Nursing Facility Bed Supply and Need

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Prepared for

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September 2000

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EXECUTIVE SUMMARY

West Virginia Code 16-2D-5(g) directed the West Virginia Health Care Authority to study the need for nursing facility beds in the state. This study was commissioned to provide relevant information and analysis.

Current Policies

West Virginia's Health Plan establishes a target ceiling of 30 beds (33 counting State facilities) per 1000 persons aged 65 and older. That ceiling, while comparatively low at the time it was set, is now consistent with goals in other states that are—like West Virginia—using a variety of policy mechanisms to control bed supply. The State's bed supply policies are substantially driven by long-standing goals to promote access to home and community-based alternatives. Researchers have found that bed supply may tend to create its own demand, especially in the absence of a strong pre-admission screening program and an array of appropriate, feasible, alternatives.

Many states have found Certificate of Need (CON) a cumbersome and "leaky" process. In 1987, West Virginia established a moratorium on nursing home bed growth; 19 other states have a similar moratorium; 25 others have CON alone. The Legislature created exceptions to the moratorium for hospital-based facilities in 1990 (low-occupancy rural hospitals) and 1992 (other hospitals meeting various criteria). These beds may not be certified for use by Medicaid patients. Thus, Medicaid costs are not directly affected, but free-standing facilities raise issues regarding the equity of the policy, which affects competition for Medicare and private-paying patients.

Bed Supply and Occupancy Rates

West Virginia's current bed supply (42 beds per 1000 elderly) is lower than the national average (53 beds) and lower than roughly two-thirds of states with similar characteristics; but the supply is notably higher than the health planning ceiling. Consistent with national trends, occupancy rates have been dropping in the state. Declining use of nursing facilities nationally is attributed to the growth of assisted living, state policies promoting alternatives for low-income persons,

and increasing health and wealth of the elderly. Occupancy rates in West Virginia's hospital-based units are substantially lower than those in free-standing facilities.

Access to Appropriate Care

Knowledgeable West Virginians interviewed for this report agreed that access to nursing home beds in general is not a problem, although certain types of patients (e.g., those who are ventilator-dependent) have difficulty finding care close to home or in the facility most preferred.

While occupancy is declining generally, some facilities are full. This study found no statistically meaningful relationship between occupancy and three available—though quite imperfect—measures of nursing home "quality."

Several people interviewed for this study noted that it is difficult to determine the number of people who might more appropriately be served with home and community-based care, rather than in nursing facilities. While the State does require certain forms indicating that a person entering a nursing home is suitably placed, little appears known about the degree to which those entering a nursing home fully understand their options.

Conclusions

West Virginia appears to have at least an adequate supply of nursing home beds. Absent a strong mechanism like the moratorium, multiple factors—many beyond the State's control, such as Medicare payments and the U.S. tax code—could invite substantial new investment at a very high cost to the State Medicaid budget.

The relatively low occupancy of hospital-based units and the overall adequacy of nursing facility bed supply suggest little need for exceptions to the moratorium. Policy-makers created the exceptions in large part because of concerns about the financial health of hospitals and rural communities. Those concerns raise issues beyond the scope of this review.

West Virginia could improve its ability to gauge current and future need by more focused attention to interventions (e.g., assuring that alternatives are carefully explored) at the point of nursing home entry.

NURSING FACILITY BED SUPPLY AND NEED

STUDY PURPOSE

West Virginia Code §16-2D-5(g) (SB 492) directed the West Virginia Health Care Authority to establish a Task Force (or use an existing one) to study "the need for additional nursing facility beds" in West Virginia. The Legislature specified that the study include "a review of the current moratorium on the development of nursing facility beds, the exemption for the conversion of acute beds to skilled nursing facility beds, the development of a methodology to assess the need for additional nursing facility beds and certification of new beds by Medicare and Medicaid." [1] This report was commissioned by the West Virginia Health Care Authority to provide information and analysis relevant to the mandated study.

NATIONAL TRENDS

The nation's supply of nursing facility beds—relative to the aged population—grew rapidly following passage of Medicare and Medicaid payment provisions in the mid-1960's but began to decelerate a decade later.[2] Over the last two decades supply has declined slightly: in 1978, there were 53.4 beds per 1000 aged (65+), compared to 52.5 in 1998.[3] Even with constrained growth in supply, occupancy rates have declined nationally over the last decade, as shown in Exhibit 1.

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[1] WV Code 16-2D-5(g).
[2] R. Vogel and H. Palmer, *Long-Term Care: Some Perspectives from Research and Demonstrations.* Health Care Financing Administration, 1981.
[3] C. Harrington, et al., *1998 State Data Book on Long Term Care: Program and Market Characteristics,* prepared for the US Department of Health and Human Services (HCFA) and the US Department of Housing and Urban Development, January 2000. Note that this researcher calculated bed supply for 1978 differently from the way the 1976 bed supply was calculated by researcher's reference in Exhibit 2.

Exhibit 1: National Nursing Facility Occupancy: One Day Census; Selected Years; 1973-1998			
Year	**National Average (Total Residents/Total Beds)**	**Occupancy Rate of the Median And Mean Facility**	
		Median	**Mean**
1973/74	91.4%	…	…
1977	92.9%	…	…
1985	91.8%	…	…
1993	….	93%	…
1994	….	93%	…
1995	87.5%	92%	…
1996	…	91%	…
1997	…	91%	…
1998	81.0%	90%	84%

Sources: Data on national averages (2nd column) except for 1998 are from the National Nursing Homes Survey for applicable years. All other data are from the OSCAR data file as reported in the American Health Care Association, *Facts and Trends: The Nursing Facility Data Book, 1999*. Other sources report slightly different numbers due to such things as different approaches to handling duplicates and computing annual totals.

Changes in nursing home bed supply and use are driven by several factors, discussed below.

Health Planning Goals and Policies

The National Health Planning and Resources Development Act of 1974 (PL 93-641) spurred the development of state efforts to assess the need for various health care services. By 1979 almost all states had developed Certificate of Need (CON) programs to implement state health plans.[4] The Law required federal approval of state plans. Thus, despite competing academic theories regarding how to assess bed need, most states initially pegged targets to national averages, as suggested in federal guidelines. Not surprisingly, a federal

[4] J. Feder and W. Scanlon, "Regulating the Bed Supply in Nursing Homes," *Milbank Memorial Fund Quarterly,* 58 (1), Pp 54-87, 1980.

study of state health plans completed in 1981 found that those states with the greatest bed supply planned to restrain growth, while states with the smallest supply officially considered their states under-bedded (Exhibit 2, on the following page). In 1976, West Virginia had the nation's second lowest bed supply (25 beds per 1000 elderly), and plans to increase supply to 33 beds per 1000 elderly.

Federal CON requirements and support for health planning ended in 1986, with researchers still debating the law's effect.[5] Despite the change in federal law, most states have retained and strengthened controls on bed supply to restrain Medicaid spending and/or to promote the development of alternatives. Some states found CON a cumbersome and "leaky" policy instrument. In the 1980s some states—including West Virginia in 1987—began to implement moratoria on nursing home licensure and/or certification. By 1998, 44 states (including the District of Columbia) regulated the growth of nursing home bed supply by one or more policy instruments, as shown in Exhibit 3. Planning goals now are less consistently pegged simply to national averages (Exhibit 2).

Exhibit 3: Number of States With Various Approaches to Regulating Nursing Facility Bed Supply

	1982	**1998**
CON Only	44	25
CON & Moratorium	6	13
Moratorium Only	0	6

Source: data from C. Harrington, et al., *1998 State Data Book on Long Term Care Program and Market Characteristics,* January 2000.

[5] J. Swan and C. Harrington, "Certificate of Need and Nursing Home Bed Capacity in States," *Journal of Health and Social Policy*, 2(2), Pp 87-105, 1991;

Exhibit 2
Changes in Nursing Facility Bed Supply:
West Virginia and Comparison States
1976-1998

	(1) 1976		(2) 1998	
	Beds per Aged 65+	**Planning Officials' Opinion of Supply**[6]	**Beds per Aged 65+**	**Planning Officials' Opinion of Supply**[7]
National Average	64		53	
High Supply in 1976				
• **Alaska**	87	…….[8]	21	adequate
• **Colorado**	88	over	52	over
• **Iowa**	92	……	82	adequate
• **Minnesota**	96	over	75	…….
• **Nebraska**	119	over	83	over
• **N. Dakota**	92	over	76	……
• **S. Dakota**	98	over	77	……
• **Vermont**	97	……	53	…….
• **Wisconsin**	101	over	70	adequate
Low Supply in 1976				
• **Arizona**	25	under	30	over
• **District of C.**	42	…….	42	adequate
• **Florida**	24	…….	30	adequate
• **Mississippi**	35	under	52	under
• **Nevada**	35	…….	22	adequate
• **New Mexico**	36	…….	36	adequate
• **South Carolina**	37	under	27	under
• **West Virginia**	25	under	42	…….

Sources: (1) B. Manard, et al. *Working Papers on Long-Term Care, Prepared for the 1980 Under Secretary's Task Force on Long-Term Care*, US Department of Health and Human Services, October 1981. (2) C. Harrington, et al. *1998 State Data Book on Long Term Care Program and Market Characteristics,* prepared for US Department of Health and Human Services and US Department of Housing and Urban Development, January 2000.

[6] From analysis of state health plans.
[7] Opinion of state health planners reported in 1998 survey.
[8] "……" indicates data not available

Public Payments

Nationally, Medicaid pays for approximately 68 percent of nursing home care; this expenditure frequently comprises the single largest item in states' budgets. Many states regulate nursing facility supply in an effort to control Medicaid expenditures. "Roemer's Law," named for the researcher who observed in 1961 that hospital bed use was directly related to hospital bed supply,[9] holds that bed supply creates its own demand. Investigators continue to find a strong correlation between nursing home bed supply and use rates.[10]

The same effect (i.e., controlling Medicaid nursing home spending) can be achieved in other ways: for example, by a combination of a strong pre-admission screening program and a nursing home payment system that does not recognize higher costs per day resulting from lower occupancy. That approach, however, is thought by many states to be more difficult politically than CON and/or moratoria (which are generally supported by the nursing home industry, while lower rates are not). Further, many state policy-makers are concerned that increased growth of nursing home beds, low occupancy, and Medicaid rate systems that strictly control the extent to which the state will pay for unoccupied beds will result in poor quality care. Finally, researchers studying nursing home bed supply changes in states over a 13-year period (1979-1993) recently concluded that "States that had a certificate of need and/or moratorium did have significant

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[9] M. Roemer, "Bed Supply and Hospital Utilization: a Natural Experiment," *Hospitals,* 35, Pp 36-42, 1961.
[10] J. Wiener, et al., "Controlling the Supply of Long-Term Care Providers in Thirteen States," *Journal of Aging and Social Policy,* 10 (4), Pp 51-72, 1999.

reductions in bed growth but Medicaid nursing home reimbursement rates were not related to change in bed stock."[11]

Although the *level* of Medicaid payments *per se* (i.e., the per diem rate) is not demonstrably related to bed supply nationally, the *structure* of public payment systems is strongly related to nursing home investments and hence both to bed supply and the distribution among different types of owners. First, the potential "profitability" of nursing homes, defined as revenues minus expenses, is a function of the degree to which the payment system ties rates to reported expenditures. Payment systems that do not tie facility-specific rates to facility-specific expenditures are called "flat rate" or "pricing systems." The new Medicare SNF payment system is an example; 5 states also use nearly pure pricing systems for Medicaid rates. The remainder of the states—including West Virginia, discussed in a following section—pay rates based in varying degrees on facility-specific nursing home expenditures.

Secondly, and more importantly to investors' decisions, is the after-tax cash flow, relative to equity, that nursing homes can generate.[12] Using generally accepted accounting practices, depreciation is an expense. But since depreciation is not a *cash* expenditure, nursing homes can have a positive cash flow, despite negative financial ratios based on accounting costs. Further, depreciation is a deductible expense for income tax purposes. Thus, the economic value of a nursing home is driven by public payments (which account

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[11] C. Harrington, et al., "The Effect of Certificate of Need and Moratoria Policy on Change in Nursing Home Beds in the United States," *Medical Care,* 35 (6), Pp 574-88, 1997.
[12] D. Shulman and R. Galanter, "Reorganizing the Nursing Home Industry: A Proposal," *Health and Society,* Pp 129-143, Spring 1976.

for most of the income stream) and federal tax policies. Tax deductions are worth most to those in the highest brackets (and nothing to not-for-profit entities). Therefore, as one set of analysts noted, "[If] Medicaid rates of payment for nursing home care are such that low-tax bracket or nonprofit owners can serve public patients without loss, then nursing homes are all the more attractive to higher bracket investors."[13]

Alternatives to Nursing Facility Care

In 1980, the Task Force on Long-Term Care convened by the Secretary of the U.S. Department of Health and Human Services concluded that "The Congress, government officials at all levels, consumers, and providers generally agree that the present [long-term care] programs often fail to promote…the provision of services in the least restrictive environment, preferably at home or in other community settings." Consumers' continued preferences for less restrictive settings are clearly reflected in today's growth of assisted living for those who can afford it. In 1980, it was generally thought that substantial savings could be achieved by substituting home and community-based care for nursing homes. Subsequent research has raised questions about this conclusion,[14] but programs that carefully target interventions to those truly at risk are most likely to reduce unnecessary public expenditures.[15]

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[13] C. Baldwin and C. Bishop, "Return to Nursing Home Investment: Issues for Public Policy," *Health Care Financing Review,* 3 (4), Pp 43-52.

[14] Among other things, it is better recognized now that while a day in a nursing home is more costly than home care, those two are not comparable because a nursing home provides room, board and 24-hour service. Further, as those with the least need for care are diverted to non-nursing home settings, the case-mix (care needs) of nursing homes increases, driving nursing home costs higher.

[15] P. Kemper, "The Evaluation of the National Long Term Care Demonstration: Overview of the Findings," *Health Services Research,* 23 (1), Pp. 161-74, 1988.

As noted above, nursing home use has been declining over the last decade. Analysts generally attribute this to a combination of factors, including the development of assisted living and other alternatives, the expansion of state programs to provide more support for low income people in alternative settings, and increasing wealth and health of the elderly; but definitive studies explaining relatively recent trends are not available.[16]

Over the longer term, however, it is quite clear that the elderly's use of different types of residential settings has followed the availability of public funds. From 1880 to 1990—for over a century-- the proportion of the elderly counted by the Census as living in "Institutions and Group Quarters" has remained approximately 5 percent; but the distribution among different types of residential settings has followed the availability of public funds.[17] Almshouses, T.B sanitariums and mental institutions gave way to "homes for the aged," which in turn were largely supplanted by federally-certified and medically-oriented "nursing facilities," in sync with changes in public payments.

National Trends in Expenditures on Nursing Facilities

The declining use of nursing homes and lower overall inflation resulted in a substantial decline in the rate of growth of national public spending on nursing facilities during the 1990's (Exhibit 4). There is also some evidence that the repeal of the federal "Boren Amendment" in 1997 has created downward

[16] C. Bishop, *Where are the Missing Elders? The Decline in Nursing Home Utilization, 1985-1993.* Brandeis University Working Paper, 1998.
[17] B. Manard, et al., *Assisted Living for the Frail Elderly,* U.S. Department of Health and Human Services, 1993.

pressure on state Medicaid rates, although strong economies in most states have mitigated states' response to Boren's repeal.[18]

Exhibit 4: National Expenditures on Nursing Homes: 1990-1998					
Year	**Total ($B)**	**Public Funds**		**Percent Change over Previous Year**	
		$B	**% Change**	**Medicare**	**Medicaid**
1990	50.9	25.9	….	….	….
1991	57.2	30.6	18.1%	11.8 %	19.0%
1992	62.3	34.4	12.4%	52.6%	9.8%
1993	66.4	37.9	10.2%	34.5%	7.3%
1994	71.1	41.4	9.2%	41.0%	5.6%
1995	75.5	44.4	7.2%	25.5%	3.8%
1996	80.2	48.1	8.3%	21.7%	6.8%
1997	84.7	51.3	6.7%	14.3%	5.3%
1998	87.8	53.0	3.3%	8.3%	1.8%
Source: HCFA, Office of the Actuary, National Health Statistics Group; January 10, 2000.					

BED SUPPLY AND OCCUPANCY IN WEST VIRGINIA

While West Virginia had the second lowest ratio of nursing home beds to the elderly population in 1976 (Exhibit 2), the most recent national data available indicate that West Virginia's bed supply is now more closely similar to national averages (Exhibit 5, on the following page). Bed supply (and occupancy) data are sensitive to how they are measured. As shown in Exhibit 5, despite some differences in the measurement of supply, two national data sets indicate that West Virginia's bed supply is somewhat lower than national averages and lower than supply in most of the comparison states shown.

[18] B. Manard, "The Effect of the Repeal of the Boren Amendment on Medicaid Rates," Pp 2.9-2.16 in HCFA, *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes,* Summer 2000.

Occupancy rate comparisons are more sensitive than bed supply to the method of computation. When statewide occupancy is computed using a one-day census, West Virginia appears to have very low occupancy: 77 percent, compared to a similarly computed national average of 81 percent (Exhibit 6, on the following page). Calculating statewide occupancy using full-year data provides a better measure by mitigating the distortions of a one-day census (column 5, Exhibit 6). But there are many different ways to calculate a full-year occupancy rate as bed supply changes throughout the year. Many states, including West Virginia, keep nursing home supply and use rates for different types of facilities in different agencies. Thus, researchers responsible for the best source of national comparative data (based on standard, annual surveys) have experienced an increasingly low response rate regarding nursing facility occupancy; only 22 states provided occupancy data in 1998.[21] Those limited data—shown in the last column of Exhibit 6—indicate that statewide occupancy in West Virginia (91 percent) is roughly similar to comparative states.

Statewide occupancy rates may distort the true picture of access to nursing home beds if there is considerable variation among *facilities* with respect to occupancy. Based on a one-day census, "average" (mean) facility occupancy in West Virginia at 92 percent is *higher* than the national average (84 percent) and *higher* than most of the comparison states shown in Exhibit 6 (second column). Since outliers can unduly influence an "average," analysts also consider "median" (middle) facility occupancy rates. Median facility occupancy

[21] C. Harrington, et al., *1998 State Data Book on Long Term Care Program and Market Characteristics,* January 2000.

Exhibit 6: Nursing Facility Occupancy Rates, Various Measures; US, West Virginia, and Comparison States

	(1) 1997 Federal OSCAR Data (one-day census)			(2) 1998 Survey of State Officials (full-year data)
	Mean Facility Occupancy[22]	**Median Facility Occupancy**[23]	**State-Wide Occupancy**[24]	**Statewide Occupancy Rate**[25]
US	84%	90%	81%	…..
West VA	92%	97%	77%	91%
Contiguous States				
PA	88	92	90	….
MD	83	88	82	….
VA	91	95	90	91
KY	88	94	89	….
OH	83	89	68	….
High % Poverty				
MS	91	96	93	95
ARK	80	84	62	….
LA	79	83	80	81
Rural				
ND	93	95	94	….
MO	76	80	73	79
MS	91	96	93	95
VT	90	93	90	….
AL	93	95	92	….
High % Aged	89	90	90	92
RI	88	90	90	….
PA	84	89	82	87
FL				

[22] The sum of the one-day occupancy rates for all facilities, divided by the number of facilities
[23] Half of the facilities have occupancy rates above the median; half have rates below it.
[24] The sum of all the NF residents statewide on the one-day census, divided by the total (statewide) number of certified beds.
[25] See text.

based on a one-day census, is *higher* in West Virginia (97 percent) than for the nation as a whole (90 percent).

Hospital-based nursing facilities in West Virginia have substantially lower occupancy than free-standing facilities, regardless of how occupancy is computed (Exhibits 7 and 8).

Exhibit 7: Recent Trends in West Virginia Nursing Facility Bed Supply and Statewide Occupancy

Year	(1) LTC Units in Hospitals[26]		(2) Free-Standing[27]		(3) Free-Standing[28]
	Licensed Beds?	Statewide Occupancy	Licensed Beds?	Statewide Occupancy	Occupancy Rates
1994	906	86.4%	9836	94.8%	
1995	942	88.4%	9836	96.0%	96.8%
1996	1011	88.5%	9918	95.2%	96.9%
1997	1124	85.9%	9975	94.4%	94.7%
1998	1215	84.6%	9971	93.8%	94.9%
1999					93.0%

? Number of beds reported at the end of the reporting period

[26] Excludes swing beds and state-owned facilities (except Welch Emergency). "Statewide Occupancy" = total inpatient days divided by total bed days available. Data from the West Virginia Health Care Authority, August 25, 2000.
[27] Excludes state-owned facilities. "Statewide Occupancy" = total inpatient days divided by total bed days available. Data from the West Virginia Health Care Authority, August 25, 2000.
[28] Data from freestanding facilities with December cost report year ends, from a document prepared by the West Virginia Health Care Association, July 11, 2000.

Exhibit 8: Nursing Facility Occupancy Rates (One Day Census) By Selected Facility Characteristics						
Ownership	Hospital-Based			Other		
	Medicare	Medicaid	Dually-Certified	Medicare	Medicaid	Dually-Certified
For Profit						
✍ #Facs	4		1	2	19	64
✍ Oc. Range	53-100%			79-94%	77-100%	70-100%
✍ Av. Oc.	78%		100%	87%	91%	92%
Non-Profit						
✍ #Facs	11	1	10		3	11
✍ Oc. Range	10-96%		11-100%		78-100%	90-100%
✍ Av. Oc.	56%	71%	74%		90%	96%
City/C'nty						
✍ #Facs	2		3		1	2
✍ Oc. Range	70-94%		80-99%			98-100%
✍ Av. Oc	82%		90%		98%	99%
State						
✍ #Facs					3	2
✍ Oc. Range					66-100%	93-96%
✍ Av. Oc.					84%	95%

NOTE: "Av. Oc."=The sum of the occupancy rates for all facilities in the category, divided by the number of facilities in the category.

Source: HCFA, OSCAR data as of July 16, 2000 (see Appendix, Exhibit A.1)

THE EFFECT OF THE MORATORIUM

As noted above, West Virginia implemented a moratorium on new nursing facility beds in 1987. In 1990, the legislature created an exemption for low occupancy rural hospitals converting acute care beds to skilled nursing facility (SNF) beds. [29] In 1992, the legislature expanded the hospital bed conversion exception to the moratorium, allowing more types of hospitals to convert acute care beds to SNF beds if the proposed project met a set of criteria. The criteria for both exemptions include a prohibition on certification of the new SNF beds for Medicaid patients, but conversions under the 1992 exemption also involve some relatively subjective review factors. Hospitals seeking to convert beds under that exception are required to apply for a Certificate of Need. Approval is contingent on consideration of numerous factors.

In addition to the formal exceptions to the moratorium, approximately 5 facilities (161 beds) have added to West Virginia's stock by special legislation[30]:

- Broaddus Hospital (60 beds)
- Minnie Hamilton Health Care Center (30 beds)
- Roane General Hospital (31 beds)
- Summers County ARH (15 beds)
- Richwood Area Community Hospital (25 beds)

Changes in Total Bed Supply Since 1987

Strictly comparable data on West Virginia's total bed supply today, compared to that at the time of the moratorium's passage would be difficult to

[29] Additional criteria are specified in the Law.
[30] Information supplied by Dayle Stepp, HCA, August 23, 2000.

reconstruct. But the longitudinal file on nursing facility beds maintained for the U.S. Department of Health and Human Services by researchers notes the following:

> "The number of licensed nursing facilities in West Virginia grew from 117 in 1989 to 145 in 1998. Between 1989 and 1998 the number of beds increased from 9,855 to 11,560. This represents a [net] increase of 4 facilities and 278 beds since 1997." [31]

Bed growth since the moratorium is attributable to the exceptions noted above and the fact that there were projects already approved but not yet fully operational at the time of the moratorium.

Recent Trends

Exhibit 7 (previously presented) compares changes from 1994 to 1998 in the number of licensed beds in long-term care (LTC) units in hospitals with licensed beds in free-standing facilities, excluding state-owned facilities.[32] As can be seen, there was an increase of 309 beds (34 percent) in LTC hospital units and an increase of 135 beds (1 percent) in free-standing facilities over the period.

Recently, some West Virginia hospitals have closed their LTC units. While analysis of the specifics of those closures is beyond the scope of this report, some closures of hospital-based LTC beds and units have been reported nationally.[33] Nationally, the closure of hospital-based LTC units, to the extent this

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[31] C. Harrington, et al., *1998 State Data Book on Long Term Care Program and Market Characteristics,* January 2000.

[32] Data on state-owned facilities are maintained by a different agency and were not available in a comparable fashion to that shown in Exhibit 7.

[33] The federal Medicare Payment Advisory Commission is currently assembling the data needed for a detailed review.

has occurred, has been attributed to changes in the Medicare payment system that have made distinct part SNF units less attractive financially to some hospitals. These payment changes include both changes in Medicare's hospital payment formula for patients transferred to post acute care settings and changes in Medicare's payment system for all SNFs. Among other things, the new Medicare payment system for SNFs no longer pays higher rates to hospital-based units than to free-standing SNFs. Hospital-based facilities nationally have higher costs than free-standing facilities for a number of reasons, including the fact that mandated accounting methods result in the allocation to the SNF unit of some of the acute care hospital costs.

At present, the most recent national data regarding the differential effect of recent Medicare payment changes on hospital-based versus free-standing facilities come from a survey conducted in February 2000 by the Catholic Health Association (CHA) of its members.[34] That study found that while none of CHA respondents (227 free-standing and 287 hospital-based nursing facilities) had closed; 11 percent of hospital-based LTC units, but only 2 percent of free-standing facilities had reduced the number of certified beds as a result of changes in the Medicare payment systems.

Factors Likely to Affect Nursing Home Growth Without a Moratorium

The West Virginia Health Care Association supports the current moratorium (though not the exceptions), citing concerns over declines in occupancy, the effect on the Medicaid budget, and the difficulty of finding appropriate nursing

[34] The Catholic Health Association of the USA, "Results of the SNF Prospective Payment System Survey Conducted February 2000," unpublished data.

staff for existing facilities.[35] To help address staffing needs, the Association is currently seeking increased Medicaid funding in the form of a direct pass through of certain staffing costs. Additional Medicaid money for staffing is needed, according to the Association, because public payment systems do not provide sufficient reimbursement to cover the costs of sufficient nursing staff. The Association notes that a substantial number of West Virginia facilities are currently in Chapter 11 bankruptcy proceedings and that net income (from all sources) for free-standing facilities included in a recent study conducted for the Association declined from 4.7 percent of revenues in 1998 to 1.3 percent in 1999.[36]

Despite recent declines in net income for free-standing facilities, West Virginia appears to be a relatively attractive state for potential nursing home investment. Average Medicaid rates, according to the most recently available nationally comparative data, at $76.97/day, were lower than the national average ($85.05), but higher than rates in 22 other states.[37] In addition, West Virginia's Medicaid payment system has certain features that make it comparatively attractive. Those features include bi-annual rebasing and a "fair rental" capital reimbursement system.[38] Few, if any, other states rebase Medicaid payments bi-annually. Frequent rebasing keeps payments more closely aligned with current

[35] John Alfano, telephone interview, July 2000.
[36] Study conducted by Arnett and Foster for the West Virginia Health Care Association, submitted July 11, 2000.
[37] Rates as of 3/31/95, reported in: B. Manard and J. Feder, "Repeal of the Boren Amendment: Potential Implications for Long-Term Care," The Commonwealth Fund, June 1998.
[38] The term "fair rental" is generically applied to a broad set of methods for establishing Medicaid nursing facility payments for land, buildings, and some equipment. The general concept involves paying rates based on the estimated "value" of property (e.g., as determined by an appraisal), rather than on accounting costs.

costs, though only to the extent allowed by other features of the payment system. "Fair rental" capital payment systems are also uncommon, though considered a wise approach by various experts, with cautions regarding the risk of "overpayments," depending on system details.[39] Rental approaches to capital payments, among other things, can result in substantially higher net cash flow (relative to equity) than capital payments based on accounting costs, depending on the details of the system. Finally, the relatively lower cost of land and labor in West Virginia also make the state more attractive than many other places for those comparing investment opportunities across the nation.

Even if no new beds were added to West Virginia's stock, lifting the moratorium could result in higher Medicaid costs. A representative of the West Virginia Health Care Association noted that some facilities might replace older homes with newer ones. The structure of the Medicaid capital payment system is such that new facilities could result in substantially higher rates. Newer facilities may be desirable, but if the Medicaid budget is constrained, policy-makers face a choice between spending more on nursing staff (or non-nursing home care), versus spending more on new construction.

Exceptions to the Moratorium

Prior to changes in the Medicare SNF payment system specified in the 1997 Balanced Budget Act, "subacute care" patients were particularly attractive with respect to Medicare payments for both free-standing and hospital-based nursing facilities. For hospitals, opening a distinct part SNF unit could be

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[39] C. Baldwin and C. Bishop, "Return to Nursing Home Investment: Issues for Public Policy," *Health Care Financing Review,* 3 (4), Pp 43-52, 1984.

particularly advantageous financially, as the hospital received a full DRG payment from Medicare, regardless of the patient's length of stay; transferring the patient rapidly to a distinct part SNF maximized additional per diem payments from Medicare. Controversies arose nationwide as the number of hospital-based units and free-standing facilities seeking "subacute" patients increased. Some states, including West Virginia, created special exceptions to existing bed supply controls for hospital-based "Medicare only," SNF units, reasoning in part that these units could help hospitals financially without affecting Medicaid costs. [40] Those operating free-standing facilities argued for a "level playing field," asserting nationally that free-standing facilities could provide less costly care for Medicare than hospital-based units. National studies have been inconclusive regarding differences between hospital-based and free-standing facilities with regard to both quality and overall system costs for Medicare.[41]

Recent changes in Medicare's payment system, noted above, made "subacute" patients less attractive than before to all types of nursing facilities and substantially lessened the additional advantage for hospital-based facilities. But changes to the Medicare SNF payment system are likely in the near future. Therefore, in most of the country, as in West Virginia, hospitals seek to preserve their options and free-standing facilities seek a "level playing field."

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[40] Hospitals that were built with Hill Burton funds are precluded from operating units that do not admit Medicaid patients—a factor that inhibited some planned conversions in some states.

[41] Hospitals are more costly on a per-diem basis, but it may be less expensive to renovate existing hospital beds than to build and equip a new free-standing facility. "Cost-effectiveness" appears to vary for different types of conditions, based on the limited research available (B. Manard, et al., *Subacute Care: Policy Synthesis and Market Area Analysis,* prepared for the U.S. Department of Health and Human Services, 1995).

A spokesperson for the West Virginia Hospital Association, interviewed for this report, acknowledged that financial considerations are important for hospitals as well as free-standing facilities, but also noted that the availability of post-acute care in a hospital-based unit—with ready access to physicians and emergency services—is an important part of a full continuum of services.[42] Some other interviewees added that some patients prefer a hospital-based setting for a variety of reasons including not having to transfer to a different facility and the lessened sense of finality sometimes associated with nursing home placement.

The special exception for low-occupancy rural hospitals appears to be related as much to broader issues regarding the economic well being of rural communities as to access to nursing facility care, per se. As such, analysis of that exception involves important issues beyond the scope of this report.

ACCESS TO APPROPRIATE CARE

Everyone interviewed for this report agreed that access to nursing home beds in general in West Virginia is not a problem, although certain types of patients have difficulty finding care close to home or in the facility most preferred. Patients who are ventilator-dependent were said to be particularly difficult to place. Such patients generally have to go to out-of-state nursing facilities if they cannot remain in the hospital or be cared for at home. West Virginia Medicaid, unlike neighboring Ohio and Maryland, does not pay special rates to cover the high costs of ventilator-dependent patients in nursing facilities. While out-of-state

[42] Jill McDaniel; July 2000.

placement can be an extreme hardship for the families involved, there are relatively few ventilator-dependent patients and early mortality rates are high.[43]

While occupancy rates are generally low in hospital-based units and are declining in free-standing facilities, some facilities are full. A recent analysis of nursing facility occupancy conducted by the West Virginia Bureau for Medical Services found that 29 of the 116 facilities in the study had occupancy rates of 98 percent or higher, based on cost reports for July-December, 1998 (see Appendix B).

Some analysts argue that bed supply restrictions limit access to better quality care, noting that in a freer market, better homes might expand services, while others would fail. This theory has proven difficult to test in part because there is considerable controversy regarding the meaning of "quality" in nursing homes. Using three available (though quite imperfect) measures of quality—total deficiencies, the percent of patients restrained and the percent of patients with bed sores at the last inspection—I found no statistically meaningful association between nursing facility occupancy and "quality" in West Virginia (Appendix A).[44]

West Virginia's policies with respect to nursing home supply are driven in part by the State's long-standing goal to promote access to "non-institutional" long-term care services. The introduction to the long-term care chapter of the 1984 Health Plan states:

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[43] D. Stapleton, B. Manard, S. Kaplan, et al., *Ventilator-Dependent Unit Demonstration: Outcome Evaluation and Assessment of Post-Acute Care,* prepared for the U. S. Department of Health and Human Services, 1997.

[44] The indicator most consistently associated with better nursing home outcomes, variously measured, is nurse staffing. But the data available for analysis in this study (federal OSCAR data) has been found to be unreliable with respect to staffing information.

> "The long-term care system as it currently exists in West Virginia is confusing and fragmented and inadequately meets the needs of our elderly and disabled population. Nursing homes continue to be constructed and filled while less restrictive, less costly levels of care remain underdeveloped and underutilized. Our private and public third-party reimbursement systems encourage institutionalization and dependence rather than home care and self-reliance."

Since that statement was written, West Virginia has been a national leader among the states in efforts to develop home and community-based services, ranking 6th in terms of the proportion of Medicaid expenditures going to home and community-based services[45] but, according to a 1997 review panel, more remains to be done.[46] The panel observed that "Over the past decade a strong consensus has emerged to promote home and community-based services as preferential to institutional services. Yet, hundreds of millions of dollars are spent on institutional care and new dollars for in-home and community-based are difficult to come by." The panel recommended, among other things, that "a task force made up of representative stakeholders study, discuss and debate this issue and develop recommendations for strategies to help meet the goal of a long-term care system that shifts the emphasis away from institutional care towards home and community-based care." [47]

Several people interviewed for this study indicated that it is difficult to determine the number of people who might more appropriately be served with home and community-based services, rather than in nursing homes. Some

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[45] D. Brown, "Aging Policy in Rural Appalachia," citing data from a study conducted in 1996.
[46] "Long Term Care Policy in West Virginia," July 1997.
[47] The Task Force's report is being completed this fall. Action by the State to increase access to home and community-based services since 1997 has included recently authorizing 400 new waiver "slots." In addition, Mr. Alfano noted that there has been an increasing supply—approximately 18 percent recently—of "assisted living" beds.

states have mandatory "consumer choice" programs, requiring that all people seeking nursing home placement receive a detailed explanation of alternative choices and, in some cases, an assessment to help determine appropriate services. West Virginia does require completion of forms indicating that people entering a nursing home are appropriately placed, but according to a Medicaid official and a knowledgeable person with the West Virginia Medical Institute, little is known about whether the "boxes on the forms" are checked in a perfunctory manner or the degree to which those entering nursing homes understand the array of possible alternatives.[48]

CONCLUSIONS

Based on the information discussed above, it appears that West Virginia has at least an adequate supply of nursing facility beds. Absent a strong mechanism like the moratorium, multiple factors beyond the State's control such as Medicare payments and the U.S. tax code could invite substantial new bed development in the state.

The exceptions to the moratorium have created understandable controversy but relatively few occupied beds. Some believe that community-based hospitals are preferable to out-of-state nursing facility chains (prevalent in West Virginia) as a matter of principle and hence favor limiting nursing facility bed growth to the hospital sector. But even where hospitals are currently owned by non-profit, local entities, ownership can change. In fact, ironically, charitable

[48] Interviews with Ms. Ann Stottlemyer and Ms. Joan Armbruster, July 2000. Mr. Larry Medley from the Bureau of Senior Services asked Ombudspeople about the forms. Mr. Medley, cautioning that his information was anecdotal, reported that there appeared to be limited—at best--explanation of service alternatives for those entering nursing homes.

organizations can often have more money to spend on charitable endeavors by selling a health care institution to a for-profit one (that can make use of the tax deduction) and leasing the institution back. Such changes in ownership may change the service for better or worse or not at all.

The relatively low occupancy of hospital-based units and the overall apparent adequacy of nursing facility bed supply suggest little need for exceptions to the moratorium. But policy-makers are also concerned about the financial health of hospitals and particularly those in rural areas. Those concerns raise issues beyond the scope of this review.

Finally, this appears to be a particularly inopportune time to recommend any changes regarding nursing bed supply policies. Three other relevant analyses are underway and should factor into the State's policy decisions: an analysis of access for Veterans,[49] the report of the Interagency Long-Term Care Panel, and an analysis by the Legislative Oversight Committee on Health and Human Resources Accountability. In addition, Congress is likely to pass legislation in the next few weeks affecting Medicare payments to hospitals and SNFs, rural economic development and health care, the availability of federal funds for Medicaid support of enhanced nurse staffing in nursing facilities, and potentially additional monies for home and community-based services.

West Virginia recognized in the 1984 Health Plan, before many other states, that assessing the "need" for nursing home beds is not best approached by simple formulae. For an individual, the "true need" for a nursing home bed

[49] This study, conducted by the West Virginia Health Care Authority, was mandated by the legislature in WV Code Sec. 29-22-9a.

involves comparing available options in light of preferences and resources (financial and social). The “Catch 22” in estimating a community’s need for nursing home beds is that the array of available, feasible alternatives largely drives the need for nursing home beds, but feasible alternatives do not develop without customers with money to pay for them. West Virginia could improve its ability to gauge current and future need by more focused attention to interventions (e.g., assuring that alternatives are carefully explored) at the point of nursing home entry. In addition, it would be useful to track the availability of a full array of potentially substitutable residential settings for long-term care, when considering nursing home bed supply. The historically "constant" use rate (roughly 5 beds per 100 elderly) of such settings might be used as a rough gauge of the adequacy of supply.

APPENDIX A

Exhibit A.1 Information on West Virginia Nursing Facilities
From the Federal On-Line Data System 'OSCAR' as of July 16 2000

KEY
Can Type: 1=Medicare Only; 2=M Medicaid Only; 3=Dually Certified
HB 1=Hospital-based; 2=Other
OwnerSp: 1=Proprietary; 2=Non-Profit; 3=Government (City/County); 4=State Government

County	Facility Name	Fac #	Beds	Residents	Occ%	CertType	HB	OwnerSp	Deff'cies	%Restrn'd	%BedSrs
Barbour	Barbour County Good Sam	1	60	58	97	3	0	2	5	29	7
	Broaddus Hosp. Ass. DP	2	60	58	97	3	1	2	2	33	14
Berkeley	Care Haven Center	3	68	54	79	2	0	1	15	35	9
	City Hospital Transitional	4	19	6	32	1	1	2	1		
Boone	Hartland of Martinsburg	5	120	116	97	3	0	1	3	3	3
	Boone Health Care Center	6	20	84	70	3	0	1	5	7	5
	Braxton Health Care Center	7	65	56	86	2	0	1	9	0	2
	Bnghtwood Center	8	128	127	99	3	0	1	1	9	17
	Valley Haven Geriatric	9	60	59	98	3	0	1	16	8	7
Cabell	Cabell Huntington Hosp D/P	10	15	8	53	1	1	1	1		
	Fairhaven Rest Home	11	41	37	90	3	0	1	5	16	3
	Heritage Center	12	189	178	94	3	0	1	9	3	1
	Mariner Health Care of Huntington	13	186	175	94	3	0	1	7	17	11
	St. Mary's Hospital D/P	14	38	27	71	2	1	2	7	0	11
Calhoun	Minnie Hamilton Health Care Cnt	15	24	24	100	3	0	2	8	21	8
Clay	Laurel Nursing & Rehab	16	60	51	85	3	0	1	2	2	4
Fayette	Ansted Center	17	60	59	98	3	0	1	3	10	5
	Fayette Continuing Care	18	60	56	93	3	0	1	1	7	7
	Hidden Valley Health Care	19	74	71	96	3	0	1	8	17	4
	Hilltop Center	20	120	113	94	3	0	1	14	15	7
	Montgomery General Elderly Care	21	60	58	97	3	0	2	8	3	7
	Montgomery General Hsp DIP	22	44	41	93	3	1	2	20	12	0
	Plateau Medical Center D/P	23	11	4	36	1	1	2	3		
Gilmer	Sunbridge Care and Rehab	24	65	61	94	3	0	1	7	7	2
Grant	Grant County NH	25	110	110	100	3	0	3	0	19	3
	Grant County Mem D/P	26	10	8	80	3	1	3			
Greenbr.	Briar, The	27	96	85	89	3	0	1	23	18	12
	Greenbriar Manor	28	100	92	92	2	0	2	23	23	4
	Heartland of Rainelle	29	60	60	58	3	0	1	1	14	12
	White Sulphur Springs	30	68	61	90	3	0	1	8	18	7
Hampsh.	Hampshire Center	31	62	62	100	2	0	1	2	10	8
	Hampshire Mem Hosp	32	30	30	100	3	1	1	12	3	10
Hancock	Fox NH	33	60	60	100	3	0	1	6	25	10
	Weirton Geriatric	34	137	136	99	3	0	1	4	13	13
	Weirton Med Ctr DIP	35	33	19	58	3	1	2	1	0	21
Hardy	E A Hawse	36	60	46	77	2	0	1	7	10	11
Harrison	Clarksburg Continuous Care	37	98	95	97	3	0	1	3	9	1
	Heartland of Clarksburg	38	120	120	100	3	0	1	6	2	10
	Heritage Inc	39	51	49	96	2	0	1	8	4	8
	Meadowview Manor Health C	40	60	55	92	3	0	1	10	13	2
	Sunbridge Care and Rehab	41	128	107	84	3	0	1	6	4	0
	United Transitional	42	32	14	44	1	1	2	1	0	7
Jackson	Eldercare of West Va	43	120	113	94	1	0	1	1	2	4
	Ravenswood Center	44	62	59	95	3	0	1	9	17	10
Jefferson	Canterbury Center	45	62	59	95	2	0	1	6	17	7
	Integrated Health Services	46	126	109	87	3	0	1	12	8	6
	Jefferson Mem D/P	47	30	3	10	1	1	2			
	Shenandoah Health	48	78	67	86	3	0	1	7	4	7
Kanawha	Arthur B. Hodges	49	120	108	90	3	0	2	10	2	7
	Beverly HC Cntr	50	112	103	92	3	0	1	9	5	5
	Capital Center	51	87	70	80	2	0	1	11	13	6
	Cedar Ridge	52	120	107	89	3	0	1	8	0	7
	Charleston Area Med	53	19	17	89	1	1	2	3	6	35
	Columbia D/P	54	20	17	85	1	1	1	4	0	6
	Heartland of C	55	184	181	98	3	0	1	4	4	1
	Marmet Health	56	70	65	93	3	0	1	13	18	14
	Meadowbrook Acres	57	60	60	100	3	0	1	9	40	10
	Riverside	58	98	96	98	3	0	1	17	8	11
	Sunbridge Care and Rehab	59	120	105	88	3	0	1	8	18	15
	Thomas Mem D/P	60	19	17	89	1	1	2	5	29	18
	Valley Center	61	130	92	71	3	0	1	8	10	4
Lewis	Crestview Manor	62	72	68	94	3	0	2	8	21	7
Lincoln	Lincoln c c	63	60	58	97	3	0	1	5	9	2

Logan	Logan Ctr	64	66	59	89	2	0	1	3	0	3
	Logan Prk	65	120	108	90	3	0	1	7	2	5
Marion	Arbors	66	120	119	99	2	0	1	6	9	3
	Fairmont Hosp D/P	67	61	18	30	3	1	2	3	0	22
	Marion HC Hosp	68	44	41	93	3	0	4	3	32	5
	St. Barbara Mom	69	57	56	98	3	0	2	2	20	13
	Wishing Well	70	119	118	99	3	0	1	0	5	3
	Wishing Well Manor	71	90	88	98	3	0	1	3	2	10
Marshall	Cameron Continuing	72	62	58	94	3	0	1	4	0	2
	Mound View	73	183	132	72	3	0	1	1	5	5
	Reynolds Mom DIP	74	20	19	95	1	1	2	9	0	0
Mason	Lakin Hosp	75	136	136	100	2	0	4	5	5	2
	Pleasant Valley	76	100	92	92	3	1	2	5	5	8
	Point Pleasant	77	68	53	78	2	0	2	11	6	11
McDow.	McDowell Cont Care	78	120	109	91	3	0	1	3	4	4
	Welsh Emergency	79	59	50	85	2	0	4	5	20	4
Mercer	Bluefield Reg. Mod.	80	25	14	56	1	1	2	1	0	21
	Cumberland Care Center	81	113	102	90	3	0	1	9	35	6
	Glenwood Park	82	67	63	94	3	0	2	1	3	6
	Maple's NH	83	60	56	93	2	0	1	3	13	2
	Princeton HC Center	84	120	118	98	2	0	3	1	3	8
	Princeton Special Care	85	25	19	76	1	1	2	4	0	32
Mineral	Dawn View Center	86	66	66	100	3	0	1	3	5	8
	Heartland of Kaiser	87	122	122	100	3	0	1	9	0	5
Mingo	Mingo HC Center, Inc	88	120	106	88	3	0	1	8	10	8
Monong.	Madison Genesis	89	62	52	84	3	0	1	8	29	15
	Mon Pointe Cont Care	90	120	115	96	3	0	1	4	17	8
	Morgan Manor	91	100	97	97	3	0	1	4	3	7
	Sundale NH	92	120	108	90	3	0	1	1	11	12
	West Va U Hosp SNF	93	20	15	75	1	1	1	2	53	13
Monroe	Springfield Center	94	66	66	100	2	0	2	4	9	9
Morgan	Morgan County D/P	95	16	15	94	1	1	3	3	0	7
	Valley View	96	122	109	89	3	0	1	6	9	12
Nicholas	Nicholas Cnty HC	97	120	116	97	2	0	1	2	3	8
	Richwood Area Hosp D/P	98	9	1	11	3	1	2	8		
	Summerville Mem Hosp D/P	99	52	52	100	3	1	2	9	10	4
Ohio	Bishop Hosp D/P	100	144	138	96	3	1	2	7	1	4
	Good Shepherd	101	192	190	99	3	0	2	6	3	4
	Peterson Geriatric	102	150	138	92	3	0	2	6	65	8
Pendlet.	Pendleton NH	103	91	89	98	3	0	3	5	1	8
Pleasan.	Care Haven	104	68	62	91	2	0	1	5	15	10
Pocahon.	Pocahontas Center	105	68	65	96	2	0	1	1	6	2
Preston	Heartland	106	120	95	79	1	0	1	6	0	3
	Hopemount Hospital	107	98	94	96	3	0	4	1	19	3
Putnam	Sunbridge	108	120	113	94	3	0	1	5	6	11
	Teays Valley	109	124	112	90	3	0	1	13	13	6
Raleigh	Heartland of B	110	214	185	86	3	0	1	13	15	9
	Pinecrest Hospital NF	111	199	132	66	2	0	4	2	14	3
	Raleigh Center	112	68	63	93	3	0	1	6	11	8
	Sunbridge Pine Lodge	113	120	117	98	3	0	1	0	3	10
Randolph	Davis Mom D/P	114	25	5	20	1	1	2	2		
	Elkins Regional	115	111	110	99	3	0	2	6	23	9
	Nellas Inc	116	102	101	99	2	0	1	13	3	7
	Nellas NH	117	84	77	92	2	0	1	0	5	3
Ritchie	Pineview	118	66	55	83	2	0	1	3	9	11
Roane	Miletree	119	62	52	84	2	0	1	3	4	4
	Roane Gen Hosp D/P	120	35	25	71	3	1	2	5	0	12
Summers	Summers County	121	120	116	97	2	0	1	5	1	5
	Summers County Hosp	122	39	35	90	3	1	3	10	3	17
Taylor	Grafton City Hosp	123	68	67	99	3	1	3	8	6	46
	Rosewood	124	69	67	97	3	0	1	9	3	73
Tucker	Courtland Acres	125	94	93	99	3	0	2	4	10	6
Upshur	Hillbrook	126	120	110	92	3	0	1	26	9	13
	St. Joseph's D/P	127	16	15	94	3	1	2	4	0	0
Wayne	Wayne Continuous Care	128	60	59	96	3	0	1	8	14	7
Webster	Webster Continuous Care	129	60	9612	100	3	0	1	1	3	2
Wetzel	New Martinsville	130	120	119	99	3	0	1	12	10	3
	Wetzel County D/P	131	10	7	70	1	1	3	2		
Wood	Camden Clark D/P	132	23	22	96	1	1	2	3	14	23
	Ohio Valley	133	66	66	100	2	0	1	7	2	12
	Parkview	134	164	130	79	3	0	1	14	5	18
	St. Joseph's H D/P	135	20	20	100	1	1	1	4	0	15
	Sunbridge	136	66	62	94	3	0	1	1	0	13
	Willows Center	137	97	93	96	3	0	1	8	24	13
	Worthington Manor	138	105	105	100	3	0	1	7	60	4
Wyoming	Wyoming Continuous Care	139	60	58	97	3	0	1	0	3	2

EXHIBIT A.2

Nursing Facility Occupancy and Total Deficiencies (all facilities)

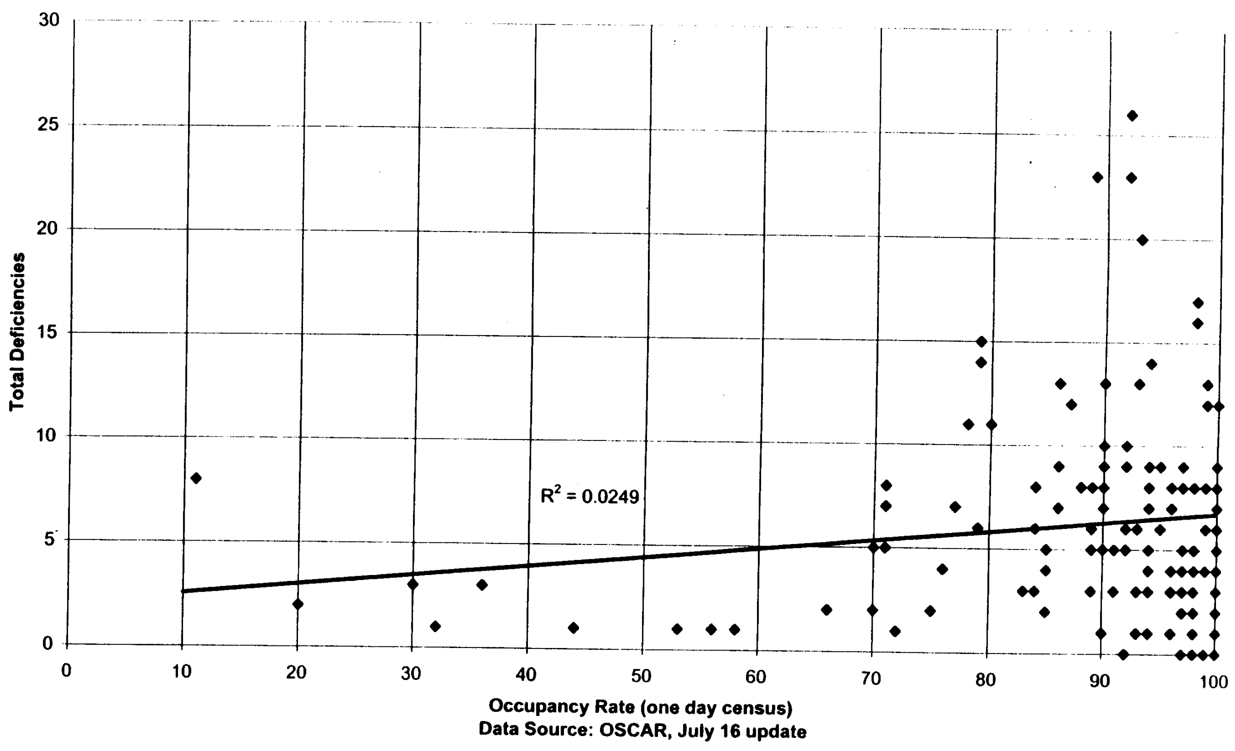
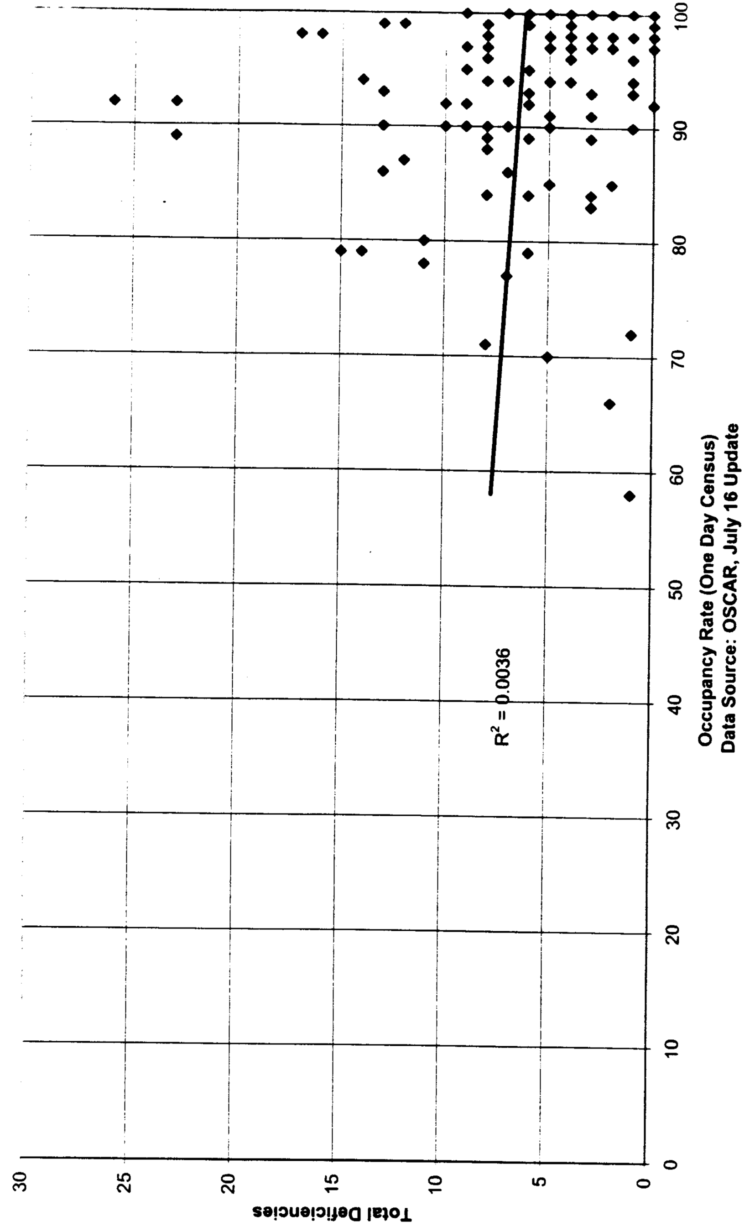


Exhibit A.3

Nursing Facility Occupancy and Total Deficiencies (All Free-standing Facilities)



Occupancy Rate (One Day Census)
Data Source: OSCAR, July 16 Update

Exhibit A.4
Nursing Facility Occupancy and Total Deficiencies (Hospital-Based Facilities Only)

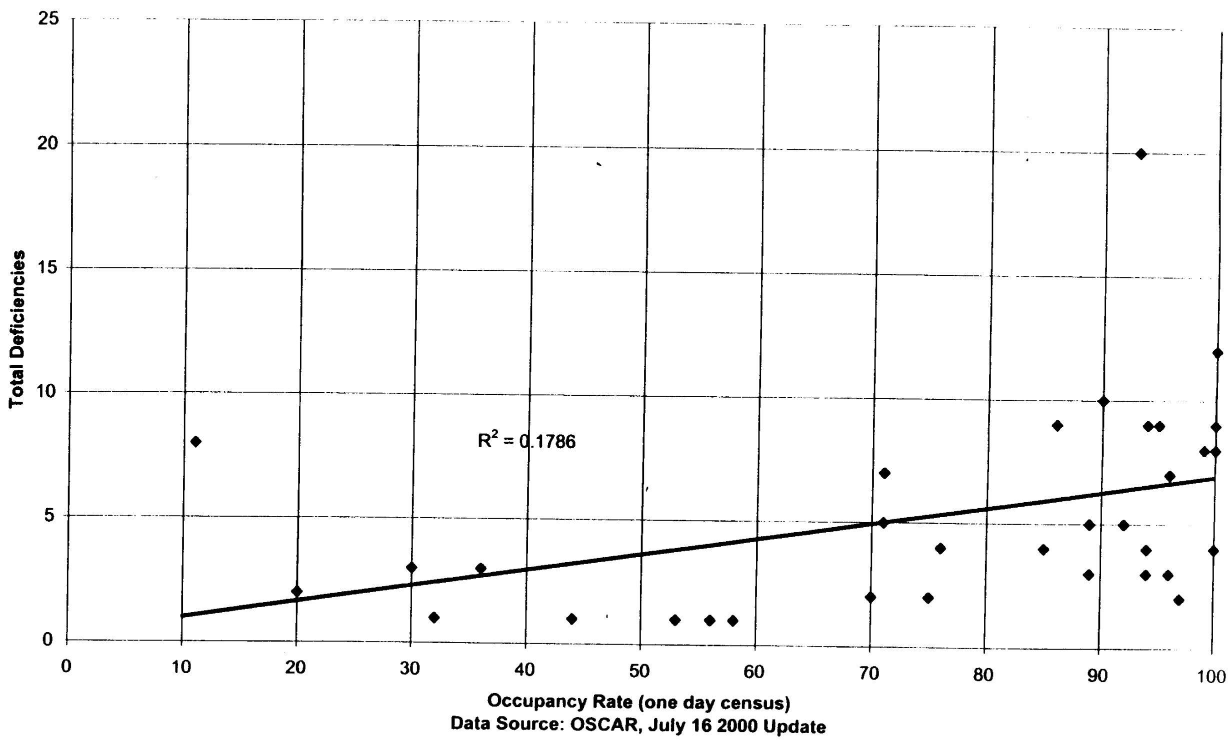


EXHIBIT A.5:
Nursing Facility Occupancy and Percent of Residents Restrained at Last Survey (all facilities)

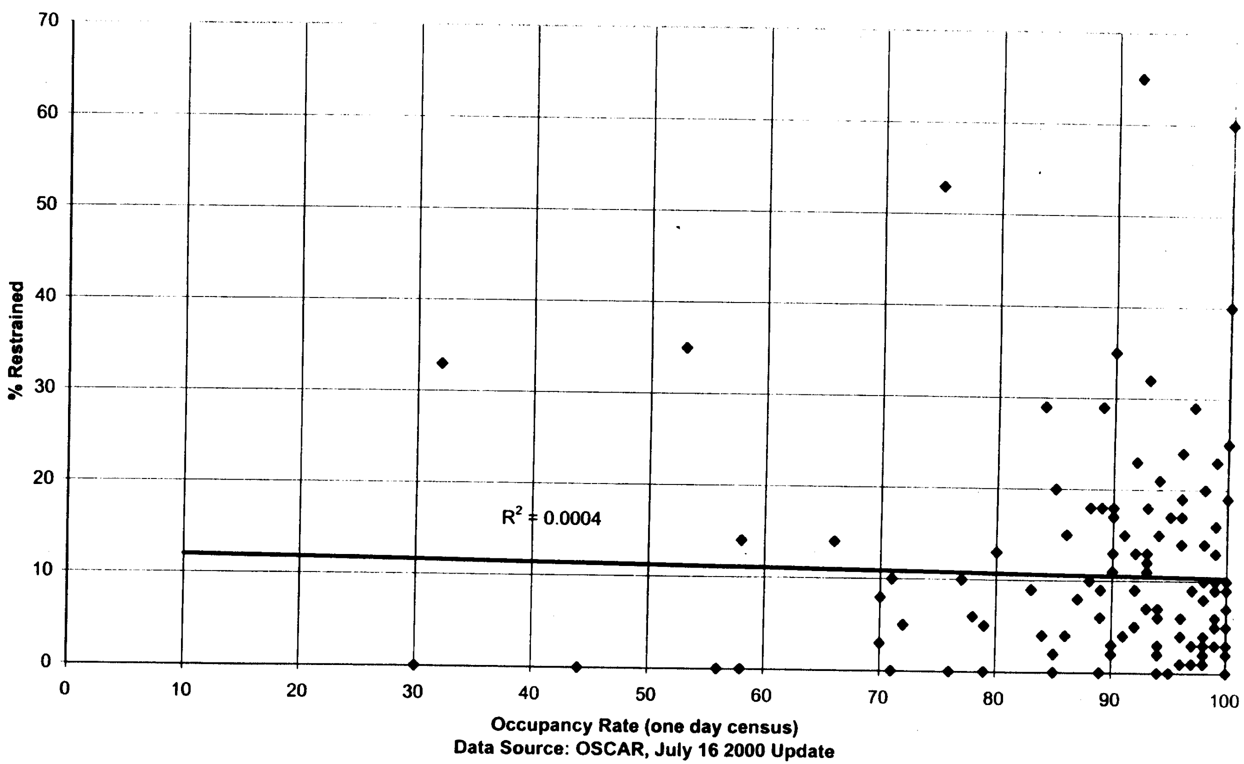


Exhibit A.6
Nursing Facility Occupancy and Percent of Residents Restrained at Last Survey
(freestanding facilities)

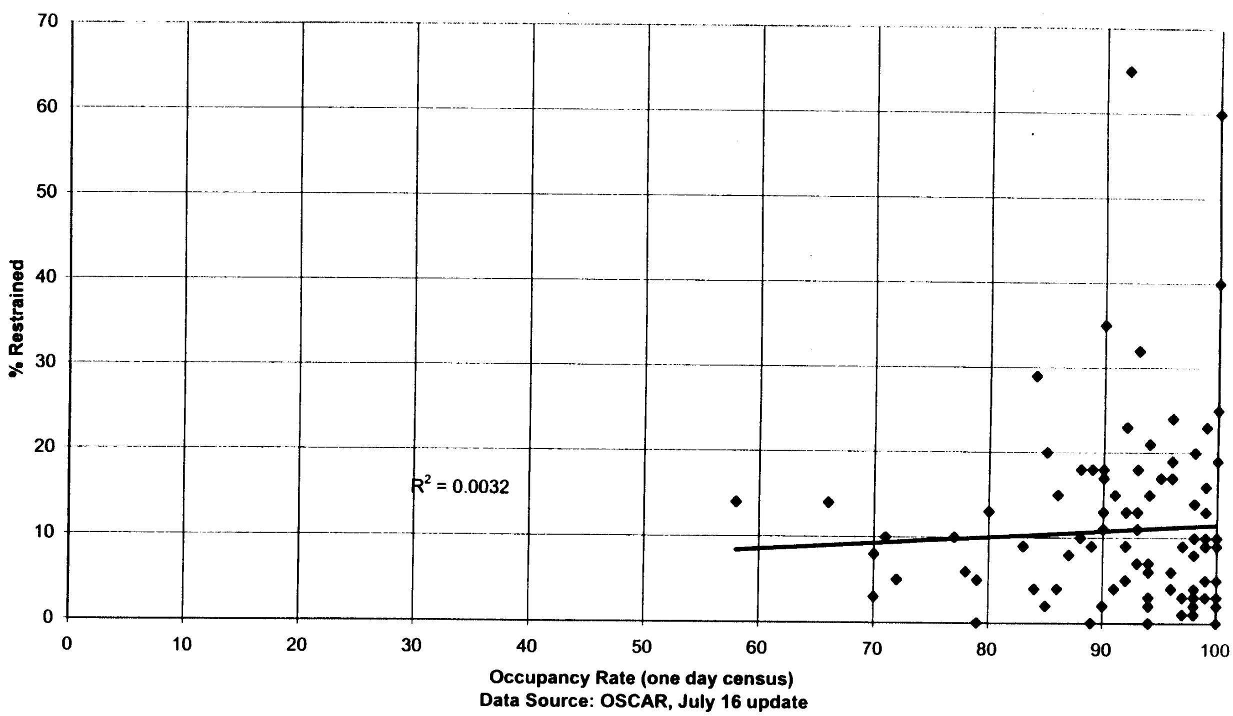


EXHIBIT A.7

Nursing Facility Occupancy and Percent of Residents with Bed Sores at Last Survey (all facilities)

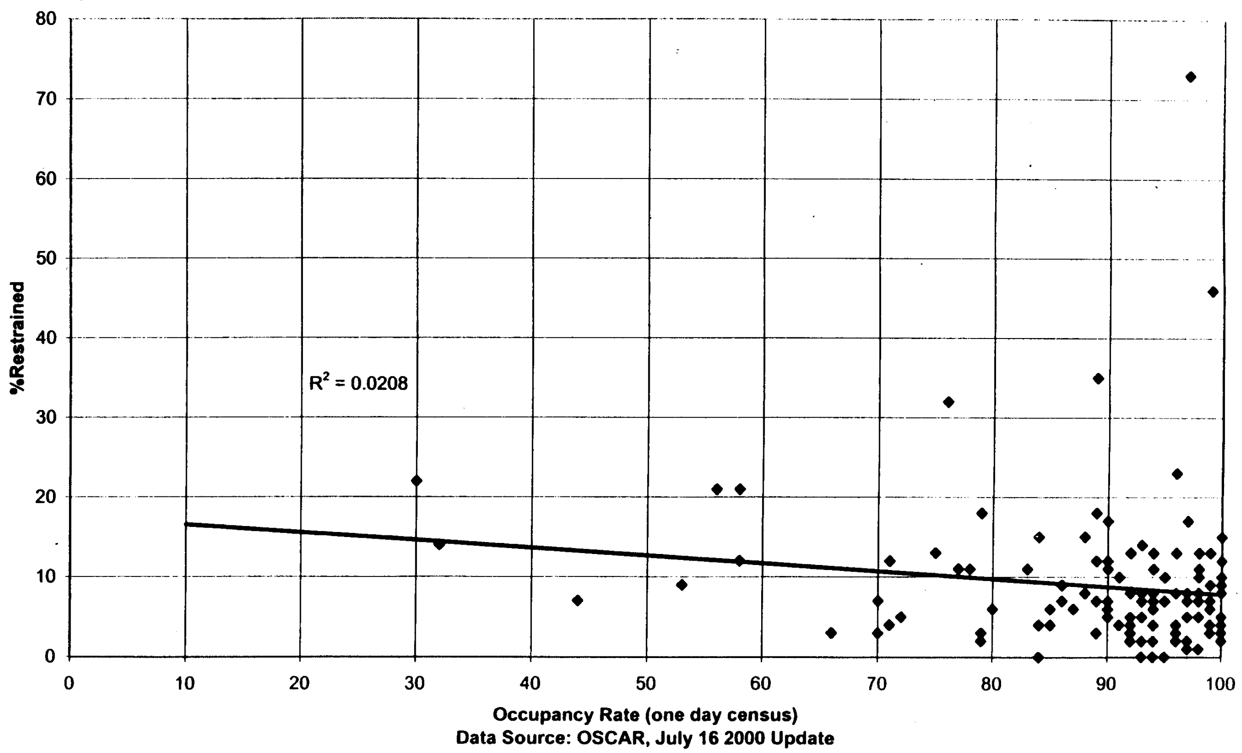
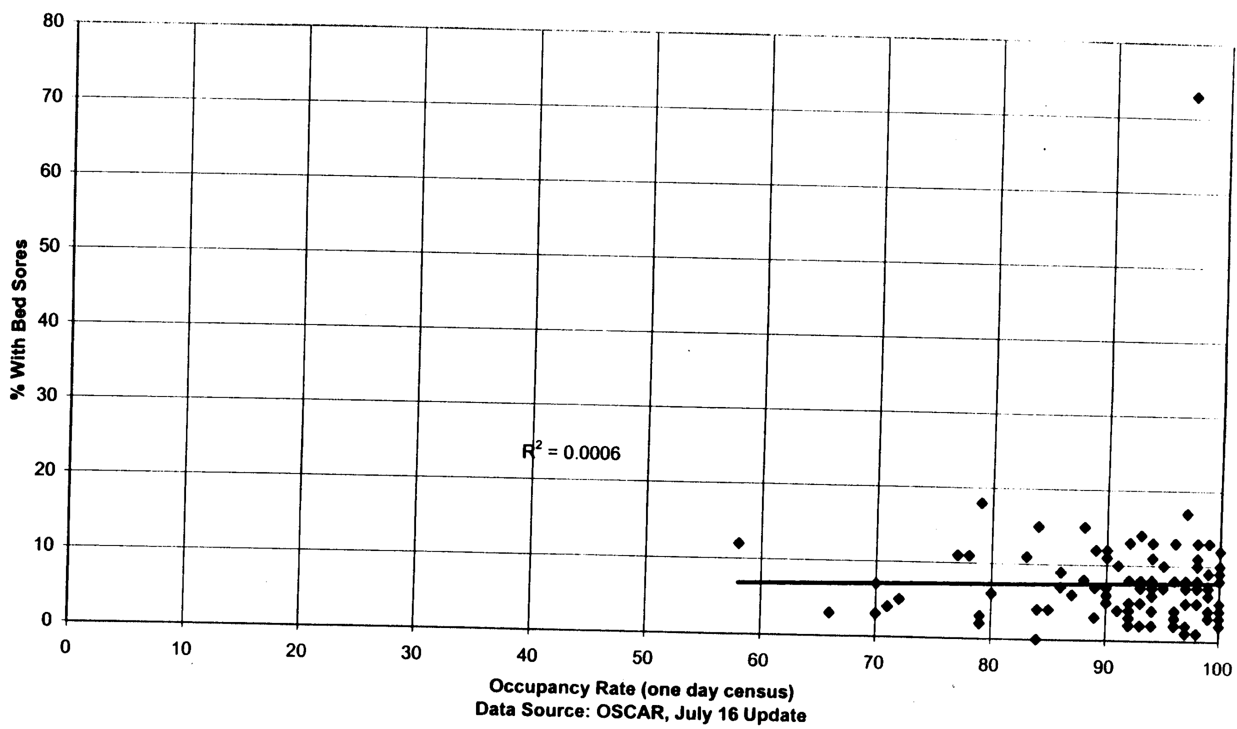


Exhibit A.8
Nursing Facility Occupancy and Percent of Resicents with Bed Sores at Last Survey
(freestanding facilities)



APPENDIX B

Nursing Home Occupancy Report

Cost Report Period: July 1999 through December 1999

	Large Bed	Small Bed
Average Total Patient Days	21,354	10,244
Average Medicaid Patient Days	16,186	7,863
Average Medicaid Percentage of Total	76.35%	74.40%
Average Occupancy Percentage	92.86%	92.80%

Facilities Below 90% Occupancy:

Large Bed

Cedar Ridge Center
Sundale Nursing Home
AMFM of McDowell Co.
IHS of Charlestown, WV
Holbrook Nursing Home, Inc
Mingo Health Care Center
Beverly Health Care Center
Pleasant Valley Nsg & Rehab
Sunbridge - Salem
Mound View Health Care, Inc.
Heartland of Beckley
Valley Center
Cumberland Care Center
Parkview Health Care Center
Boone Nursing & Rehabilitation Center

Small Bed

Fairhaven Rest Home
Laurel Nursing & Rehabilitation Center
Logan Center
Broaddus Hospital Association
AMFM of Hardy
Montgomery General Hospital Extended
Miletree Health Care Center
Weirton Medical Center
Pineview Continuous Care, Inc.
Pt. Pleasant Center
Roane General Hospital
Grant Memorial Hospital
Fairmont General Hospital

Prepared by: Bureau for Medical Services, Division of Financial Analysis and Rate Setting

Facility	Beds	Total Patient Days	Medicaid Patient Days	Medicaid % of Total	Occupancy Percentage
Large Bed Group					
Grant County Nursing Home	110	20143	15455	76.73%	99.52%
Weirton Geriatric Center	137	25067	22187	88.51%	99.44%
Brightwood Center	128	23414	17760	75.85%	99.41%
Good Shepherd Nursing Home	192	35087	16979	48.39%	99.32%
Heartland of Keyser	122	22259	14659	65.86%	99.16%
SunBridge Dunbar	120	21882	14550	66.49%	99.10%
The Arbors at Fairmont	120	21874	15205	69.51%	99.07%
Wishing Well Health Center	119	21659	19031	87.87%	98.92%
Heartland of Martinsburg	120	21826	15381	70.47%	98.85%
CORTLAND ACRES ASSOC., INC.	94	17086	13999	81.93%	98.79%
NELLA'S INC.	102	18513	15396	83.16%	98.64%
New Martinsville Health Care	120	21755	16469	75.70%	98.53%
AMFM of Clarksburg	98	17754	12588	70.90%	98.46%
WORTHINGTON MANOR, INC	105	19017	11401	59.95%	98.43%
ELKINS REGNL CONVALESCENT CNT	111	20036	14754	73.64%	98.10%
Heartland of Charleston	184	32990	26001	78.81%	97.44%
Nicholas County Health Care	120	21511	19436	90.35%	97.42%
Pendleton Nursing Home	91	16293	12764	78.34%	97.31%
Sunbridge - Putnam	120	21448	14432	67.29%	97.14%
Morgan Manor	100	17800	14672	82.43%	96.74%
BISHOP JOSEPH HODGES CONT CARE	120	21265	10199	47.96%	96.31%
PRINCETON HEALTH CARE CENTER	120	21242	17932	84.42%	96.20%
Hilltop Center	120	21204	15178	71.58%	96.03%
Mariner	186	32816	26008	79.25%	95.89%
The Willows Nursing & Rehab	97	17112	12118	70.82%	95.88%
Heartland of Clarksburg	120	21128	16645	78.78%	95.69%
Riverside Nursing Home	98	17178	13095	76.23%	95.26%
Eldercare of WV	120	20765	17334	83.48%	94.04%
Peterson Rehabilitation Hospital	150	25797	14033	54.40%	93.47%
Teays Valley Center	124	21201	15772	74.39%	92.92%
Logan Park Care Center Inc.	120	20508	17562	85.63%	92.88%
ARTHUR B. HODGES	120	20472	13450	65.70%	92.72%
GreenBrier	100	17004	12715	74.78%	92.41%
Sunbridge - Pine Lodge	120	20328	13504	66.43%	92.07%
Heritage Center	189	31746	20773	65.44%	91.29%
Heartland of Preston County	120	20074	14532	72.39%	90.91%
MonPointe Continuing Care Ctr	120	20016	15170	75.79%	90.65%
AMFM OF SUMMERS	120	19977	17810	89.15%	90.48%
VALLEY VIEW NURSING HOME, INC.	120	19953	16101	80.69%	90.37%
Cedar Ridge Center	120	19803	15985	80.72%	89.69%
Sundale Nursing Home	120	19739	15793	80.01 %	89.40%
AMFM OF MCDOWELL CO. INC.	120	19660	17927	91.19%	89.04%
IHS of Charlestown, W V	126	20534	17274	84.12%	88.57%
HOLBROOK NURSING HOME, INC.	120	19490	16990	87.17%	88.27%
Mingo Health Care Center	120	19276	17273	89.61%	87.30%
Beverly Health Care Center	112	17964	15047	83.76%	87.17%
Pleasant Valley Nsg & Rehab	100	15957	11410	71.50%	86.72%
Sunbridge - Salem	128	20330	17037	83.80%	86.32%
Mound View Health Care, Inc.	161	25292	18067	71.43%	85.38%
Heartland of Beckley	214	33300	27387	82.24%	84.57%
Valley Center	130	19464	13676	70.26%	81.37%
Cumberland Care Center	113	16335	13932	85.29%	78.56%
Parkview Health Care Center	164	23517	19627	83.46%	77.93%
Boone Nursing & Rehabilitation Center	120	15243	13565	88.99%	69.04%
Average	125	21354	16186	76.35%	92.86%

Facility	Beds	Total Patient Days	Medicaid Patient Days	Medicaid % of Total	Occupancy Percentage
Small Bed Group					
Wallace B. Murphy Nursing Home	72	13437	11050	82.24%	101.43%
Pocahontas Center	68	12583	10786	85.72%	100.57%
Fox Nursing Home, Inc.	60	11019	8809	79.94%	99.81%
HAMPSHIRE MEMORIAL HOSP, INC.	30	5492	5290	96.32%	99.49%
HARRELL MEMORIAL NURSING HOM	60	10959	7603	69.38%	99.27%
Wishing Well Manor, Inc.	90	16425	10539	64.16%	99.18%
MINNIE HAMILTON HEALTH CARE	24	4378	3542	80.90%	99.14%
Ansted Center	60	10927	8299	75.95%	98.98%
Crestview Manor	72	13092	7355	56.18%	98.82%
AMFM OF WYOMING	60	10894	10368	95.17%	98.68%
Dawnview Center	66	11977	8827	73.70%	98.62%
AMFM OF LINCOLN COUNTY, INC.	60	10887	10409	95.61%	98.61%
Summersville	52	9430	7572	80.30%	98.56%
Ther Heritage, Inc.	51	9209	4795	52.07%	98.14%
HAMPSHIRE HEALTH CARE CENTER	62	11178	9985	89.33%	97.98%
Montgomery General Elderly Care Center	60	10815	6788	62.76%	97.96%
PMHC dba: SPRINGFIELD Center	66	11896	11483	96.53%	97.96%
Sistersville Center	68	12249	9947	81.21%	97.90%
Capital Center	73	13114	12599	96.07%	97.63%
White Sulphur Springs Center	68	12208	8598	70.43%	97.57%
SunBridge - Parkersburg	66	11847	7855	66.30%	97.55%
Carehaven of Pleasants	68	12177	10510	86.31%	97.32%
AMFM OF MARSHALL COUNTY, INC.	60	10718	9711	90.60%	97.08%
Carehaven Center	68	12131	10122	83.44%	96.95%
AMFM OF WEBSTER COUNTY, INC.	60	10702	9441	88.22%	96.94%
VALLEY HAVEN GERIATRIC CENTER	60	10689	8628	80.72%	96.82%
AMFM OF FAYETTE COUNTY, INC.	60	10682	8483	79.41%	96.76%
St. Joseph's Hospital of Buckhannon, Inc	16	2848	1566	54.99%	96.74%
Sunbridge-Glenville	65	11569	7538	65.16%	96.73%
NELLA'S NURSING HOME,INC.	84	14943	13701	91.69%	96.68%
Rosewood Center	69	12274	10283	83.78%	96.68%
Meadowview Manor Health Care Center In	60	10653	6779	63.63%	96.49%
MARMET HEALTH CARE CENTER INC.	70	12381	7422	59.95%	96.13%
Heartland of Rainelle	60	10607	9508	89.64%	96.08%
St. Barbara's Memorial Nursing Home. Inc	57	10053	7260	72.22%	95.85%
Morgan County War Memorial Hospital	16	2815	2088	74.17%	95.62%
Barbour County Good Samaritan Center	60	10552	7091	67.20%	95.58%
SHENANDOAH MANOR OF RONCEVE	90	15822	11817	74.69%	95.54%
AMFM OF WAYNE COUNTY, INC.	60	10515	9669	91.95%	95.24%
The Maples	60	10500	9674	92.13%	95.11%
Raleigh Center	68	11853	8648	72.96%	94.73%
GlenWood Park. Inc.	67	11659	8784	75.34%	94.57%
Shenandoah Health Village Cent	78	13492	7980	59.15%	94.01%
Canterbury Center	62	10645	6327	59.44%	93.31%
FAYETTE COMMUNITY HEALTH CAR	74	12686	8960	70.63%	93.17%
Braxton Health Care Center	65	11049	9157	82.88%	92.38%
OHIO VALLEY HEALTH CARE	66	11161	7973	71.44%	91.91%
Ravenswood Center	62	10397	8938	85.97%	91.14%
Madison Center	62	10284	4544	44.19%	90.15%
FAIRHAVEN REST HOME, INC.	41	6784	5613	82.74%	89.93%
Laurel Nursing & Rehabilitation Center	60	9902	9012	91.01%	89.69%
Logan Center	66	10801	10130	93.79%	88.94%
Broaddus Hospital Association	60	9784	6441	65.83%	88.62%
AMFM of HARDY	60	8018	7557	94.25%	72.63%
Montgomery General Hospital Extended Care	44	6939	5239	75.50%	85.71%
Miletree Health Care Center	62	9657	8633	89.40%	84:65%
Weirton Medical Center	33	5136	153	2.98%	84.58%
Pineview Continuous Care, Inc.	66	9468	8220	86.82%	77.96%
Pt. Pleasant Center	68	9613	9333	97.09%	76.83%
Roane General Hospital	35	4644	1747	37.62%	72.11%
Grant Memorial Hospital	10	1048	352	33.59%	56.96%
Fairmont General Hospital	61	3447	0	0.00%	30.71%
Average	60	10244	7863	74.40%	92.56%

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