Office of Statewide Health Planning and Development

Long-Term Care Facilities Utilization and Financial Trends

2003-2007

SPRING 2010

oshpd

"...baby boomers...are now between 45 and 63 years of age and have yet to reach the point in their lives...where they may need LTC services. Over the next two decades we may start to see an increased demand for LTC services."

What is this report about?

The Office of Statewide Health Planning and Development (OSHPD) collects and reports information on long-term care facilities in California. This report presents information gathered by OSHPD from 2003 through 2007. Its purpose is to provide a closer look at some of the trends in the use and financing of these facilities offering a better understanding of recent developments in this part of the healthcare system. Note that the data in this report represent totals for all facilities; individual facility trends may vary significantly. This trend report covers only three types of Long-Term Care settings: Skilled Nursing Facilities – Free-standing, Intermediate Care Facilities and Congregate Living Facilities.

What is Long-Term Care?

Long-term care (LTC) generally refers to a variety of health and human services programs for persons with physical, developmental or mental conditions who need care for an extended period of time.

According to the federal Web site on long-term care (www.longtermcare.gov), "Many people who need long-term care develop the need for care gradually. They may begin needing care only a few times a week or one or two times a day, for example, to help with bathing or dressing. Care needs often progress as they age or as their chronic illness or disability becomes more debilitating, causing them to need care on a more continual basis, for example help using the toilet or ongoing supervision because of a progressive condition such as Alzheimer's disease.

"Some people need long-term care in a facility for a relatively short period of time while they are recovering from a sudden illness or injury, and then may be able to be cared for at home. Others may need long-term care services on an on-going basis, for example someone who is disabled from a severe stroke. Some people may need to move to a nursing home or other type of facility-based setting for more extensive care or supervision if their needs can no longer be met at home."

Long-term care services can be delivered in a variety of settings ranging from private residences to certain outpatient or day care facilities to residential care homes and ultimately to skilled nursing facilities. The following is a partial list of LTC facilities and services:

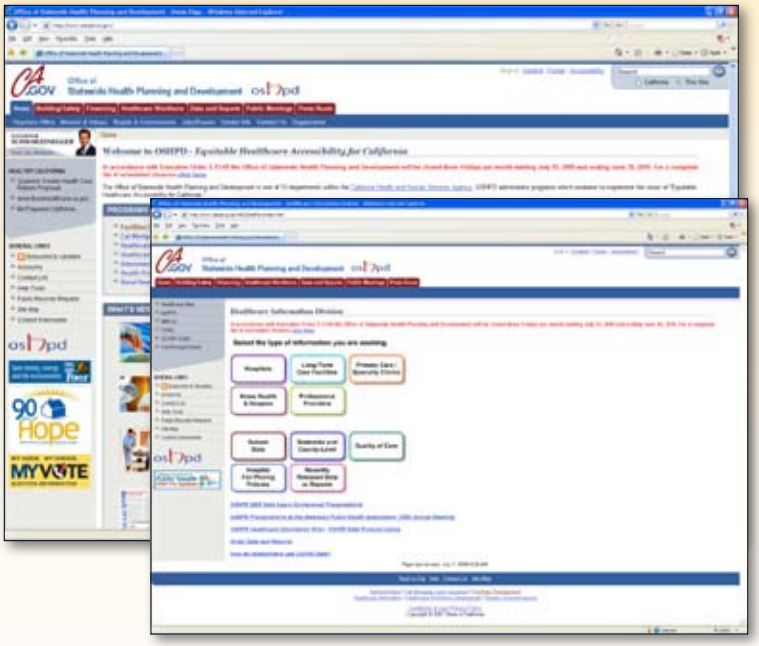
- Skilled Nursing Facilities – Freestanding *
- Intermediate Care Facilities *
- Congregate Living Facilities *
- Distinct Part Skilled Nursing Units in General Acute Care Hospitals (Not Freestanding)
- Residential Care Facilities
- Continuing Care Retirement Communities
- Home Health Care Agencies
- Hospice Services
- Adult Day Health Care
- Adult Day Care
- Palliative Care
- In-Home Supportive Services

This trend report covers only those types of LTC facilities indicated above by an asterisk (*).

More information describing LTC facilities can be found at: www.calnhs.org

Licensing and regulatory enforcement information is available through the Health Facilities Consumer Information System (HFCIS) developed and maintained by the California Department of Public Health at: http://hfcis.cdph.ca.gov/

Additional information on nursing home quality is available through the recently released federal Medicare Nursing Home Compare Web site at: www.medicare.gov/NHcompare/



What is the role of OSHPD?

The Office of Statewide Health Planning and Development (OSHPD) plays an important role in the public oversight of a portion of long-term care in California. It collects, reports and publishes Annual Utilization and Annual Financial Disclosure data on the following LTC facilities licensed by the California Department of Public Health:

Skilled Nursing Facility (Freestanding)

A nursing facility with the staff and equipment to provide a level of care that includes services that can only be performed safely and correctly by either a registered nurse or a licensed vocational nurse.

Intermediate Care Facility

A health facility that provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require availability of continuous skilled nursing care.

Intermediate Care Facility/Developmentally Disabled

A facility that provides 24-hour personal care, habilitation, developmental, and supportive health services for persons with developmental disabilities whose primary need is for developmental services and who have a recurring but intermittent need for skilled nursing services.

Congregate Living Health Facility

A residential home with a capacity of no more than 12 beds that provides inpatient care, including the following basic services: medical supervision, 24-hour skilled nursing and supportive care, pharmacy, dietary, social, recreational, and services for persons who are mentally alert, have a physical disability and may be ventilator dependent, or who have a diagnosis of terminal illness, a diagnosis of a life-threatening illness, or both, or who are catastrophically and severely disabled. This care is generally less intense than that provided in general acute care hospitals, but more intense than that provided in skilled nursing facilities.

"Women have long outnumbered men in LTC facilities…in part because they out live men…gains in female longevity continue to outpace those of males in several industrialized nations."

ANNUAL UTILIZATION DATA

What are the sources of utilization data?

Every licensed LTC facility noted on page 3 is required by law to report the following information to OSHPD each year:

- Facility and corporate contact information
- Ownership/control information
- Whether or not it is certified to accept Medicare and/or Medi-Cal patients
- Number of patients at the beginning and end of the report period, along with the number of admissions and discharges that occurred during the report period
- Number of patient days of service provided
- Number of discharges by how long the patient stayed (11 groupings)
- Where patients came from (source of admission) and where they went (destination of discharge)
- Number of patients on December 31 by age, sex, race, ethnicity and source of payment
- Existence of a hospice program or programs for AIDS or AIDS/HIV-related conditions or a specialized program for Alzheimer's patients
- Whether or not the facility purchased any diagnostic or therapeutic equipment in excess of $500,000 or commenced any building projects in excess of $1,000,000 during the report period

How do we use the utilization data?

This information has been reported for more than 30 years. It was initially designed to be used by OSHPD in planning for and managing the addition or expansion of health facilities and services (in order to control healthcare costs while promoting access). While the utilization data is no longer used for facilities planning purposes, it continues to be used by the public and by researchers, policymakers, industry analysts and others interested in the status of these selected long-term care resources in California.

ANNUAL FINANCIAL DISCLOSURE DATA

What are the sources of the financial data?

Every licensed LTC facility noted on page 3 is required by law to report the following information to OSHPD each year:

- A balance sheet detailing the assets, liabilities, and net worth of the health facility at the end of its fiscal year
- A statement of income, expenses, and operating surplus or deficit for the annual fiscal period, and a statement of ancillary utilization and patient census
- A statement detailing patient revenue by payer, including, but not limited to, Medicare, Medi-Cal, and other payers
- A statement of cash flows, including, but not limited to, ongoing and new capital expenditures and depreciation

These new Excel® files can be downloaded at:
http://www.oshpd.ca.gov/HID/DataFlow/LTCData.html
What do the data tell us?
What services are out there?

More information about residential care facilities for the elderly can be found at: http://ccld.ca.gov

How do we use the financial data?

This information has been reported for more than 30 years and is used to set Medi-Cal reimbursement rates for long-term care facilities. The data are also made available by OSHPD for use by the public, and by researchers, policymakers, industry analysts and others interested in the status of these selected long-term care resources in California.

Figure 1

Date Prepared: 8/25/2009

Long Term Care Utilization Profile Report - 2006

Excludes State, Not in Operation Facilities, & Facilities that did not file Report data

FACILITY DESCRIPTION (Individual Facility Information will appear only if one Facility is selected)

No. LTC Locations	1,106	Report Period Begin Date	(All)
OSHPD Facility No.	(All)	Report Period End Date	(All)
Facility Name	**(All)**	Medicare Certified SNF	(All)
		Medi-Cal Certified SNF	(All)
Address	(All)	Hospice Program	(All)
City	(All)	Alzheimer program	(All)
State	(All)	Health Service Area (HSA)	(All)
ZIP code	(All)	MSSA Designation	(All)
County	(All)	Federal Congressional District	(All)
Licensed Bed Size Range	(All)	State Senate District	(All)
Licensed Bed Size	(All)	State Assembly District	(All)
Type of Control	(All)	In Operation during current year	Yes
License Type	(All)	Non-Responders	No
		State-Owned Facilities	No

CENSUS AND UTILIZATION Licensed Bed Classification r Designation	Licensed Beds	Licensed Bed Days	2006 Patient Days	Patient Census December 31 of Prior Year	+ Facility Admissions	- Facility Discharges	Patient Cens December 3 of Report Ye
Skilled Nursing	101,412	36,993,271	31,985,981	87,862	266,689	267,315	87,236
Skilled Nursing Mentally Disordered	2,248	820,520	811,713	2,177	4,265	4,283	2,159
Intermediate Care	857	337,763	258,939	759	334	420	673
Intermediate Care Developmentally Disabled	978	356,970	317,811	886	114	138	862
Congregate Living Health Facility	348	121,592	91,602	261	2,031	2,046	246
Facility Total	105,843	38,630,116	33,466,046	91,945	273,433	274,202	91,176

Patients Admitted From and Discharged To	**Admitted From**	**Discharged To**
Home	15,620	102,451
Hospital	237,188	102,022
State Hospital	1,875	1,032
Other LTC	8,940	10,187
Residential Board & Care*	4,395	16,930
Other	5,415	2,684
AWOL / AMA		3,027
Death		35,869
Facility Total	**273,433**	**274,202**

Patients by Payment Source on December 31 of Report Year	
Medicare	10,408
Medi-Cal	59,752
Managed Care**	4,482
Private Insurance	2,480
Self-Pay	10,442
All Other	3,612
Total	91,176

Discharges by Length of Stay	
Less than 2 weeks	93,620
2 weeks to less than 1 month	66,449
1 month to less than 3 months	55,317
3 months to less than 7 months	23,144
7 months to less than 1 year	12,961
1 year to less than 2 years	9,957
2 year to less than 2 years	5,344
3 year to less than 5 years	4,263
5 year to less than 7 years	1,865
7 year to less than 10 years	897
10 years or longer	385
Total	274,202

Special Programs	
AIDS or HIV Patients	586
Alzheimer's Patients	13,649

*Includes RCFE, ARF, Other Assisted Living Facilities, or a secured facility such as an Alzheimer's unit, jail or prison. ** Includes patients enrolled in Medicare and Medi-Cal manage care health plans.

Source: OSHPD Annual Utilization Report of LTC Facilities, 2006 1 of 4 LTC_Utilization_Pivot06.xls

Table 1: Licensed LTC Facilities

	2003	2004	2005	2006	2007
Skilled Nursing	1,132	1,164	1,138	1,152	1,151
Intermediate Care Facility	9	8	8	7	7
Intermediate Care/DD	13	13	13	12	12
Congregate Living Health Facility	30	35	36	42	44
Total	1,184	1,220	1,195	1,213	1,215

Table 2: Licensed LTC Facility Beds
(includes only submitted reports)

	2003	2004	2005	2006	2007
Skilled Nursing	101,021	106,427	99,838	102,855	101,918
Skilled Nursing/MD	2,524	2,487	2,726	2,865	2,310
Intermediate Care	1,334	1,362	1,140	1,037	958
Intermediate Care/DD	1,158	1,158	944	1,099	1,118
Congregate Living Health Facility	240	298	317	353	377
Total	106,277	111,732	104,965	108,209	106,681

How do we display the data?

Although originally the data were available only in printed form, over time the data became available in electronic format. In recent years, the data have been placed into Microsoft Excel® workbooks and a special Excel® feature called a pivot table was employed. Pivot tables allow users to easily create pre-formatted reports for specific facilities or groups of facilities. However, until recently the data in the workbooks have covered only a single year so in order to look at trends over time users had to gather and merge multiple years' worth of data. In response, OSHPD created a series of tables and charts displaying statewide trend data covering several years. These publications, available on the OSHPD Web site, were static and could not be manipulated to display trends for individual facilities or groupings. The latest trend publications not only include static tables and charts, but also include new Excel® workbooks with a pivot table and pivot charts allowing the examination of trends by facility or groupings of facilities.

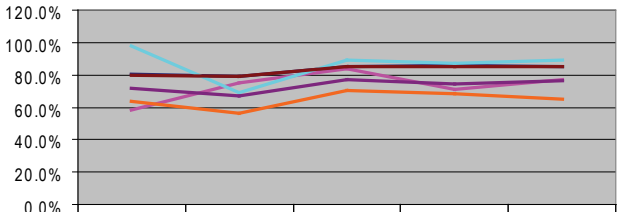
What do we learn from the data?

The overall number of skilled nursing, intermediate care and congregate living health facilities in California (Table 1) has remained relatively unchanged over the past several years and has declined from a high of 1,260 in 1997, a reduction of about 3.6%. The number of beds (Table 2) and occupancy rates (Table 3) have similarly declined.

"Other factors that could be contributing to the decline in use of facilities and beds include such things as the overall improved health of the aging population...and the availability of more services such as Adult Day Health Care centers allowing seniors to 'age-in-place'..."

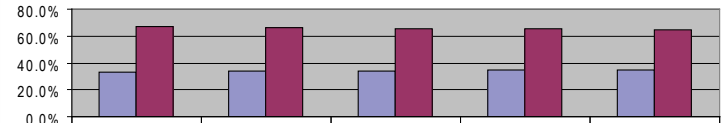
One statistic that is particularly telling is the decline in intermediate care beds. In 1992, these beds totaled more than 2,500, while today they number 958 (see Table 2). This decline could be due in large part to the increased use of residential care facilities for the elderly. These facilities are often referred to as assisted living facilities and are licensed by the California Department of Social Services to provide care, supervision and assistance with activities of daily living, such as bathing and grooming. They may also provide incidental medical services under special care plans. It is safe to say that a typical patient in an intermediate care facility in 1992 would most likely be a resident in an assisted living facility today. The difference between intermediate and residential care is the need for direct nursing care, something not provided in residential care facilities. With the exception of intermediate care facilities for the developmentally disabled, the need for intermediate care facilities has simply declined.

Table 3: LTC Facility Occupancy Rate



	2003	2004	2005	2006	2007
Skilled Nursing	80.5%	79.3%	85.3%	85.8%	85.2%
Skilled Nursing / MD	58.7%	74.8%	83.9%	71.2%	77.1%
Intermediate Care	63.7%	56.3%	70.2%	68.2%	65.1%
Interm Care / DD	97.6%	69.0%	89.1%	87.1%	89.0%
CLHF	71.7%	67.0%	77.1%	74.2%	76.7%
Statewide Average	80.0%	78.9%	85.2%	85.2%	84.9%

Table 4: Patients by Gender (12/31)



	2003	2004	2005	2006	2007
Male	33.2%	33.5%	34.2%	34.6%	35.0%
Female	66.8%	66.5%	65.8%	65.4%	65.0%

Other factors that could be contributing to the decline in use of facilities and beds include such things as the overall improved health of the aging population, the decline in reimbursement for these services and the availability of more services such as Adult Day Health Care centers allowing seniors to "age-in-place" and delay or even avoid institutionalization. Finally, baby boomers (persons born between 1946 and 1964) are now between 45 and 63 years of age and have yet to reach the point in their lives (ages 75-94) where they may need LTC services. Over the next two decades we may start to see an increased demand for LTC services. Whether or not that demand will include the need for institutional care will depend on alternatives to institutionalization and also on the overall health of baby boomers at that time. Declines in population risk factors such as smoking, high blood pressure and obesity, as well as advances in treatment for chronic conditions like diabetes could have a significant effect.

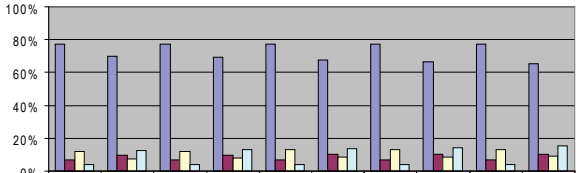
Who is using LTCs ?

GENDER - Women have long outnumbered men in LTC facilities, as shown in Table 4, in part because they outlive men. There are many theories about why this is so, including genetic and behavioral factors; nevertheless, gains in female longevity continue to outpace those of males in several industrialized nations. We can expect this nearly 2 to 1 ratio to continue for the foreseeable future.

More information about residential care facilities for the elderly can be found at: http://ccld.ca.gov

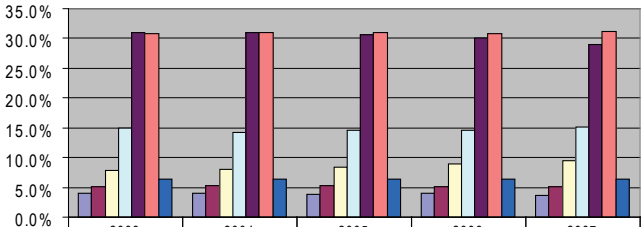
More information on the subject of developmental disabilities is available through the California Department of Developmental Disabilities Fact Book at: http://www.dds.ca.gov/FactsStats/Factbooks.cfm

Table 5: Patient Racial Mix Compared to California Population



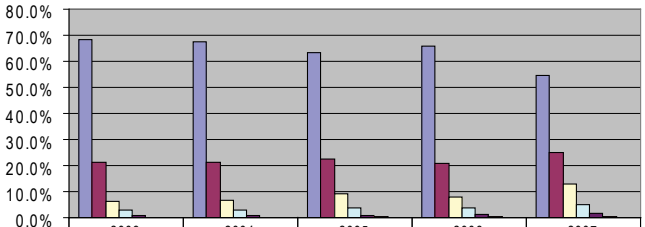
	Pop 2003	Patients 2003	Pop 2004	Patients 2004	Pop 2005	Patients 2005	Pop 2006	Patients 2006	Pop 2007	Pop 2007
White	77%	70%	77%	69%	77%	68%	77%	67%	77%	65%
Black	7%	10%	7%	10%	7%	10%	7%	10%	7%	10%
Asian / Pacific Islander	12%	7%	12%	8%	13%	8%	13%	9%	13%	9%
Native Am / Other / Unknown	4%	13%	4%	13%	4%	14%	4%	14%	4%	15%

Table 6: Patients by Age Group (12/31)



	2003	2004	2005	2006	2007
Less than 45 years	4.0%	4.0%	3.9%	4.0%	3.7%
45 to 54 years	5.1%	5.3%	5.2%	5.2%	5.1%
55 to 64 years	7.8%	8.1%	8.4%	8.9%	9.4%
65 to 74 years	14.9%	14.3%	14.5%	14.6%	15.2%
75 to 84 years	31.0%	31.0%	30.7%	30.1%	29.0%
85 to 94 years	30.9%	31.0%	30.9%	30.8%	31.2%
95 years or older	6.4%	6.4%	6.4%	6.4%	6.4%

Table 7: Patients by Age Group (12/31) Intermediate Care Facilities for the Developmentally Disabled



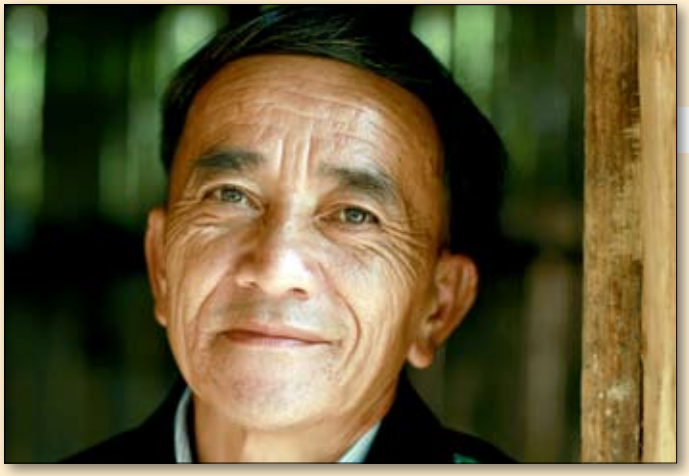
	2003	2004	2005	2006	2007
Less than 45 years	68.4%	67.7%	63.3%	65.9%	54.5%
45 to 54 years	21.4%	21.2%	22.5%	20.7%	25.1%
55 to 64 years	6.2%	6.8%	9.3%	8.0%	13.1%
65 to 74 years	3.0%	3.1%	3.6%	3.9%	5.1%
75 to 84 years	1.0%	1.0%	1.0%	1.1%	1.8%
85 to 94 years	0.1%	0.2%	0.4%	0.3%	0.4%
95 years or older	0.0%	0.0%	0.0%	0.0%	0.0%

RACE - The racial makeup of LTC patients generally follows the racial mix of California's population, with some notable exceptions (Table 5). There is a greater percentage of Black patients in facilities than in the general population. This also appears to be the case for the Native American/Other/Unknown category. At the same time, there are disproportionately fewer Asian/Pacific Islander patients in LTC facilities than in the general population. Unfortunately, without more detailed socio-demographic and clinical information few conclusions can be drawn.

AGE - As expected, the vast majority of LTC patients (83%) are elderly (65 years and older) and of those, most are over 75 (Table 6). The overall LTC age mix has changed little over time. However, a closer look at Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) reveals a different picture. Table 7 shows that the vast majority of patients are under 55 and of that group nearly two-thirds are under 45. It is interesting to note, however, that the percentage of ICF-DD patients in the 55 to 64 age group has more than doubled during the trend period while the under 45 age group has declined by 20%. Further study with more detailed information is required to explain the reasons for these trends.

Who pays for care?

Long-term care facilities collect revenue from three main sources – Medi-Cal, Medicare and patients who are financially responsible for their own care (i.e., not covered by insurance or



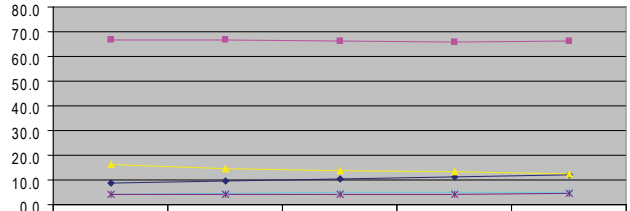
"Medicare provides 28% of the revenue, but it accounts for only 12% of the patient days; whereas Medi-Cal accounts for nearly two-thirds of the days but provides only about half of the revenue."

a government program). A small percentage of revenue also comes from managed care plans.

There are two ways to look at who is paying. The first is by patient. Table 8 shows that Medicare patients comprised 11.9% of all LTC patient days in 2007; this share has been steadily growing over the years. The other way is by payer. Table 9 shows Medicare provided 28% of all LTC revenue in 2007, up from 22.3% in 2003. Managed Care has also increased, but comprises a much smaller share. At the same time, self-pay has been decreasing both in terms of days and revenue, while Medi-Cal's share has remained relatively flat.

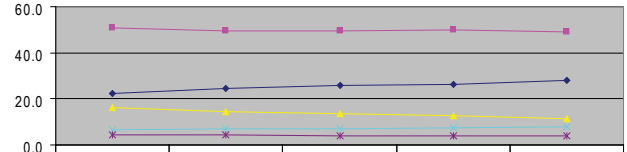
As Table 9 indicates, Medicare provides 28% of the revenue, but accounts for only 12% of the patient days; whereas Medi-Cal accounts for nearly two-thirds of the days but provides only about half of the revenue. The reasons for this disproportion require some explanation.

Table 8: Percent Days by Payer



	2003	2004	2005	2006	2007
Medicare	8.8	9.7	10.5	11.4	11.9
Medi-Cal	66.6	66.7	66.3	65.8	66.3
Self Pay	16.1	14.7	13.9	13.4	12.3
Managed Care	4.2	4.6	4.9	5.2	5.1
Other	4.3	4.3	4.3	4.3	4.5

Table 9: Percent Net Revenue by Payer



	2003	2004	2005	2006	2007
Medicare	22.3	24.4	25.8	26.2	27.9
Medi-Cal	50.6	49.6	49.3	49.9	49.2
Self Pay	16.2	14.6	13.7	12.5	11.2
Managed Care	6.7	7.1	7.1	7.4	7.7
Other	4.2	4.3	4.1	4.0	4.1

Medicare does pay more per patient day than Medi-Cal ($227 versus $185 in 2007) but for fewer patients and for shorter periods of time. Medicare only pays for long-term care after a qualifying hospital stay and then 100% for only the first 20 days. For the next 80 days Medicare pays all but the daily coinsurance (which can be paid by Medi-Cal if a patient qualifies). After 100 days per year, Medicare stops paying. So why is Medicare's share of LTC revenue so high? It is because Medicare Part B coverage pays for ancillary services for Medi-Cal, self pay and other patients who qualify for Medicare benefits. These services include such things as laboratory and diagnostic tests, physical therapy, durable medical equipment and oxygen. So while Medicare LTC patients are fewer, Medicare pays for a great deal of care to non-Medicare patients.

What is being paid?

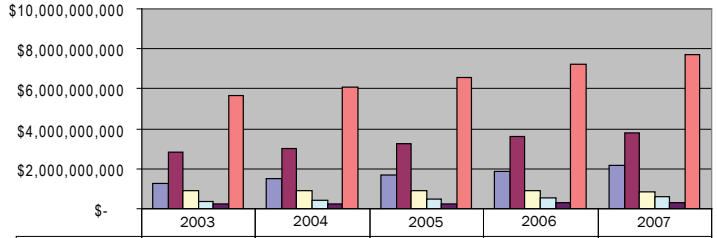
Net revenue does not result from what a facility charges (gross revenue), but from what it actually receives from each payer. For example, a facility may charge $190 for a day of care but may receive only $185 from a particular payer. The net revenue in this case would be $185.

The total net revenue for long-term care facilities in California has been increasing at an average annual rate of about 8.2% each year from 2003 to 2007 (Table 10). In comparison, acute hospital net operating

More information on Medicare coverage of LTC can be found at:
http://www.medicare.gov/LongTermCare/Static/Home.asp

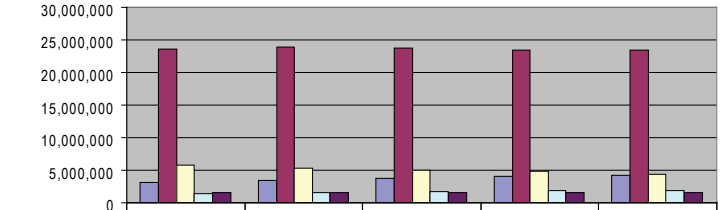
More information on Medi-Cal and LTC services can be found at:
http://www.dhcs.ca.gov/SERVICES

Table 10: Net Revenue by Payer



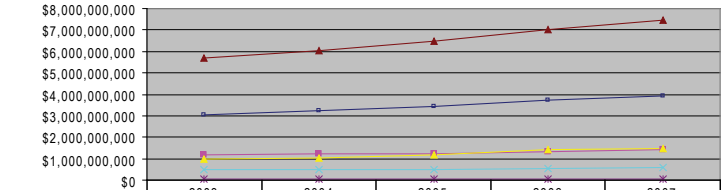
	2003	2004	2005	2006	2007
Medicare	$1,255,725,490	$1,485,849,947	$1,687,868,251	$1,890,031,354	$2,153,566,632
Medi-Cal	$2,851,660,442	$3,019,587,450	$3,223,558,937	$3,606,509,325	$3,790,583,118
Self Pay	$912,198,054	$890,139,544	$897,786,798	$902,960,890	$861,179,512
Managed Care	$379,529,383	$433,563,300	$467,340,886	$533,556,282	$590,652,703
Other	$235,703,507	$260,064,695	$268,053,309	$288,853,457	$314,207,521
Total	$5,634,816,876	$6,089,204,936	$6,544,608,181	$7,221,911,308	$7,710,189,486

Table 11: Patient Days by Payer



	2003	2004	2005	2006	2007
Medicare	3,132,908	3,500,490	3,771,985	4,049,552	4,209,873
Medi-Cal	23,627,033	23,952,345	23,717,923	23,442,252	23,476,046
Self Pay	5,732,147	5,262,185	4,966,470	4,772,299	4,343,721
Managed Care	1,477,719	1,639,940	1,762,255	1,837,199	1,800,855
Other Payer	1,528,162	1,555,306	1,555,106	1,520,539	1,587,610

Table 12: Expenses by Type



	2003	2004	2005	2006	2007
Direct Care	$3,037,541,515	$3,254,963,246	$3,448,413,347	$3,706,266,284	$3,948,523,484
Support Services	$1,171,398,863	$1,214,214,822	$1,251,071,253	$1,325,705,423	$1,403,747,870
Administration	$966,612,039	$1,026,007,611	$1,198,113,681	$1,401,146,560	$1,476,785,807
Property	$472,369,024	$486,833,123	$512,049,099	$532,708,694	$569,056,068
Other	$49,226,407	$48,170,938	$47,011,167	$62,982,970	$71,232,603
Total	$5,697,147,848	$6,030,189,740	$6,456,658,547	$7,028,809,931	$7,469,345,832

revenue increased at an average annual rate of about 7.1% each year for the same period.

Because total LTC patient days during the same period have generally remained level, (Table 11) it means the increase in net revenue for LTC facilities comes from increased reimbursements from payers.

MEDI-CAL REIMBURSEMENT

In 2004 the California Legislature passed and the Governor signed Assembly Bill (AB) 1629 which included a provision titled the Medi-Cal Long-Term Care Reimbursement Act. The bill changed the way Medi-Cal pays nursing homes to a facility-specific, cost-based system resulting in increased rates. The Legislature's expressed intent in doing this was to devise a method of Medi-Cal long-term care reimbursement that "more effectively ensures individual access to appropriate long-term care services, promotes quality resident care, advances decent wages and benefits for nursing home workers, supports provider compliance with all applicable State and Federal requirements, and encourages administrative efficiency" (Section 14126.02 of the Welfare and Institutions Code).

Since Medi-Cal patient days are the largest share of total patient days (over 66% in 2007) (Table 11), this change in Medi-Cal reimbursements had a significant impact on LTC revenues.

What is being spent?

Total expenses increased by an average annual rate of 7% from 2003 to 2007 (Table 12). A driving factor behind this increase has been a 6.8% average annual increase in direct care expenses which comprise more than 50% of total expenses (Table 12).

"Employee turnover can have a significant effect on quality of care since the longer employees remain on the job the better they become at performing their duties. They begin to understand unique patient needs and develop valuable skills."

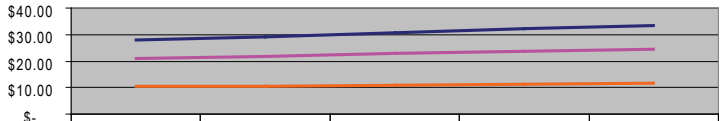
A closer examination reveals that while direct care expenses increased on average 6.8% per year from 2003 to 2007, the salaries of direct care staff in LTC facilities also increased during the same period. On average the salaries for registered nurses increased by 4.5%, licensed vocational nurses by 4.0% and nurse assistants by 2.9% (Table 13). This means that overall hours of direct care must have increased, a finding that is confirmed in Table 14, which shows a 1.8% increase in hours from 2003 to 2007.

Another factor revealed in the data is employee turnover, or the average number of times an employee is replaced during the period. This is expressed as a percentage and is calculated by dividing the total number of people employed during the period by the average number of employees, multiplying the result by 100 and then subtracting 100. Table 15 shows a decline in turnover since 2003 with an overall drop of between 8 and 9 percent for nursing staff. Employee turnover can have a significant effect on quality of care since the longer employees remain on the job the better they become at performing their duties. They begin to understand unique patient needs and develop valuable skills.

What's the effect on the bottom line?

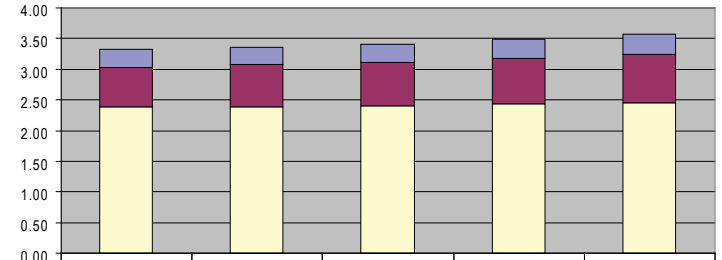
LTC patient revenues are up and so are expenditures. Subtract expenditures (Table 12) from revenues (Table 10) and the resulting net income is up as well, as shown in Table 16. This is often referred to as the operating margin or patient care bottom line and can be expressed

Table 13: Nursing Hourly Rates



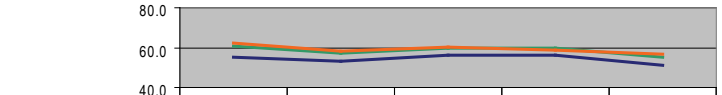
	2003	2004	2005	2006	2007
RN	$27.89	$29.09	$30.73	$32.26	$33.30
LVN	$20.85	$21.82	$22.79	$23.75	$24.47
NA	$10.48	$10.63	$10.88	$11.35	$11.76

Table 14: Nursing Hours per Day



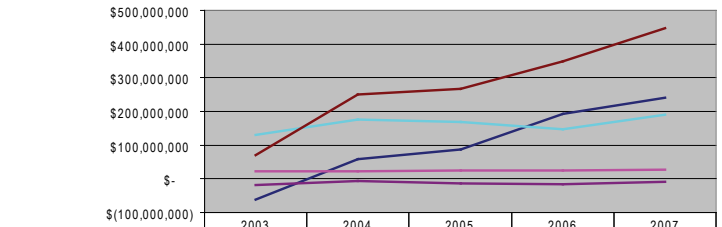
	2003	2004	2005	2006	2007
RN	0.30	0.29	0.30	0.31	0.32
LVN	0.65	0.68	0.71	0.75	0.80
NA	2.38	2.39	2.40	2.43	2.45

Table 15: Employee Turnover Percentages



	2003	2004	2005	2006	2007
Total Employees	55.4	53.1	56.1	56.3	51.3
Nursing Employees	60.7	57.4	59.6	60.0	55.4
Nurse Assistants	62.2	58.0	60.5	58.8	56.6

Table 16: Bottom Line (s)



	2003	2004	2005	2006	2007
Net from Patient Care	$(62,330,972)	$59,015,196	$87,949,634	$193,101,377	$240,843,654
Other Operating Revenue	$21,975,605	$23,008,212	$24,778,404	$24,275,954	$26,028,022
Net of Non-Patient Rev & Exp	$129,416,388	$175,337,967	$168,796,941	$148,027,367	$190,238,780
Income Taxes & Other	$(18,840,396)	$(6,252,014)	$(14,718,766)	$(16,121,744)	$(9,251,610)
Net Income (Bottom Line)	$70,220,625	$251,109,361	$266,806,213	$349,282,954	$447,858,846
Operating Margin	-0.71%	1.34%	1.72%	2.98%	3.45%

More information regarding the stakeholder workgroup can be found at:
http://www.dhcs.ca.gov/services/medi-cal/Pages/SNFQualityWorkgroup.aspx

The long-term care data used in this report may be examined in more detail at:
http://www.oshpd.ca.gov/HID/DataFlow/LTCMain.html

as a percentage. In 2007 the margin was 3.45%, up from a negative 0.71% in 2003, an increase directly attributable to enhanced Medi-Cal reimbursements from AB 1629. LTC facilities also have other sources of revenue generated by healthcare operations, but not from patient care services (Other Operating Revenue – Table 16). Examples include non-patient food sales, refunds and rebates, and supplies sold to non-patients. Facilities also have revenues and expenses not directly related to patient services. For the most part, these revenues come from providing residential care in facilities that have multiple levels of care. The net of these amounts totaled $190M in 2007, an increase of 10.1% per year on average since 2003.

Taking all this into consideration and including taxes and other miscellaneous items, the net income or "bottom line" has risen from $70M in 2003 to almost $448M in 2007. Most of that increase (80%) came from increases in the net from patient care.

In 2008 the Legislature enacted and the Governor signed AB 1183. The bill extended the way Medi-Cal pays nursing homes under AB 1629 through July 31, 2011. It also created a stakeholder workgroup to make recommendations to the Department of Health Care Services to ensure compliance with the intent of AB 1629. The workgroup uses a variety of data and information, including OSHPD's LTC data, to meet its responsibilities, as set forth in Section 14126.034 of the Welfare and Institutions Code. The new law also requires the Department of Health Care Services to review and analyze all recommendations to see if they can be feasibly implemented and to deliver the recommendations and its analysis to the Legislature.

What does it all mean and what can we expect?

PATIENTS - All things being equal, one might expect that an increase in population would have a direct effect on the use of health services. In other words, if the population increases 5% we might expect to see the number of patient days in long-term care facilities increase by 5%. However, we did not. From 2003 to 2007 California's total population increased by almost 5% and the portion of the population aged 75 and above increased by almost 9.8%. Yet the total number of days that patients spent in long-term care facilities during that same period remained essentially unchanged (Table 11). As noted earlier, it could be that people who might have become patients in long-term healthcare facilities in years past are now becoming residents in long-term residential care facilities for the elderly. It could also be that many individuals are finding it easier to "age-in-place" with a wider array of medical treatments and support services now available.

As noted earlier, we may have to contend with the baby boomer segment of the population in about 10 years. In another 25 to 30 years we may have to contend with their offspring, a kind of rolling wave in population statistics. Will they all have the same need for long-term care services or will advancements in medical treatment combined with improvements in health status further reduce that need? Time will tell.

"From 2003 to 2007 California's total population increased by almost 5% and the portion of the population aged 75 and above increased by almost 9.8%. Yet the total number of days that patients spent in long-term care facilities during that same period remained essentially unchanged..."

Providing long-term care is not easy. Ask anyone who has cared for an aging parent or a physically or developmentally disabled person in their home. Moreover, when responsibility falls to a business such as a long-term care facility, issues of cost, quality and safety quickly become paramount.

The Office of Statewide Health Planning and Development will continue to gather essential financial and utilization data to support the efforts of the stakeholder workgroup and others engaged in monitoring and improving the delivery of long-term care services in California.

The long-term care data used in this report may be examined in more detail at:
http://www.oshpd.ca.gov/HID/DataFlow/LTCMain.html

For further information visit OSHPD's Web site at: **www.oshpd.ca.gov**

oshpd

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