the report.	_____	_____	_____
4. Review the report for obvious, material errors.	_____	_____	_____
5. Review the various checklists or programs used in the engagement for potential problems.	_____	_____	_____
6. Determine that the Provider Cost Report Reimbursement Questionnaire HCFA 339 has been completed for submission with the report.	_____	_____	_____
7. Review the accountant's report on the HCFA 339 for appropriateness and consistency with firm guidelines.	_____	_____	_____
8. Review the HCFA 339 for appearance.	_____	_____	_____
9. Review the cost report for appearance.	_____	_____	_____
10. Discuss changes and clear all review notes with In-Charge Accountant and, if appropriate, the Engagement Partner.	_____	_____	_____

Exhibit 84C-3

Checklist for Engagement Partner's Review of the SNF Medicare Cost Report Work Program

Client _____

FYE _____

	Performed By	*Date*	*W/P Reference*
1. Obtain engagement letter and insert it into the file if the engagement is not already included in another engagement letter.	_____	_____	_____
2. Complete all applicable sections of the attached Work Program.	_____	_____	_____
3. Complete the Medicare Cost Report. Determine that the report is appropriate in form and free from obvious material errors.	_____	_____	_____
4. Ensure that the accountants' report for the cost report uses the appropriate prescribed forms.	_____	_____	_____
5. Date the cost-report compilation report using the date the compilation was completed.	_____	_____	_____
6. Complete the Provider Cost Report Reimbursement Questionnaire, HCFA 339. Determine that the report is appropriate in form and free from obvious material error.	_____	_____	_____
7. Ensure that the accountants' report for the HCFA 339 uses the appropriate prescribed forms.	_____	_____	_____
8. Date the HCFA 339 compilation report using the date the compilation was completed.	_____	_____	_____
9. Perform technical reviews on the report.	_____	_____	_____
10. Perform Partner-in-Charge reviews on the report.	_____	_____	_____

Exhibit 84C-4

Checklist for SNF Medicare Cost Report Work Program

Client _____

FYE _____

	Performed By	*Date*	*W/P Reference*
1. Ascertain the type of report to be filed—2540-86, 2540-S-87, or short-form 2540.	_____	_____	_____
2. Ascertain the type of certification of the skilled nursing facility (e.g., dually certified unit, distinct unit).	_____	_____	_____
a. If the facility is a totally dually certified unit, the following information should be obtained:			
(1) SNF/ICF patient days by financial class	_____	_____	_____
(2) SNF/ICF admissions and discharges by financial class	_____	_____	_____
(3) Number of full-time equivalents	_____	_____	_____
b. If the unit is a distinct unit, the following information should be obtained:			
(1) Obtain the following information for the ICF unit:			
(a) Patient days by financial class	_____	_____	_____
(b) Admissions and discharges by financial class	_____	_____	_____
(2) Obtain the following information for the SNF unit:			
(a) SNF patient days by financial class	_____	_____	_____
(b) SNF admissions and discharges by financial class	_____	_____	_____

	Performed By	*Date*	*W/P Reference*
(c) Patient days by financial class			
(d) Admissions and discharges by financial class			
(3) Number of FTEs applicable to SNF unit and total FTEs for the entire facility.			
3. Obtain a detailed analysis of insurance expense indicating the amount of expense by the following categories:			
a. Professional liability			
b. General liability			
c. Property and equipment premiums			
d. Professional liability premiums paid on behalf of provider-based physicians			
4. Obtain a detailed analysis of interest expense indicating the amount of expense by the following categories:			
a. Bond, note, and equipment			
b. Capital leases			
c. Working capital			
d. Other (identify)_____			
5. Obtain detailed analyses of interest income indicating the amount by the following sources:			
a. General cash			
b. Payroll, savings, and other unrestricted funds			
c. Bond-related deposits			
(1) Depreciation reserve			
(2) Debt reserve			
(3) Other			
d. Board designated funds			
e. Other (identify)_____			

	Performed By	Date	W/P Reference
6. Obtain mark-up percentage for medical supply charges.			
7. Obtain mark-up percentage for pharmacy charges.			
8. Determine if the Director of Nursing provides any direct patient care related services. If so, obtain a time study to allocate costs between supervisory and direct patient care activities.			
9. Ascertain whether physical therapy or respiratory therapy services are provided under a contract basis. If so, obtain the following information:			
a. Number of weeks in which the service was provided during the period			
b. The total number of hours provided during the period by the following job classifications:			
(1) Supervisor			
(2) Therapist			
(3) Aides			
c. The amount of equipment costs provided by the vendor under contract, if at all			
d. The salary equivalency			
e. The standard of expense rate			
10. Ascertain the amount of patient television costs, if any, being provided by the nursing home. If the costs cannot be determined, other operating revenues may be used for offset.			

	Performed By	*Date*	*W/P Reference*
11. Ascertain the amount of patient telephone costs, if any, being provided by the nursing home. If patient calls are handled by the switchboard, then a time study should be obtained to allocate costs between patient and nonpatient phones.			
12. Obtain the amounts of other operating revenues, if any, for the following areas:			
a. Cafeteria			
b. Laundry			
c. Sale of medical records			
d. Sale of drugs (nonpatients)			
e. Sale of medical supplies (nonpatients)			
f. Vending machines			
g. Rebates and refunds of expenses			
h. Miscellaneous, identify			
13. Obtain the following information pertaining to the Medical Director:			
a. Full name of physician			
b. Copy of contract			
c. Amount of compensation			
d. Number of hours compensated for the year			
14. Obtain the full names of all attending physicians performing their own billing for direct patient related services.			
15. Obtain the following information on attending physicians who are compensated by the nursing home for direct patient related services:			
a. Full names of all physicians			
b. Copy of contract			
c. Amount of compensation by physician including fringe benefits, malpractice insurance costs, CPE, etc. Separately identify the various components.			
d. Frequencies and CPT codes for various services provided during the year, if the physician is compensated on a fee-for-station by procedure.			

	Performed By	*Date*	*W/P Reference*
e. Copy of time allocation if physician provides administrative services in addition to patient-related services.	_____	_____	_____
16. Obtain copies of contracts with all major independent contractors.	_____	_____	_____
17. Obtain the amount of bad debts expense recorded for the period. Be sure these costs are not included in the cost report.	_____	_____	_____
18. Obtain the amount of Medicare bad debts, if any, incurred by the facility during the cost reporting period. (Also inquire if there have been any recoveries of Medicare bad debts.) Prepare a detailed schedule of bad debts by patient for submission with HCFA 339. **Note**: Medicare bad debts relate only to deductibles and coinsurance amounts.	_____	_____	_____
19. Determine the existence of any related-party costs. If a related party provides significant services to non-related entities, then costs do not have to be reduced to cost. Obtain financial statements of the related party to reduce amounts to the related entity's costs. **Note**: Interest expense with related party is a non-allowable cost.	_____	_____	_____
20. Obtain the following B-1 statistics:			
a. Square footage	_____	_____	_____
b. Pounds of laundry	_____	_____	_____
c. Housekeeping hours of service	_____	_____	_____
d. Dietary meals	_____	_____	_____
e. Direct nursing hours of service	_____	_____	_____
f. Central supply costed requisitions	_____	_____	_____
g. Pharmacy costed requisitions	_____	_____	_____
h. Medical records - time spent	_____	_____	_____
i. Social service - time spent	_____	_____	_____

Note: For the HCFA 2540-S-87, square footage is the only statistic to be accumulated.

GLOSSARY

Accreditation The process by which an agency or organization evaluates and recognizes a program as meeting certain standards. The standards are usually set for the physical plant, governing body, administration, medical and other staff, and scope and organization of services. Accreditation is usually given by a private organization, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), to assure the public of the quality of the accredited facility or service.

Active treatment A standard of care that has been used for mentally retarded individuals living in an ICF/MR. This care standard requires the development of an intensive, specialized plan of services for each resident to promote maximum function and independence. The services range from medical and nursing care to personal care and vocational training.

Administration on Aging (AOA) A subunit of the Department of Health and Human Services. The AOA was established by the Older Americans Act of 1965 to serve as the coordinator of social services programs for the elderly and as the primary focal point for Federal policies affecting the aged. Amendments to the Older Americans Act since 1965 have expanded the role of AOA to include supervising state units on aging and the network of area agencies on aging established at the local level. AOA manages the long-term care ombudsman programs authorized under the Older Americans Act, assists in coordinating the channeling programs for long-term care, provides grants for numerous community-based long-term care programs and directs research and training programs on gerontology.

Admission certification A form of review for Medicare and Medicaid patients in which the medical necessity of a patient's admission to a hospital is certified. Admission certification helps assure that only patients requiring a specific level of care are admitted to the hospital without unnecessary delay and with proper planning of the stay. The lengths of stay appropriate for the patient's admitting diagnosis is assigned and certified, and payment by any program requiring certification for the assigned stay is assured. Certification can be performed before (preadmission) or shortly after (concurrent) admission.

Adult day care A community-based program of health, social, and support services provided under the auspices of a health care facility or freestanding day care center for adults who do not require twenty-four hour care and, yet, because of social, physical, or mental impairments, are incapable of full-time independent living. Supervised day care programs are designed to provide the maximum support to an elderly person who, because of mobility or chronic conditions, would require admission to a health care facility.

Advisory Council on Social Security and Medicare A thirteen-member commission constituted every four years, mandated by statute to review the Social Security system (including Medicare and Medicaid) and to report to Congress and the Secretary of Health and Human Services on health issues.

Allowable charge The maximum fee a third-party payer can reimburse a provider for a service. An allowable charge may not be the same as *reasonable, customary*, or *prevailing charges* as the terms are used under the Medicare program.

Allowable costs Items or elements of a facility's costs that are reimbursable. Both Medicare and Medicaid reimburse health facilities for certain costs. Allowable costs usually exclude the cost of uncovered services and luxury accommodations, and costs not considered reasonable.

Ambulatory care Health services provided on an outpatient basis, in contrast to services provided in the home or an inpatient facility. Although many inpatients may be ambulatory, the term implies that the patient goes to a location to receive services and returns home the same day.

Ancillary services Inpatient health services other than room, board, and professional nursing and physician services. Such services may include x-ray, drug, laboratory, or therapeutic services.

Assisted living facility A setting in which personnel offer assistance with the activities of daily living, such as eating, bathing, dressing, grooming, and toileting. Assisted living is also known as personal care, residential care, or domiciliary care.

Bed hold The act of reserving a nursing care bed for a patient who is absent from the facility. Public payment policies for reserved beds are based on state Medicaid requirements. Most state plans specify requirements for allowable absences, such as short-stay hospitalization. Payment for bed hold days is not allowable under Medicare.

Benefit period The period of time for which benefits covered by an insurance policy are available. Benefits often are limited to a specific period.

Board and care homes Organized or informal facilities that provide room, board, and custodial care for a fee. The core programs of a board and care facility involve social support. Under the federal regulations implementing Section 1616(e) of the Social Security Act, facilities that provide basic nutritional services and protective oversight may be subject to state-imposed regulations governing safety, staffing, admissions, and civil rights. Licensure requirements differ greatly from state to state. Board and care homes are often restricted from providing medical assistance; however, the restrictions vary from state to state.

Case management The process by which an individual's care and treatment are coordinated to ensure safety and to avoid duplication of services.

Case-mix reimbursement A payment system under which reimbursement for nursing service costs, or ceilings on these costs, is set prospectively and is based on the amount of resources needed to serve the patient. The needier the patient, the higher the payment or payment ceiling.

Certificate of Need (CON) A state-operated program designed to contain health care costs by limiting the growth of health care services. Most programs provide for competitive review of applications seeking to provide services.

Charity care Health care services that were never expected to result in cash inflows. Charity care results from a provider's policy to provide health care services free of charge to individuals who meet certain financial criteria.

Claims review The process used by public agencies, insurers, or others responsible for payment to determine liability and amount of payment. This review includes determination of beneficiary eligibility, provider eligibility, and service coverage.

Coinsurance Cost-sharing wherein an insured individual pays a percentage of the cost of covered services.

Congregate housing Independent living facilities providing shelter, nutritional, and social support to residents. Participation of the resident in a congregate facility is usually by choice (thereby distinguishing congregate housing from a board and care environment in which an individual is often placed by a public agency). Many congregate housing programs assess the needs of the resident and provide interventions to ensure maximum independent functioning.

Continuum of care The entire spectrum of specialized health, rehabilitative, and residential services available to the frail, elderly, disabled, and chronically ill. The services focus on the social, residential, rehabilitative, and supportive needs of individuals as well as needs that are essentially medical in nature.

Contractual adjustments Differences between revenue at established rates and amounts realizable from third-party payers under contractual agreements.

Copayment See *Coinsurance* and *Cost sharing*.

Cost center An activity or a department in a health care facility to which costs are attributed for cost reporting purposes.

Cost finding The process of allocating the costs of nonrevenue-producing cost centers to revenue-producing cost centers on the basis of the amount of service rendered by each nonrevenue-producing center to the revenue-producing centers.

Cost reimbursement Reimbursement, usually for all reasonable costs of patient care incurred by providers, and paid by a third-party payer according to law, regulation, or contract.

Cost reports Prescribed forms for certifying the costs and charges of providers participating in reimbursement programs. These forms are required by government agencies and are used in auditing program fiscal performance.

Cost sharing Provisions of a health insurance policy that require the enrollee to pay some portion of costs for covered health care services. Cost sharing may be required through deductibles, coinsurance, or copayments. Cost sharing does not refer to the amounts paid in an insurance premium. The amount of the premium is directly related to the benefits provided and reflects the amount of cost-sharing required. Cost sharing is used to reduce insurance premiums and to control utilization by requiring a large copayment for services likely to be overused.

Cost shifting Cross subsidization of costs whereby the price of one service is increased to compensate for the short fall of revenues generated from another, or the charges to one group of payers are increased to compensate for the short fall caused by another payer's practice of paying less than actual costs.

Courtesy and policy discounts Differences between revenue recorded at established rates and amounts realizable for services provided to specific individuals such as employees, medical staff, and clergy.

Custodial care Board, room and other personal assistance services that do not include a health service component, usually provided on a long-term basis.

Daily inpatient census The number of inpatients present at the census-taking time each day. The inpatient census generally is taken each night. The census is adjusted for any inpatients admitted and discharged after the census-taking time the previous day.

Day care Organized delivery of social services and health care to individuals in a daytime program. Many programs are licensed and regulated by the state, but payment generally is unavailable through Medicaid.

Deductible The portion of hospital and medical charges that an insured person is responsible for paying before receiving policy benefits. It is designed as a mechanism to discourage over-utilization and to avoid processing small claims.

Deductions from revenue Reductions in gross revenue arising from contractual adjustments, courtesy and policy discounts, and other adjustments and deductions.

Demand billing The term used to refer to a claim submitted to the Medicare fiscal intermediary at the insistence of the nursing home resident after the nursing home has made a judgment that the resident is ineligible for Medicare benefits. It is important to distinguish this type of Medicare claim because the nursing home is held financially responsible for errors it makes in determining Medicare eligibility.

Disability Limitation of normal physical, mental, or social activity of an individual. There are varying types (functional, occupational, learning), degrees (partial, total), and durations (temporary, permanent) of disability. Benefits are often available only for specific disabilities, such as total and permanent (the requirement for Social Security and Medicare).

Discharge planning Patient care planning that concentrates on readiness for discharge or transfer to another level of care and the activities needed to arrange appropriate services following discharge.

Disclosure of ownership Statutorily required release of information by a health care provider of all ownership interests under Medicare and Medicaid. Complete information must be supplied on the identity of each person having, directly or indirectly, an ownership interest of five percent or more in the facility. In the case of a provider organized as a corporation, each officer and director must be identified, and in the case of a provider organized as a partnership, each partner. Any changes that affect the accuracy of the ownership information must be promptly reported.

Extended-care facility (ECF) Once used to mean a skilled nursing facility qualifying for participation in Medicare. In 1972, the law was amended to use the more generic term *skilled nursing facility* for Medicare and Medicaid. Currently, the term *extended care facility benefits* refers to the benefit limitations on skilled nursing facility care under Medicare.

Federal financial participation (FFP) The federal government's contributions to the Medicaid program. The percentage of Medicaid funds allotted to each state is based on a formula and varies by state.

Freedom of choice Provision allowing Medicare and Medicaid beneficiaries to obtain needed health services from any participating provider. State Medicaid programs may apply for a waiver to limit beneficiaries' freedom of choice.

Freestanding A term describing a provider that operates independently of other providers. For example, a freestanding nursing home operates independently of a hospital.

Full-time equivalent (FTE) An employee who is paid on the basis of 40 hours per week, 173 hours per month or 2,080 hours per year. No distinction is made between employees who actually work full-time and those who work only part time. For example, two employees who each work 1,040 hours per year equal one FTE.

Health Care Financing Administration (HCFA) Agency within the Department of Health and Human Services responsible for developing and implementing policies governing the Medicare and Medicaid programs.

Hill-Burton The popular title of the Medical Facility Construction and Modernization Program, enacted as part of the Public Health Services Act in 1946. Although the program has been amended several times, its purposes remain to develop programs for construction of public and nonprofit hospitals, skilled nursing facilities, and clinics and to modernize existing public and nonprofit health care facilities. The program authorizes assistance in the form of grants, loans, or loan guarantees.

Health Insurance Manual-15 (HIM-15) Medicare's provider reimbursement manual, which contains allowable cost definitions and policies.

Homemaker services Nonmedical support services (for example, food preparation, bathing) given to homebound individuals unable to perform these tasks themselves. Such services, if not covered under Medicare, may be covered by Medicaid under home and community-based waivers. These services also may be included in the Social Service Block Grant programs developed by the states. Homemaker services are intended to preserve independent living and normal family life for the aged, disabled, sick, or convalescent.

Hospital Insurance Program (Part A) The part of Medicare that automatically enrolls individuals age 65 and over who are entitled to Social Security or Railroad Retirement benefits, as well as individuals under 65 who have been eligible for Social Security disability for more than two years, and insured workers (and their dependents) who require kidney dialysis or transplantation. After various cost-sharing requirements are met, the program pays for covered services provided by hospitals, skilled nursing facilities, and home health agencies. The program is financed by a payroll tax levied on employers, employees, and the self-employed.

Inpatient Under most circumstances, a patient who is provided with room, board, and general nursing services and is expected to remain at least overnight and occupy a bed.

Intermediary A private insurer who enters into an agreement with the Secretary of Health and Human Services, under Medicare, to pay claims and perform other functions.

Intermediate-care facility (ICF) A facility that provides basic medical, nursing, and social services in addition to room and board for persons incapable of independent living. This category of nursing care provided in an ICF is less intensive than that provided by skilled nursing facilities. ICFs are recognized for participation in the Medicaid program only.

Level of care A term referring to the degree of care provided in different health care settings. An acute level of care (acute care) is provided in hospitals. Skilled nursing care is provided in skilled nursing facilities. Residential care is provided in facilities with social and personal care programs.

Life care community A facility that provides a wide range of long-term care services, usually including housing organized according to degree of personal care provided. Home care and health clinics are also included, generally at one set price.

Living will A legal statement specifying the preferences of an individual for medical treatment if mechanical support systems or "heroic efforts" are required to sustain life.

Long-term care Health or personal services required in an institution or at home, on a long-term basis by persons who are chronically ill, aged, physically or developmentally disabled. The term is often used more narrowly to refer to care provided in nursing homes.

Long-term care insurance Any insurance policy or rider designed to provide coverage for at least twelve consecutive months for one or more diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services provided in a setting other than an acute care unit of a hospital.

Mandatory services Minimal services that states must provide to eligible Medicaid recipients. These services include nursing facility care, inpatient and outpatient hospital care, x-ray and laboratory services, rural health clinic services, family planning, and nurse-midwife services.

Medicaid A federally aided, state operated and administered program providing medical benefits to certain low-income individuals under Title XIX of the Social Security Act. Subject to broad federal guidelines, states determine program benefits, eligibility requirements, rates of payment for providers, and methods of administering the program. Medicaid is estimated to provide services to 24.2 million people, with federal-state expenditures of approximately $55.2 billion in fiscal 1988.

Medical audit Detailed retrospective review and evaluation of selected medical records by qualified professional staff. Medical audits are used for evaluating professional performance by comparing it with accepted criteria, standards, and current professional judgment. A medical audit is usually concerned with the care of a given illness and is undertaken to identify deficiencies in that care in anticipation of educational programs to improve it.

Medical director In a nursing facility, a physician who is responsible for overall coordination of medical care in the facility and for ensuring the adequacy and appropriateness of the medical services provided to all patients.

Medically needy In the Medicaid program, individuals who have the income and resources to pay for basic living expenses (and do not need welfare), but cannot pay for medical care. Medicaid law requires that the standard for income used by a state to determine if someone is medically needy cannot exceed 133 percent of the maximum amount paid to a family of similar size under the welfare program Aid to Families with Dependent Children (AFDC).

Medicare The nationwide health insurance program for people age 65 and over, for people eligible for Social Security disability payments for more than two years, and for certain workers and their dependents who need a kidney transplant or dialysis. Health insurance protection is available to insured individuals without regard to income. Moneys from payroll taxes and premiums from beneficiaries are deposited in special trust funds for use in meeting the expenses incurred by the insured. The Medicare program was enacted in 1965, as Title XVIII of the Social Security Act, and became effective July 1, 1966. The program includes two separate but coordinated programs: hospital insurance (Part A) and supplementary medical insurance (Part B).

Nursing facilities Facilities other than hospitals that provide nursing care maintenance and personal care to individuals unable to care for themselves because of health problems. Nursing homes (now called nursing facilities) include skilled nursing facilities but not personal care homes or residential board and care homes.

Occupancy rate The ratio of actual beds occupied to the total number of beds operated (or licensed) during any given period of time.

Occupational therapy Treatment of physically or developmentally disabled individuals through activities designed by professionally qualified occupational therapists to restore, develop, and maintain an individual's ability to perform daily living tasks.

Older Americans Act The federal law, passed in 1965, to encourage the development of comprehensive planning of and to coordinate the provision of services for the elderly, including health, housing, employment, transportation, and social services. Direct services provided under the Act include in-home services, transportation, information, and referral. Eligibility for the direct services is extended to all persons age 60 and older, without regard to income. Under the direction of the Administration on Aging, a network of state and area agencies on aging is responsible for planning, coordinating, and funding services. Particular services available in given communities depend on funding available and locally determined service priorities.

Omnibus Budget Reconciliation Act of 1987 (OBRA) More commonly known as the Nursing Home Reform Act, since it contains provisions for increased nurse staffing levels in nursing facilities, nurse assistant training, standardized resident assessments, and preadmission screening of mentally ill and mentally retarded patients. Many of the provisions resulted from recommendations contained in an Institute of Medicine Study on nursing home regulation.

Patient days The number of patients who are resident at the time of census-taking each day.

Patient mix The numbers and types of patients served by a nursing home or other health facility. Patients may be classified according to diagnosis, severity of illness, resource needs, or socioeconomic characteristics. Knowledge of a program's patient mix is important for planning and comparison and is commonly used in establishing the facility's reimbursement for services provided.

Per diem cost The inpatient institutional cost for one day of care. Per diem costs represent averages and do not reflect the true cost of care for an individual patient.

Personal care Services to assist individuals with activities of daily living, including bathing, toileting, grooming, and eating.

Personal care facility An entity providing personal care services and limited health care services to individuals who need the structure and comfort of group living.

Physical therapy Therapy that addresses problems of mobility, ambulation, and function. Physical therapists evaluate the functional ability of patients and provide treatment under the supervision of a licensed physician to relieve pain, strengthen muscles, improve coordination, and restore mobility.

Physician certification Under Medicaid, a requirement that each patient living in a long-term care facility has a physician's written statement, upon admission and at least every sixty days thereafter, that verifies the patient's need for the services being delivered.

Preadmission screening and annual resident review (PASARR) A process, mandated by the Omnibus Budget Reconciliation Act of 1987, to determine whether individuals suspected of or identified as being mentally ill or developmentally disabled need nursing facility care or active treatment.

Prior authorization Under some systems of utilization review, a requirement imposed by a third-party payer that a provider justify service provided to a patient in order to receive reimbursement. Generally, prior authorization is required for nonemergency services that are expensive (involving a hospital stay, for example) or likely to be overused or abused (many state Medicaid programs require prior authorization of all dental services, for instance). The justification must be demonstrated to a peer review committee or insurance representative before the service is provided to the patient.

Provider A term used in public health programs to refer to a supplier of health services (for example, nursing facility, hospital, or physician).

Reasonable charge For any specific service covered under Medicare, the lower of either the customary charge by a particular physician for the service and the prevailing charge by physicians in the area for that service. The amount of reimbursement is based on the lower of the reasonable and actual charges.

Reasonable cost Generally the amount which a third-party payer, using cost-based reimbursement, will actually reimburse. Reasonable costs are often less than a facility's actual cost to deliver care.

Residential care Broadly defined as the provision of twenty-four-hour supervision of individuals who, because of old age or impairments, need assistance with the activities of daily living. Residental care falls between the nursing care delivered in nursing facilities and the assistance provided through social services. Residential care facilities do not directly receive federal funding for the services they provide.

Resident's rights Specific rights guaranteed to all residents of nursing facilities. They include the right to voice concern about a facility, the right to receive visitors, the right to form resident councils, and the right to informed consent, privacy, and freedom of choice.

Respiratory therapy Diagnostic evaluation, management, and treatment of patients with deficiencies in the cardiopulmonary system.

Retrospective reimbursement Payment to providers by a third-party payer for costs or charges actually incurred by subscribers in a previous time period.

Routine services Regular room, dietary services, nursing services, minor medical and surgical supplies, and the use of equipment and facilities for which separate charges are not customarily made. Charges for routine services are normally made in the aggregate.

Section 504 Part of the Rehabilitation Act of 1973, Section 504 provides that "no otherwise qualified handicapped individual in the United States . . . shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefit, or be subjected to discrimination under any program or activity receiving federal financial assistance."

Skilled nursing care Nursing services provided to a patient who requires care that must be provided under the supervision of a registered nurse. Medicare guidelines often define skilled nursing care; however, in certain states Medicaid criteria for patients meeting skilled nursing care guidelines may differ.

Skilled nursing facility (SNF) Under Medicare, an institution (or a distinct part of an institution) that provides skilled nursing care and related services for patients who require medical, nursing, or rehabilitation services. In an SNF, the health care of every patient is under the supervision of a physician who is available to furnish medical care in case of an emergency. In addition, SNFs provide twenty-four hour nursing service and have at least one registered professional nurse employed full time (the HHS Secretary may waive this requirement under certain conditions). SNFs dispense and administer drugs and biologicals and are licensed or approved by a state or local agency responsible for licensing institutions of this nature.

Stepdown A method of cost finding that starts with the nonrevenue-producing center serving the greatest number of other centers allocating its costs proportionately among those centers it serves. This process continues with the next nonrevenue-producing center serving the next greatest number of other centers, allocating its costs, (never allocating any costs to a previously allocated center), and so forth until all costs are associated with revenue-producing services.

Supplemental Security Income (SSI) A program of support for low-income aged, blind, and disabled persons. Established by Title XVI of the Social Security Act, SSI replaced state welfare programs for the aged, blind and disabled in 1972, with a federally administered program, paying a monthly basic benefit nationwide. Approximately 4 million people currently receive benefits under the program. Receipt of a federal SSI benefit or a state supplement under the program is often used to establish Medicaid eligibility.

Supplementary Medical Insurance Program (Part B, SMI) The voluntary portion of Medicare in which those entitled to the hospital insurance program (Part A) may enroll. The program is financed from monthly premiums paid by people insured under the program and a matching amount from general federal revenues. About 95 percent of eligible people are enrolled. Covered services include physician services, home health care, medical and other health services, outpatient hospital services, and laboratory, pathology and radiology services. State Medicaid agencies may buy Part B coverage for elderly and disabled public assistance recipients and pay the premiums on their behalf.

Third-party payer A public or private organization that pays or insures health expenses on behalf of beneficiaries. Private individuals pay a premium for coverage in all private and some public programs. The insurer then pays bills on their behalf. Such payments are called third-party payments and are distinguished by the separation between the individuals receiving the service (the first party), the individuals or institutions providing the service (the second party), and the organizations paying for the service (the third party).

Title XVIII The title of the Social Security Act which contains the legislative authority for Medicare and, therefore, a common name for the program.

Title XIX The title of the Social Security Act that contains legislative authority for Medicaid and, therefore, is a common name for the program.

Transfer of assets Dispossessing oneself of assets by transferring them to another party at less than fair market value in order to obtain eligibility for programs such as Medicaid and Supplemental Security Income (SSI).

Utilization and Quality Peer Review Organization The Tax Equity and Fiscal Responsibility Act of 1982 required peer review organizations (PROs) in each state to monitor health care facility activity under the prospective payment system. Each facility must contract with a PRO, which will review the appropriateness of admissions and the adequacy of care provided.

Voluntary contributions A technique used by some states to enhance their Medicaid budgets by maximizing federal dollars. Providers make voluntary contributions or donations to the state, which are added to the state funds that are matched by the federal government. These combined state and federal funds are then redistributed through payments to providers by means of an established formula. Depending on the rate of the federal match a state receives, each dollar donated may generate up to two or more dollars in federal matching funds.

Waiver of liability Under Medicare, payment may be made for services if both the provider and the beneficiary did not know, and could not have been expected to know, that services would not be covered. Because Medicare coverage determinations are made retroactively, the waiver was created to protect providers acting in good faith against inconsistent denial decisions. Under the waiver, payment is made if a provider's Medicare claims denials do not exceed five percent.

READER'S RESPONSES TO *NURSING HOMES*

Your assessment of this practice aid will help to ensure that future publications of the Management Consulting Services Division will be valuable to practitioners. Please photocopy this questionnaire and complete and mail or fax it to **Editor/Coordinator, Management Consulting Services Division, AICPA, Harborside Financial Center, 201 Plaza Three, Jersey City, NJ 07311-3881**, facsimile number (201) 938-3329.

Thank you for your assistance.

1. How familiar were you with this subject before you read this practice aid?

0	1	2	3	4	5
Unfamiliar		Somewhat familiar		My area of expertise	

2. How useful is the practice aid to your practice?

0	1	2	3	4	5
Not useful at all				Extremely useful	

3. Is there additional information that you think should have been included or information that should be modified in this practice aid? Yes ____ No ____

If yes, please explain _____

_____

_____

4. Do you think that an advanced level practice aid on this subject should be available?
Yes ____ No ____

5. What other subjects would you like to see covered in Consulting Services Practice Aids?

_____

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Additional comments and suggestions _____

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