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Charges for Care and Sources of Payment for Residents in Nursing Homes

United States: National Nursing Home Survey August 1973-April 1974

Data are presented on charges for care and sources of payment for nursing home residents in relation to certification, service, ownership, size, geographic region of the nursing home and age, sex, primary reason for admission, length of stay since current admission, primary source of payment, and health status of the resident. Health status was measured by primary diagnosis at last examination, reported chronic conditions and impairments, number of chronic conditions, and level of patient care received. Data on charges and sources of payment for 1973-74 are compared with those for 1964 and 1969 to examine changes during the 10-year period.

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CHARGES FOR CARE AND SOURCES OF PAYMENT FOR RESIDENTS IN NURSING HOMES

Esther Hing, *Division of Health Resources Utilization Statistics*

INTRODUCTION

SCOPE OF REPORT

This report presents an analysis of average total monthly charges and sources of payment for residents in nursing homes in the United States from August 1973 to April 1974. Included in the average total monthly charge were all charges for lodging, meals, nursing care, special services, drugs, and special medical supplies. Charges were analyzed in relation to certain characteristics of the nursing home (certification, service, ownership, size, and geographic region) and certain characteristics of the resident (age, sex, length of stay since current admission, primary reason for admission, primary source of payment, and health status). Health status was measured by primary diagnosis at last examination, prevalence of selected chronic conditions, number of chronic conditions, and level of care received.

Special emphasis was placed on the analysis of average total monthly charge by primary source of payment to assess the impact that the Medicare and Medicaid programs had on charges for residents and patterns of utilization of nursing homes in 1973-74. In addition, 1973-74 data were compared with similar data from 1964 and 1969 surveys to examine trends that have occurred during the 10-year period.

BACKGROUND INFORMATION

Data presented in this report are based on the 1973-74 National Nursing Home Survey conducted by the Division of Health Resources Utilization Statistics. The survey was conducted from August 1973 to April 1974 in the conterminous United States in a sample of homes that provided some level of nursing care (i.e., nursing care homes and personal care homes with nursing). Homes that provided personal or custodial care at the time the sample was drawn are not included, even if they subsequently began to provide nursing care to residents. Within each sampled home, subsamples of both residents and employees were selected to obtain detailed information about the population served and persons involved in direct care.

Reports based on data collected in the 1973-74 National Nursing Home Survey have been published about the operating and financial characteristics of the home,[1] social and demographic characteristics of the residents,[2] utilization of nursing homes,[3] the health status of residents,[4] and general characteristics of the home.[5]

Data on charges for care were collected for each sampled resident by asking the question, "Last month, what was the total charge for this resident's care, including all charges for special services, drugs, and special medical supplies?" (See question 25c of the Resident Questionnaire in appendix III.) Although most of the Resident Questionnaire was completed by interviewing the nurse who usually provided care for the resident, the charges for care usually were supplied by a bookkeeper or similar staff member who referred to billing records for the exact amount. Since the question asked for charges for

last month, charge data were not collected for 63,900 residents living in the home for less than a full month. In this report, charges are reported by the *total* figure for the resident's care last month (question 25c of the Resident Questionnaire) rather than by the *basic* charge last month (question 25b of the Resident Questionnaire) because, on the average, the basic charge for lodging, meals, and nursing care ($468) did not differ in a statistically significant amount from the total charge for care ($479). (Total charge included the basic charge plus any special charges for medical or nursing services, medical supplies or equipment, miscellaneous services or personal items.)

In calculating the average total monthly charge, the 9,600 residents with no-charge arrangements (e.g., residents of homes supported by religious or fraternal organizations who were not charged for care) and the 6,200 residents who had made an initial payment for lifetime care were included so that the figure for the total average monthly charge represented charges for all nursing home residents. Even though these residents usually did not pay a basic monthly fee for care, in some cases they were charged small amounts for miscellaneous or personal services such as laundry, television rental, beautician or barber visits, and personal items.

To examine trends over a 10-year period, average monthly charges for residents in the 1973-74 survey were compared with average monthly charges for residents in similar surveys conducted earlier by the National Center for Health Statistics in 1964[6] and 1969[7]. To permit a valid comparison of 1964, 1969, and 1973-74 data, average monthly charges were adjusted to exclude charges for the 35,300 residents in the 1964 survey and for the 35,600 residents in the 1969 survey who resided for at least 1 month in personal care homes. This adjustment was necessary because the 1973-74 survey excluded this type of facility. Average monthly charges for both 1964 and 1969 also included total charges for residents with life-care plans and residents with no-charge plans, just as in the 1973-74 survey data.

SOURCES AND QUALIFICATIONS OF DATA

A detailed description of the sampling frame, the sampling design, and the survey procedures used is presented in appendix I. Appendix I also includes imputation procedures and estimation techniques. Since the data in this report are national estimates based on a sample and are subject to sampling errors, tables and charts of standard errors and illustrations of their use are provided in appendix I.

Appendix II presents definitions of terms used in this report. Reference to the definitions in appendix II is essential to the interpretation of data in this report, particularly for definitions of certification, type of services provided, and level of care received by the resident. Appendix III presents the Resident Questionnaire used in the survey.

CHARGES FOR CARE

OVERVIEW

In 1973-74, there were 15,700 nursing homes in the United States providing some level of nursing care to 1,075,800 residents. Of the 1,012,000 residents who had been in a nursing home at least 1 month, 71 percent were female and 89 percent were 65 years of age or older. The median age was 81 years. Senility was the most frequently reported chronic condition (58 percent of these residents), and arthritis or rheumatism was reported as a chronic condition for 35 percent of the residents. The average number of chronic conditions per resident was 2.2. For 42 percent of these residents, the primary diagnosis at last examination involved diseases of the circulatory system.

The total monthly charge for residents in a facility at least 1 month ranged from $0 to over $800. These extreme charges were the exception, however, since only 1 percent of the residents paid nothing and 7 percent paid $800

or more. The average total monthly charge for residents was $479 per month, with about two-thirds of the residents paying less than $500 (table 1). In 1973-74, 60 percent of the residents used public funds in some form for primary payment—48 percent of the residents used Medicaid as the primary source of payment.

FACILITY CHARACTERISTICS

Certification

In 1966, the Medicare and Medicaid programs began to provide coverage for the elderly in nursing care institutions. In 1973-74, nearly 8 of every 10 (77 percent) facilities providing some level of nursing care in the United States were participating in either the Medicare or Medicaid program or in both.[1] Participating Medicare facilities, designated as extended care facilities (ECF's), provided inpatient skilled nursing care and related services to Medicare enrollees eligible for posthospital benefits. To be certified by the Medicare program, a facility had to meet specific regulatory standards as required by the Medicare legislation (Title XVIII of the Social Security Act) in effect at the time of the survey. The Medicaid program offered coverage for both skilled and intermediate nursing care services to the medically indigent. Nursing homes participating in the Medicaid program were certified as either skilled nursing homes (SNH's) or as intermediate care facilities (ICF's) or as both according to the requirements of the Medicaid legislation (Title XIX of the Social Security Act). In July 1973, the extended care facility designation under Medicare and the skilled nursing home designation under Medicaid were replaced by the term "skilled nursing facility." Both types of facilities were required to meet the same standards. In this report, the extended care facility and skilled nursing home designations are used since most of the survey was conducted prior to the legislation that created the skilled nursing facility.

Nearly 87 percent of all residents were in facilities certified by Medicare, Medicaid, or both (77 percent of all facilities). Proportionately more residents were in certified facilities because Medicare extended care facilities and Medicaid skilled nursing homes tended to be larger, on the average, than facilities with lower levels of certification.[1] Thirty-seven percent of the residents were in facilities certified to participate in both the Medicare and Medicaid programs and 50 percent were in facilities certified by Medicaid only (either as SNH's, ICF's, or as both).

In the remainder of this report, some small certification subgroups were combined with larger ones when both provided similar levels of care in order to provide detailed data by certification status. Thus, in table 1, the 372,300 residents of homes classified as certified by both Medicare and Medicaid include 20,900 residents who were in homes certified by Medicare only. Similarly, the 278,100 residents in homes classified as Medicaid skilled nursing homes included 122,900 residents who were in homes also certified as intermediate care facilities.

The average total monthly charges according to the four certification levels are presented in table A. Examination of these charges showed that as the level of certification increased (from not certified facilities, to ICF's, to SNF's, to facilities certified by both Medicare and Medicaid), the average total monthly charge increased. Residents in facilities not certified by either Medicare or Medicaid paid significantly lower charges per month ($329) than did those in ICF's ($376) and those in SNH's ($484). Residents in facilities certified by both Medicare and Medicaid paid the highest charge ($592) on the average. The increase in average charge by these certification levels was directly related to the care received or available in the home as required for Medicare and/or Medicaid certification. Based on data from the same survey, a previously published report on the utilization of nursing homes showed that as the certification level of the homes increased more staff was available to provide services.[3] Facilities certified by both Medicare and Medicaid and those certified by Medicaid as SNH's had more full-time equivalent staff per 100 residents than those certified as ICF's or those not certified had. In addition, a smaller proportion of not certified homes (64 percent) had the services of some member of the staff available round the

Table A. Average total monthly charge for care and percent distribution of residents, by certification, type of service provided, ownership, size, and geographic region of the home: United States, August 1973-April 1974

Certification, type of service provided, ownership, size, and geographic region	Average total monthly charge[1]	Percent distribution of residents
All homes[2]	$479	100.0
Certification		
Both Medicare and Medicaid[3]	592	36.8
SNH only[4]	484	27.5
ICF only	376	22.4
Not certified	329	13.3
Type of service provided		
Nursing care	495	64.8
Personal care with nursing	448	35.2
Ownership		
Proprietary	489	69.8
Nonprofit and government	456	30.2
Size		
Less than 50 beds	397	15.2
50-99 beds	448	34.1
100-199 beds	502	35.6
200 beds or more	576	15.1
Geographic region		
Northeast	651	22.0
North Central	433	34.6
South	410	26.0
West	454	17.4

[1]Includes life-care residents and no-charge residents.
[2]Includes only those residents who have lived in the nursing homes for at least a month.
[3]Includes 20,900 residents in facilities certified by *Medicare* only.
[4]Includes 122,900 residents in facilities certified by Medicaid as *both* SNH's and ICF's.

clock than homes certified by both Medicare and Medicaid (96 percent), SNH's (93 percent), or ICF's (88 percent) had. Furthermore, facilities with higher certification levels had a clientele that required more intensive nursing services (as opposed to personal services); a larger proportion of the residents in facilities certified by both Medicare and Medicaid were transferred to the home from a general or short-stay hospital (50 percent) than were residents in SNH's (33 percent), ICF's (22 percent), and homes not certified (17 percent).[3]

It should be noted that the lower average charge in not certified facilities was also related to the disproportionate number of residents in these facilities with either initial-payment/life-care plans or with no-charge arrangements. Of these residents who paid little or nothing, 63 percent resided in facilities that were not certified (table 1).

Type of Service Provided

Institutions included in the 1973-74 National Nursing Home Survey were those classified as either nursing care homes or personal care homes with nursing. The criteria used for these classifications constitute another indicator of the level of service provided. Basically, a nursing care home was defined as a home in which *50 percent or more* of the residents received nursing care during the week prior to the survey and in which at least one full-time registered nurse or licensed practical nurse was employed. A personal care home with nursing, on the other hand, was a facility in which *less than 50 percent* of the residents received nursing care (see appendix II for detailed definitions of nursing care and types of service provided). Thus, residents in nursing care homes were more likely to require intensive nursing care services than residents of personal care homes with nursing were. The intensity of services provided to residents of nursing care homes was reflected in the higher average total monthly charge that they paid ($495), compared with the amount that residents in homes providing personal care with nursing paid ($448) (table A). This finding is consistent with those of previous surveys conducted in 1964 and 1969.[6,7] Table 2 gives additional information on the distribution of charges by type of service provided.

Ownership

In 1973-74, most residents of nursing homes resided in proprietary facilities rather than in nonprofit or government facilities. About 70 percent of the residents lived in proprietary facilities, in contrast with 30 percent who lived in nonprofit or government facilities (table A).

Table B. Average total monthly charge for care and percent distribution of residents by certification, according to ownership, size, and geographic region of the home: United States, August 1973-April 1974

Ownership, size, and geographic region	All types of certification	Certification				All types of certification	Certification			
		Both Medicare and Medicaid[1]	SNH only[2]	ICF only	Not certified		Both Medicare and Medicaid[1]	SNH only[2]	ICF only	Not certified
	Average total monthly charge[3]					Percent distribution of residents[4]				
Ownership										
Proprietary	$489	$588	$483	$382	$353	100.0	40.4	25.9	23.1	10.6
Nonprofit and government	456	605	486	358	299	100.0	28.4	31.1	20.9	19.5
Size										
Less than 50 beds	397	537	482	378	316	100.0	11.0	18.7	41.7	28.5
50-99 beds	448	559	461	369	322	100.0	32.6	26.4	26.9	14.1
100-199 beds	502	592	473	377	310	100.0	47.4	29.2	15.8	7.6
200 beds or more	576	658	547	404	430	100.0	47.2	34.8	8.6	9.5
Geographic region										
Northeast	651	784	617	481	375	100.0	45.3	33.1	10.6	11.1
North Central	433	557	465	366	334	100.0	25.6	24.6	29.7	20.0
South	410	504	422	359	300	100.0	27.7	28.7	32.2	11.4
West	454	502	405	369	265	100.0	61.9	24.3	8.3	5.5

[1]Includes 20,900 residents in facilities certified by *Medicare* only.
[2]Includes 122,900 residents in facilities by Medicaid as *both* SNH's and ICF's.
[3]Includes life-care residents and no-charge residents.
[4]Includes only those residents who have lived in the nursing home for at least a month.

The average charge for residents of proprietary facilities ($489) was higher than that for residents of nonprofit or government facilities ($456).[a] The higher charge for residents of proprietary facilities was influenced by level of certification and by intensity of services available in these facilities. Table B shows that the proportion of residents in facilities certified by both Medicare and Medicaid was greater for proprietary facilities (40 percent of the residents) than for nonprofit and government facilities (28 percent). In addition, the proportion of residents receiving intensive nursing care tended to be greater in proprietary facilities (43 percent) than in nonprofit and government facilities (35 percent).

[a]This conclusion differs from that in a previous report on operating and financial characteristics of nursing homes[1] because the final standard errors used in the test of significance were more precise than the provisional standard errors used in that report.

Another factor that may have influenced charges was the disproportionate representation of residents paying low or no charges in nonprofit and government facilities. Fully 89 percent of the residents with either life-care or no-charge arrangements resided in nonprofit or government facilities (table 1).

Size

When examined in relation to the size of the facility, there was a direct relationship between the average total monthly charge and the size of the facility: the average charge increased from $397 for residents in facilities with less than 50 beds to $448 for those in facilities with 50-99 beds and to $502 for those in facilities with 100-199 beds. Residents in facilities with 200 beds or more paid the highest average charge ($576). The direct relationship between charges and size was probably related to the fact that larger facilities (100 beds or more) were more

likely to be certified by both Medicare and Medicaid.[1] Of the large facilities, those certified for Medicare or Medicaid provided care for nearly half (47 percent) of all nursing home residents (table B). Thus, the higher charges in larger homes were due, in part, to the expense of meeting the standards for staffing, construction, equipment, and provision of services required for Medicare and Medicaid certification.

Geographic Region

In 1973-74, the North Central Region had the largest proportion of nursing home residents (35 percent), followed by the South (26 percent), Northeast (22 percent), and West Regions (17 percent). When charges were compared by geographic region, residents in the Northeast paid a higher average total monthly charge than residents in the North Central, South, or West Regions did. The average charge in the Northeast was $651, compared with $454 in the West, $433 in the North Central, and $410 in the South (table A).

The substantially higher *cost* of providing care in the Northeast was a major factor in the higher charge for the residents in that region. According to a previous report on the operating and financial characteristics of nursing homes,[1] the average cost per resident day incurred by the facility in 1972 was $19.60 in the Northeast, compared with $15.62 in the West, $15.05 in the North Central, and $13.50 in the South. The primary reason for this difference was the higher cost for labor in the Northeast, which was 35 percent greater than in the next highest region. The higher charge in the Northeast also coincides with a high proportion (45 percent) of residents in homes certified by both Medicare and Medicaid. Further information on the distribution of charges by region are presented in table 3.

Summary

The preceding discussion noted that charges were highest in the Northeast Region and in proprietary facilities. Charges increased with the size of the facility and with increasing levels of certification (i.e., from not certified facilities to ICF's, to SNH's, to facilities certified by both Medicare and Medicaid). Figures 1-3 show that the major influence on the average total monthly charge for residents in 1973-74 was the certification level of the facility. Average charges increased with higher certification levels regardless of ownership (figure 1), size (figure 2), or region classification (figure 3). Within each certification level, in contrast, the differences in average charge by size, ownership, and for three of the four regions were not significant and generally could have resulted from sampling error. For example, in proprietary facilities, the average charge increased from $353 in not certified facilities to $588 in facilities certified by both Medicare and Medicaid. Similarly, in nonprofit or government facilities, the average charge increased from $299 in not certified facilities to $605 in facilities certified by both Medicare and Medicaid (figure 1). Among residents of facilities certified by both Medicare and Medicaid, however, the average charge paid by those in proprietary facilities ($588) did not differ from that paid in nonprofit or government facilities ($605). Among residents in each of the remaining certification groups, there also were no significant differences in charges by ownership. This pattern was also present when charges were examined by size. For each size class, charges increased with higher certification levels

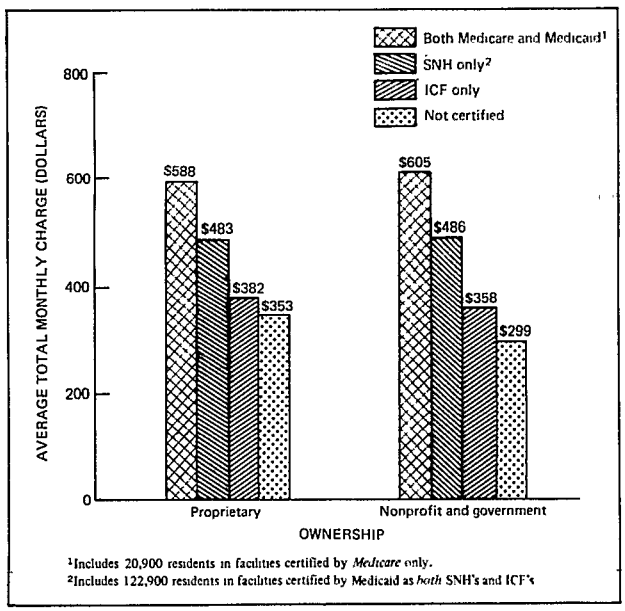
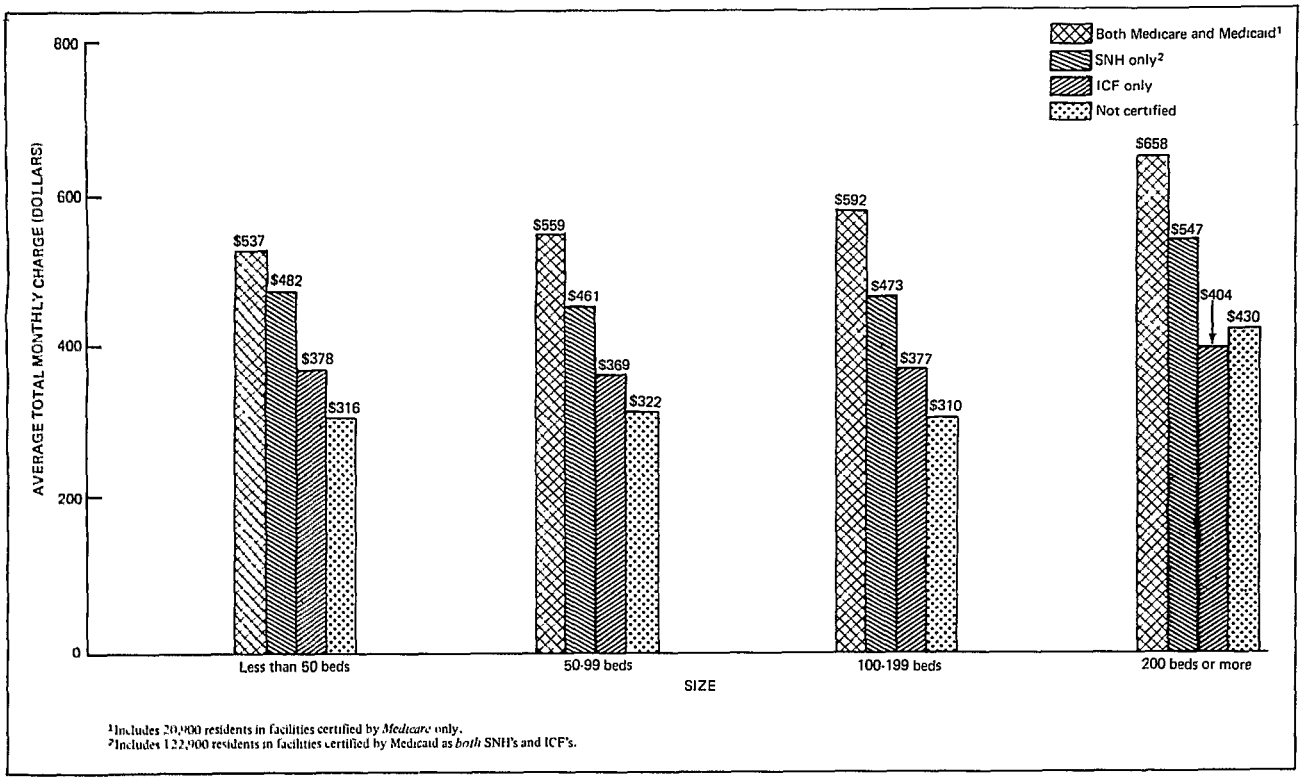
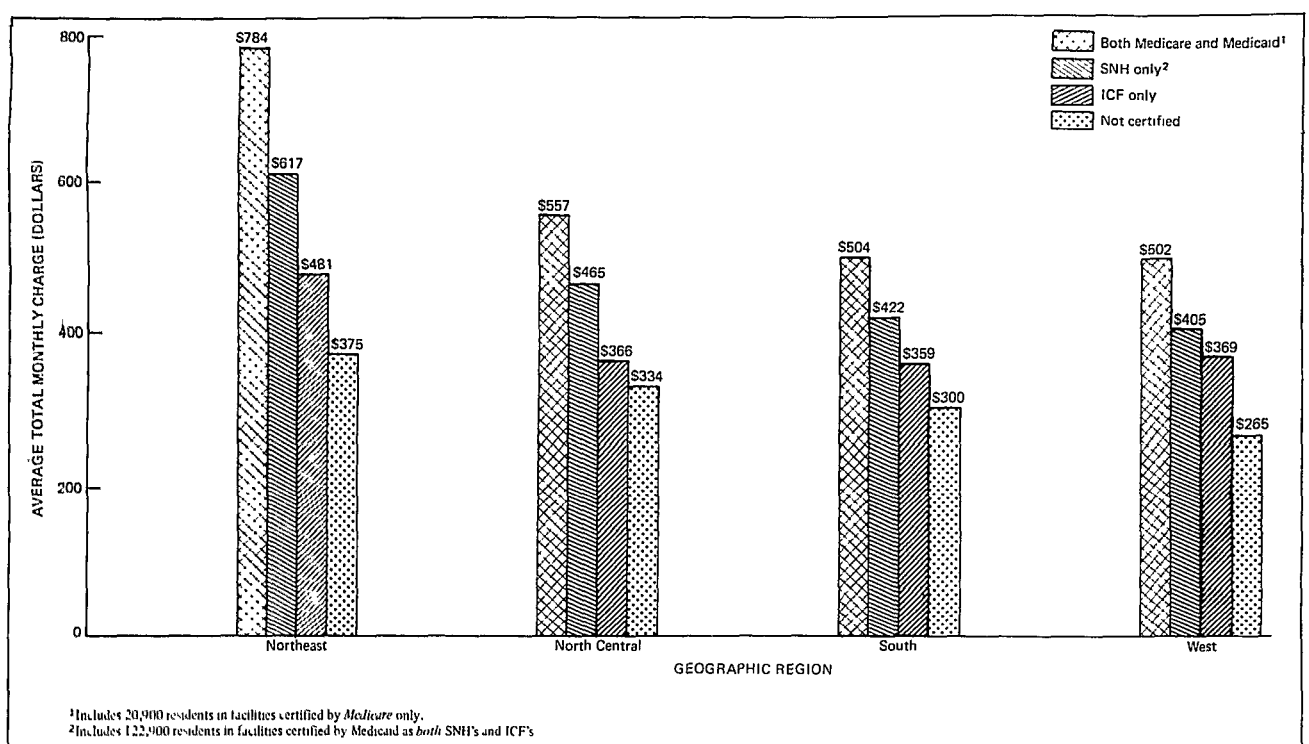


Figure 1. Average total monthly charge for care, by certification and ownership: United States, August 1973-April 1974



[1]Includes 20,900 residents in facilities certified by *Medicare* only.
[2]Includes 122,900 residents in facilities certified by Medicaid as *both* SNH's and ICF's.

Figure 2. Average total monthly charge for care, by certification and size: United States, August 1973-April 1974



[1]Includes 20,900 residents in facilities certified by *Medicare* only.
[2]Includes 122,900 residents in facilities certified by Medicaid as *both* SNH's and ICF's

Figure 3. Average total monthly charge for care, by certification and geographic region: United States, August 1973-April 1974

(figure 2), while within each certification level the differences in charges by size were not significant.

RESIDENT CHARACTERISTICS

Age and Sex

Residents in nursing homes were an aged population. Eighty-nine percent of those in the facility for at least 1 month were 65 years and over; the median age was 81 years. Seventy-one percent of the residents were female, and 29 percent were male.

Not only were there more females than males, but females also tended to be older than males. Ninety-two percent of the females were 65 years and over, compared with 83 percent of the males (tables C and 4). Furthermore, the median age for females, 82 years, was significantly higher than the median age for males, 78 years.

In general, residents who were under 65 years of age paid less ($434) than residents who were 65 years and older ($484). One reason for this lower charge for younger residents is that a smaller proportion (35 percent) of these residents received intensive nursing care than residents 65 years and older (41 percent) did (tables D and 5). No statistically significant difference existed between the average total monthly charge paid by males ($466) and that paid by females ($484) (table C). There also were no differences in average charge by age for each sex.

Primary Reason for Admission

The question on the primary reason for the resident's admission to the home had four possible responses: (1) physical reasons (e.g., illness or need for treatment); (2) social reasons (e.g., no family or lack of family interest); (3) behavioral reasons (e.g., disruptive behavior, mental deterioration; (4) economic reasons (e.g., no money and/or resources). (See question 7 of the Resident Questionnaire in appendix III.) The majority of the residents (81 percent) entered the home primarily for physical reasons. About 12 percent entered the home for behavioral reasons, 7 percent for social reasons, and 1 percent for economic reasons (tables E and 4).

Residents entering the home for physical reasons paid higher monthly charges ($499), on the average, than residents entering the home for any other reason. A major factor in this difference was the intensity of the care received. A greater proportion of those admitted for physical reasons received intensive nursing services (44 percent) than did residents admitted for behavioral reasons (30 percent), social reasons (18 percent), or economic reasons (24 percent).

Length of Stay Since Current Admission

The length of stay as defined in this report is the time interval between the resident's *current*

Table C. Average total monthly charge for care and percent distribution of residents by age, according to sex: United States, August 1973-April 1974

Age	Both sexes		Male		Female	
	Average total monthly charge[1]	Percent distribution of residents	Average total monthly charge[1]	Percent distribution of residents	Average total monthly charge[1]	Percent distribution of residents
All ages[2]	$479	100.0	$466	100.0	$484	100.0
Under 65 years	434	10.6	426	16.8	441	8.1
65-74 years	473	15.0	464	20.5	479	12.8
75-84 years	488	35.5	475	32.1	493	37.0
85 years and over	485	38.8	478	307	487	42.2

[1]Includes life-care residents and no-charge residents.
[2]Includes only those residents who have lived in the nursing home for at least a month.

Table D. Average total monthly charge for care and percent distribution of residents by level of care received, according to age: United States, August 1973-April 1974

Age	All levels	Level of care received				
		Intensive nursing care	Limited nursing care	Routine nursing care	Personal care	No nursing or personal care
	Average total monthly charge[1]					
All ages[2]	$479	$510	$480	$466	$435	$315
Under 65 years	434	491	421	421	381	*
65-74 years	473	508	492	454	432	*
75-84 years	488	517	486	476	447	*
85 years and over	485	509	485	473	451	*
	Percent distribution of residents					
All ages[2]	100.0	40.6	9.8	32.3	16.4	0.9
Under 65 years	100.0	34.8	9.2	30.2	24.9	*
65-74 years	100.0	36.2	11.2	34.0	17.5	*
75-84 years	100.0	40.6	10.2	33.3	14.9	1.0
85 years and over	100.0	44.0	9.0	31.5	15.0	0.7

[1]Includes life-care residents and no-charge residents.
[2]Includes only those residents who have lived in the nursing home for at least a month.

admission to the home and the day the survey was conducted (see question 5 of the Resident Questionnaire). Only 19 percent of the residents were in the home from 1 to 6 months, 51 percent were in the home for 6 months to 3 years, and 30 percent were in the home for 3 years or more (tables E and 4). The median length of stay for residents in the home at least 1 month was 1.6 years.

Table E shows that the longer a resident had been in the facility, the lower the average charge (for last month). The average charge for residents in the home from 1 to less than 3 months was $541. In contrast, the average charge for those in the home 5 years or more was $411. Two factors influenced this pattern. One was that facilities certified by both Medicare and Medicaid had a significantly larger percentage of short-term residents (less than 1 year) as a result of Medicare's provisions for coverage of only the first 100 days of care following hospitalization. Since these residents received skilled nursing or rehabilitative services on a *daily* basis, their care tended to be more expensive than for those

Table E. Average total monthly charge for care and percent distribution of residents, by primary reason for admission and length of stay since current admission: United States, August 1973-April 1974

Primary reason for admission and length of stay since current admission	Average total monthly charge[1]	Percent distribution of residents
All residents[2]	$479	100.0
Primary reason for admission		
Physical	499	80.6
Social	369	6.6
Behavioral	419	11.8
Economic	294	1.0
Length of stay since current admission		
1 to less than 6 months	530	19.0
1 to less than 3 months	541	8.9
3 to less than 6 months	520	10.2
6 to less than 12 months	501	15.6
1 to less than 3 years	479	35.3
3 to less than 5 years	459	14.8
5 years or more	411	15.2

[1]Includes life-care residents and no-charge residents.
[2]Includes only those residents who have lived in the nursing home for at least a month.

receiving personal or custodial care. In addition, residents with either initial-payment/life-care or no-charge arrangements tended to have longer lengths of stay. Of these residents, 44 percent were in the home 5 years or more compared with 15 percent of residents with other payment arrangements. Furthermore, the median length of stay for residents with life-care or no-charge arrangements (4.4 years) was significantly longer than the median length of stay for residents with other payment arrangements (1.6 years). The zero or low charges for residents with life-care or no-charge arrangements contributed to the association of lower charges with longer stays.

Primary Diagnosis at Last Examination and Reported Chronic Conditions

The average total monthly charge varied according to the primary diagnosis at last examination (see question 8 of the Resident Questionnaire—note that only one diagnosis was recorded for each resident). Charges ranged from a low of $406 for residents with mental disorders (11 percent) to a high of $545 for those in the home because of accidents, poisonings, and violence (4 percent) (tables F and 6). The three most frequent primary diagnoses, covering 67 percent of the residents, were diseases of the circulatory system (42 percent); senility, old age, other symptoms and ill-defined conditions (14 percent); and mental disorders (11 percent). Residents with the two most frequent primary diagnoses (diseases of the circulatory system and senility) paid, on the average, the same monthly charge of $495.

In contrast to the situation for primary diagnosis, the percent distribution of residents by reported chronic conditions (see question 9 of Resident Questionnaire) exceeded 100 percent, since most residents had more than one chronic condition. The average number of chronic conditions per resident was 2.2. Only 5 percent of the residents reported no chronic conditions. Twenty-seven percent had one chronic condition, 63 percent had from two to four, and 5 percent had five or more chronic

Table F. Average total monthly charge for care and percent distribution of residents, by primary diagnosis at last examination: United States, August 1973-April 1974

Primary diagnosis at last examination	Average total monthly charge[1]	Percent distribution of residents[2]
All diagnoses	$479	100.0
Accidents, poisonings, and violence	545	4.2
Diseases of the skin and subcutaneous tissue	504	0.6
Neoplasms	498	2.2
Diseases of the circulatory system	495	42.0
Senility, old age, other symptoms and ill-defined conditions	495	13.9
Diseases of the genitourinary system	493	1.4
Diseases of the respiratory system	484	2.0
Diseases of the nervous system and sense organs	483	6.1
Endocrine, nutritional, and metabolic diseases	474	4.6
Diseases of the digestive system	467	1.9
Diseases of the blood and blood-forming organs	464	0.7
Congenital anomalies	*	0.3
Diseases of the musculoskeletal system and connective tissue	443	6.9
Infective and parasitic diseases	*	*
Mental disorders[3]	406	11.0
Certain causes of perinatal morbidity and mortality	*	*
Unknown diagnoses[4]	400	2.2

[1]Includes life-care residents and no-charge residents.
[2]Includes only those residents who have lived in the nursing home for at least a month.
[3]Includes mental retardation and mental illness.
[4]Includes complications of pregnancy and childbirth, and other diagnoses not listed above.

conditions. When standard errors were considered, there were no differences in average charge by number of chronic conditions reported. The most frequently reported chronic conditions were senility (58 percent), arthritis and rheumatism (35 percent), and chronic heart trouble (33 percent). Although charges for selected chronic conditions are presented in table 7, they should be interpreted with caution. Since the total charge for each resident with multiple conditions (68 percent) appears in the average charge for *each* reported condition, comparison of these charges is misleading (and generally not significant) due to the high correlation.

Level of Care Received

Information on the level of care the resident actually received was elicited by asking the nurse if the resident had received any of a list of services within the past 7 days (see appendix II for a complete list of services). The responses were classified into the five following levels of patient care with each subsequent category representing a lower level of care:

Intensive nursing care

Limited nursing care

Routine nursing care

Personal care

No nursing or personal care

Forty-one percent of the residents received intensive nursing care, 10 percent received limited nursing care, 32 percent received routine nursing care, and 16 percent received personal care services. Less than 1 percent of the residents received no nursing or personal care. This is due perhaps to the scope of the survey, which included only those homes providing some level of nursing care (tables D and 5).

Residents receiving intensive nursing care paid higher total monthly charges, on the average, than residents receiving routine nursing care, personal care, or no nursing or personal care. The average total monthly charge for residents receiving intensive nursing care was $510, compared with $466 for residents receiving routine nursing care, $435 for residents receiving personal care, and $315 for residents receiving no nursing or personal care. The difference in the average total monthly charge for residents receiving intensive nursing care ($510) and residents receiving limited nursing care ($480) was not statistically significant.

SOURCES OF PAYMENT

Data on the residents' means of paying for care (i.e., sources of payment) and on the variation in the average monthly charges according to source of payment are presented in this section. The data were based on responses to questions 26a and 26b of the Resident Questionnaire in appendix III. These questions dealt with both the resident's primary (question 26b) and total (question 26a) sources of payment. The nine possible payment sources were: own income or family support, Medicare (Title XVIII of the Social Security Act), Medicaid (Title XIX of the Social Security Act), other public assistance or welfare, church support, VA (Veterans Administration) contract, initial payment/life care, no charge for care, and miscellaneous sources. Because residents using church support, VA contract, initial-payment/life-care, no charge, or miscellaneous sources comprised only 3 percent of the residents (table 8), data for these categories have been grouped into one category labeled "all other sources" in the remainder of the report.

PRIMARY SOURCE OF PAYMENT

In 1973-74, Medicaid was the most frequent primary source of payment used. Forty-eight percent of all nursing home residents received care financed primarily by Medicaid. The next most frequent primary source of payment was the resident's own income or family support (37

percent) followed by other public assistance or welfare (11 percent). Only a minority of the residents (1 percent) used Medicare for primary payment. Less than 1 percent of all residents used each of the remaining sources (church support, VA contract, initial payment/life care, no charge for care, and miscellaneous sources) as the primary source of payment (tables G and 8). Overall, 60 percent of the residents used public funds (Medicare, Medicaid, other public assistance or welfare) for primary payment.

The average charge for residents receiving care primarily financed by Medicare ($754) was significantly higher than that financed by any other source of payment and higher than the national average of $479. In comparison, significantly lower average charges were paid by residents using Medicaid ($503) and own income or family support ($491). (No significant differences, however, existed in the average charge for these two groups.) The average charge for residents receiving care financed by other public assistance or welfare was $381 while the average charge for residents using all other sources ($225) was lowest, probably due to the minimal charges for life-care and no-charge residents included in this category.

Because Medicare and Medicaid provided funding for nearly half (49 percent) of nursing home residents, the following discussion on primary source of payment by facility and resident characteristics will emphasize the impact Medicare and Medicaid programs had on resident charges and patterns of utilization of nursing homes.

Table G. Average total monthly charge for care and percent distribution of residents, by primary source of payment: United States, August 1973-April 1974

Primary source of payment	Average total monthly charge	Percent distribution of residents
All sources[1]	$479	100.0
Own income or family support	491	36.7
Medicare	754	1.1
Medicaid	503	47.9
Other public assistance or welfare	381	11.4
Church support	*	*
VA contract	446	0.8
Initial payment/life care	-	0.6
No charge	*	0.9
Miscellaneous sources	467	0.4

[1]Includes only those residents who have lived in the nursing home for at least a month.

Facility Characteristics

The Medicaid program, initiated in 1966, was designed to ease the burden of financing medical care for the poor of all ages. The 1973-74 data show that utilization of Medicaid funds for provision of nursing home care was extensive. As table H shows, Medicaid was the dominant source of payment for most residents in certified facilities: The proportion of Medicaid residents was 54 percent in facilities certified by both Medicare and Medicaid, 59 percent in Medicaid certified skilled nursing homes, and 53 percent in intermediate care facilities. In 1964 and 1969, similar surveys of nursing homes found that the resident's own income was the most frequent primary source of payment.[6,7] (See section on "Primary Source of Payment" in 1964, 1969, and 1973-74 surveys.) In 1973-74, in contrast, the proportion of private pay residents (relying on their own income or family support for primary payment) was 36 percent in facilities certified by both Medicare and Medicaid, 32 percent in Medicaid-certified skilled nursing homes, and 36 percent in intermediate care facilities. Medicaid was also the most frequent primary payment source for residents in both nursing care homes (51 percent) and personal care homes with nursing (42 percent), in proprietary facilities (52 percent), and in three of the four geographic regions (53 percent in the Northeast and 55 percent in the South and West).

Utilization of Medicaid benefits was greater in large facilities since these facilities were most likely to be participating in the program. The proportion of Medicaid residents increased from 37 percent in small facilities (less than 50 beds) to 52 percent in large facilities (200 beds or more) (table H). In contrast, use of own income for payment correspondingly decreased as the size of the facility increased—the proportion of residents relying on their own income was highest in small facilities (42 percent) and lowest

Table H. Average total monthly charge for care and percent distribution of residents by primary source of payment, according to certification, type of service provided, ownership, size, and geographic region of the home: United States, August 1973-April 1974

Certification, type of service provided, ownership, size, and geographic region	Primary source of payment					Total	Primary source of payment				
	Own income or family support	Medicare	Medicaid	Other public assistance or welfare	All other sources[1]		Own income or family support	Medicare	Medicaid	Other public assistance or welfare	All other sources[1]
	Average total monthly charge					Percent distribution of residents					
All homes[2]	$491	$754	$503	$381	$225	100.0	36.7	1.1	47.9	11.4	3.0
Certification											
Both Medicare and Medicaid[3]	613	754	591	480	334	100.0	36.0	2.9	54.0	4.9	2.2
SNH only[4]	489	. . .	489	469	308	100.0	31.8	. . .	58.6	7.8	1.8
ICF only	388	. . .	375	333	*	100.0	35.8	. . .	53.1	9.7	1.4
Not certified	377	. . .	. . .	330	*	100.0	50.6	. . .	. . .	39.3	10.2
Type of service provided											
Nursing care	516	803	501	398	296	100.0	35.9	1.2	51.1	9.5	2.3
Personal care with nursing	447	*	507	361	156	100.0	38.2	0.8	41.9	14.7	4.3
Ownership											
Proprietary	525	754	486	373	406	100.0	34.5	1.2	52.0	11.0	1.4
Nonprofit and government	427	*	556	397	136	100.0	41.9	0.9	38.4	12.2	6.6
Size											
Less than 50 beds	429	*	431	296	*	100.0	41.5	*	37.1	17.5	3.4
50-99 beds	484	*	449	356	186	100.0	37.8	0.9	47.9	10.9	2.5
100-199 beds	523	787	508	414	256	100.0	36.3	1.3	50.8	8.8	2.8
200 beds or more	506	*	656	496	307	100.0	30.7	*	51.6	12.3	4.1
Geographic region											
Northeast	637	*	718	538	131	100.0	30.6	1.4	53.2	10.5	4.5
North Central	449	*	454	360	252	100.0	44.4	0.8	35.6	16.1	3.0
South	452	*	408	306	278	100.0	31.0	1.1	55.2	10.3	2.4
West	487	*	442	323	*	100.0	37.9	*	54.6	4.6	1.9

[1]Includes church support, VA contract, initial payment/life care, no charge for care, and miscellaneous sources.
[2]Includes only those residents who have lived in the nursing home for at least a month.
[3]Includes 20,900 residents in facilities certified by *Medicare* only.
[4]Includes 122,900 residents in facilities certified by Medicaid as *both* SNH's and ICF's.

in large facilities (31 percent). This pattern may reflect a tendency on the part of private pay residents to utilize lower cost services (since charges tended to be lower in small facilities—see section titled "Size" earlier in this report) or it may be related to the high utilization by private pay residents of not certified facilities (51 percent) which tended to be smaller.[1] The resident's own income was also the most frequent primary source of payment in nonprofit and government facilities (42 percent) and in the North Central Region (44 percent). For further details of resident utilization by primary source of payment, see tables 9-11.

In contrast to Medicaid, use of Medicare benefits in nursing homes was infrequent. Nationally, only 1 percent of the residents used this source for primary payment; about the same proportion used this source regardless of type of service, ownership, size, or region classification (table H). Within facilities certified by both Medicare and Medicaid, Medicare recipients made up only 3 percent of the residents. Although Medicare benefits are available to persons aged 65 years and older, a report from the Social Security Administration noted that utilization in nursing homes was low because "Medicare extended care benefits are not intended primarily for the purpose of providing extended or long-term . . . care but rather are

designed to be a less expensive 'extension' of inpatient hospital care for persons still requiring active institutional medical treatment after hospitalization."[8] According to Medicare regulations in effect at the time of the survey, admission to an extended care facility was possible only if the Medicare recipients had been discharged from a hospital (after a stay of at least 3 days) and if the recipient was certified as needing *daily* skilled nursing or skilled rehabilitative services (usually for a condition treated in the hospital). These strict levels of care requirements resulted in the limited use of extended care services.[8]

With increasing certification levels, the average charge for residents using their own income and for residents using Medicaid increased. The average charge for Medicaid residents increased from $375 in intermediate care facilities to $591 in facilities certified by both Medicare and Medicaid, while that for private pay residents increased from $377 in not certified facilities to $613 in facilities certified by both programs (table H). The average charges for these two primary payment groups, however, did *not* differ statistically within each certification level, nor when examined for each region and for each size class under 200 beds. In general, the similarity in charges for Medicaid and private pay residents was due to similar use of services by these two groups. (This finding will be discussed more fully in the next section, "Resident Characteristics.") The exception to this pattern was in nonprofit facilities and in facilities with 200 beds or more, where the average charge for Medicaid residents was higher than that for private pay residents.

The average charges for residents using other public assistance or welfare or all other sources were significantly lower than those for residents using either their own income or Medicaid when examined by the facility characteristics in table H. The charges for these two payment groups tended to be lower because only 33 percent of the residents using other public assistance or welfare and 30 percent using all other sources received intensive nursing care in contrast to the 43 percent of the residents using Medicaid and 41 percent of the private pay residents. Another reason for the lower charges was the inclusion of residents with life-care/initial-payment or no-charge arrangements in the "all other sources" category. For example, the lower average charge in nonprofit and government facilities for residents using all other sources ($136 compared with $397-$556 for residents using other public assistance, their own income, or Medicaid) was principally due to the fact that 89 percent of the residents with either life-care or no-charge arrangements resided in nonprofit or government facilities.

Resident Characteristics

When Medicare began in 1966, it covered only "aged" persons, defined as those aged 65 years and over. Effective July 1, 1973, amendments to Title XVIII (Medicare) of the Social Security Act extended the full range of Medicare benefits to two additional high-risk groups: disabled persons under age 65 who had been entitled to receive social security cash benefits for at least 2 years and persons with end-stage renal disease.[9] During the 1973-74 survey period, Medicare was used primarily by the aged in nursing homes; 99 percent of the Medicare recipients were aged 65 years or over. The median age of Medicare recipients (81 years), however, did not differ from that of residents using their own income (83 years), Medicaid (82 years), other public assistance or welfare (80 years), or all other sources (80 years).

Although Medicaid provides funds for the medically indigent of *all* ages, within nursing homes it was also used primarily by the elderly, similar to the utilization of Medicare. Nearly 9 out of 10 (88 percent) of the Medicaid recipients were aged 65 years and over (table J) while the median age was 82 years. Women recipients substantially outnumbered the men in both the Medicare and Medicaid programs, making up 76 percent of the Medicare recipients and 72 percent of the Medicaid recipients (tables J and 12). Women represented a smaller proportion of the residents using all other sources (57 percent), however, than they did in the remaining primary payment groups (69-76 percent). When charges were separately examined for each primary source of payment group, there were no statistically significant differences in charges by age or by sex.

Table J. Average total monthly charge for care and percent distribution of residents by age, sex, primary reason for admission, and length of stay since current admission, according to primary source of payment: United States, August 1973-April 1974

Age, sex, primary reason for admission, and length of stay since current admission	Primary source of payment					Primary source of payment				
	Own income or family support	Medicare	Medicaid	Other public assistance or welfare	All other sources[1]	Own income or family support	Medicare	Medicaid	Other public assistance or welfare	All other sources[1]
	Average total monthly charge					Percent distribution of residents				
All residents[2]	$491	$754	$503	$381	$225	100.0	100.0	100.0	100.0	100.0
Age										
Under 65 years	497	*	457	351	325	5.2	*	12.0	20.9	19.8
65-74 years	470	*	503	367	*	12.6	*	16.3	17.6	12.4
75-84 years	490	725	517	385	219	40.2	46.1	33.7	26.9	36.1
85 years and over	498	*	505	402	152	42.0	31.5	38.0	34.6	31.7
Sex										
Male	471	*	495	360	341	28.4	23.9	28.3	31.5	43.3
Female	499	735	506	390	*	71.6	76.1	71.7	68.5	56.7
Primary reason for admission										
Physical	506	764	514	408	281	81.2	96.1	84.2	67.5	59.2
Social	384	*	452	305	*	8.6	*	4.0	7.9	20.5
Behavioral	467	*	436	331	*	9.6	*	11.3	22.9	9.6
Economic	*	*	*	*	*	0.6	*	0.6	*	10.8
Length of stay since current admission										
1 to less than 6 months	549	795	517	412	331	21.7	82.5	17.1	13.2	17.9
6 to less than 12 months	512	*	516	400	*	18.3	*	15.1	12.1	8.5
1 to less than 3 years	485	*	503	392	261	34.5	*	37.6	33.6	25.9
3 to less than 5 years	456	*	500	367	*	13.0	*	15.9	17.3	15.5
5 years or more	412	*	474	348	136	12.6	*	14.3	23.9	32.2

[1]Includes church support, VA contract, initial payment/life care, no charge for care, and miscellaneous sources.
[2]Includes only those residents who have lived in the nursing home for at least a month.

The length of stay for Medicare recipients was considerably shorter than that for residents using any of the remaining sources because of Medicare's provisions for coverage of only the first 100 days of inpatient care in an extended care facility. Eighty-three percent of the Medicare recipients resided in the facility less than 6 months, compared with less than 22 percent of recipients in any of the remaining source of payment groups (table J). Furthermore, the median length of stay for Medicare residents (0.2 years) was significantly shorter than that for residents using their own income (1.4 years), Medicaid (1.7 years), other public assistance or welfare (2.2 years), or all other sources (2.9 years) for primary payment.

Nationally, charges tended to be higher among those residents with shorter lengths of stay (table 12). A contributing factor toward this pattern was the shorter and more expensive stay of Medicare residents (tables J and 13). The average total monthly charge for Medicare residents with a length of stay of under 6 months was $795. In contrast, the average charge for residents staying for the same amount of time but using any of the remaining primary sources

Table K. Average total monthly charge for care and percent distribution of residents by level of care received, according to primary source of payment: United States, August 1973-April 1974

Level of care received	Primary source of payment				
	Own income or family support	Medicare	Medicaid	Other public assistance or welfare	All other sources[1]
	Average total monthly charge				
All levels of care[2]	$491	$754	$503	$381	$225
Intensive nursing care	541	773	504	427	267
Limited nursing care	492	*	506	392	*
Routine nursing care	467	*	498	364	231
Personal care	430	*	508	339	178
No nursing or personal care	327	-	*	*	*
	Percent distribution of residents				
All levels of care[2]	100.0	100.0	100.0	100.0	100.0
Intensive nursing care	40.8	62.6	42.5	32.9	29.5
Limited nursing care	9.2	*	9.9	10.9	10.5
Routine nursing care	31.2	*	33.6	32.3	30.1
Personal care	17.3	*	13.7	22.7	27.3
No nursing or personal care	1.5	-	*	*	*

[1]Includes church support, VA contract, initial payment/life care, no charge for care, and miscellaneous sources.
[2]Includes only those residents who have lived in the nursing home for at least a month.

ranged from $331 to $549. Although the average charges for residents using their own income or all other sources also tended to decrease with longer stays, those for residents using Medicaid or other public assistance or welfare were not significantly different regardless of the length of stay.

Nationally, the average charge for residents using Medicare was higher than the average charge for residents using any of the remaining primary sources. The higher charge for these residents was in large part due to the strict level of care requirements necessary for Medicare coverage (i.e., skilled nursing or skilled rehabilitative services are required on a *daily* basis). As a result of these strict requirements, a larger proportion of the Medicare recipients (96 percent) were admitted to the home for treatment of physical illness than of the remaining source of payment groups (59-84 percent—table J), and 73 percent of those receiving Medicare benefits were admitted from general or short-stay hospitals.[b] Consequently, of all the primary payment groups, Medicare residents were most likely to receive intensive nursing care. Sixty-three percent of the Medicare residents received intensive nursing care compared with less than 43 percent for the remaining groups (table K). Among residents admitted to the home for physical reasons, the average charge for Medicare residents ($764) was significantly higher than that for private pay residents ($506) and Medicaid residents ($514) (table J).

When examined by the resident characteristics in tables J and K, the average charge for Medicaid residents and private pay residents were similar regardless of age, sex, length of

[b]Although Medicare coverage in a nursing home requires a hospital stay prior to admission, there may be a brief interim stay (up to 14 days) in a private residence if, for example, no nursing home bed is available or if it is medically appropriate.

stay, reasons for admission, or level of care received. In general, the similarity in charges for private pay residents and Medicaid residents was due to similar use of services by these two groups. As table K shows, the proportion of residents receiving each level of care was similar for both Medicaid recipients and residents using their own income. For example, the proportion of private pay residents receiving intensive nursing care (41 percent) did not differ significantly from the proportion of Medicaid residents receiving such care (43 percent). Similarly, the proportion of residents receiving limited nursing care, routine nursing care, or personal care differed at most by less than 4 percentage points for the two groups. The proportion of residents admitted to the home for physical reasons for these two groups was also similar (table J).

TOTAL SOURCES OF PAYMENT

Table 14 shows the distribution of residents according to their total sources of payment (see question 26a of the Resident Questionnaire). In 1973-74, 662,000 residents (65 percent) used public funds (Medicare, Medicaid, other public assistance, or welfare) in partial or full payment for care; 787,700 residents (78 percent) used their own income or family support for partial or full payment (calculated from table 14). The percent distribution of residents by total sources of payments exceeds 100 percent since 461,600 residents (46 percent) had two payment sources and a small proportion of the residents (2 percent) had three or more sources for payment (calculated from table 14). About 533,400 residents (53 percent) had only one source of payment.

Table 15 shows the most likely payment arrangements used by residents in 1973-74 to finance their care in the facility. Overall, residents using their own income were most likely (89 percent) to rely on it as the only source for payment. In contrast, less than 50 percent of the residents used any of the remaining sources solely for payment. Residents using public funds (Medicare, Medicaid, or other public assistance or welfare) for primary payment were most likely to have two sources for payment; the proportion of residents with two sources was 63 percent for Medicare, 71 percent for Medicaid, and 53 percent for other public assistance or welfare. In most cases, this second source was the resident's own income (table L). When the 461,600 residents using two sources were examined, the resident's own income was used to supplement payment for 84 percent of the Medicare recipients, for 96 percent of the

Table L. Percent distribution of residents with two payment sources, by primary and secondary sources of payment: United States, August 1973-April 1974

Primary source of payment	Two sources	Secondary source of payment				
		Own income or family support	Medicare	Medicaid	Other public assistance or welfare	All other sources[1]
	Percent distribution of residents					
All sources[2]	100.0	87.0	1.0	4.6	4.5	2.8
Own income or family support	100.0	...	8.1	47.9	22.9	21.1
Medicare	100.0	83.9	...	*	*	*
Medicaid	100.0	96.1	*	...	3.0	*
Other public assistance or welfare	100.0	96.9	*	*	...	*
All other sources[1]	100.0	65.6	-	*	*	...

[1]Includes church support, VA contract, initial payment/life care, no charge for care, and miscellaneous sources.
[2]Includes only those 461,600 residents having two payment sources who have lived in the nursing home for at least a month.

Medicaid recipients, and for 97 percent of those receiving other public assistance or welfare.

This pattern of payment arrangements for recipients of public funds was a consequence of the limitations of coverage of the various programs, especially in the area of coverage of personal convenience items such as the services of a beautician or barber, rental of a television, or use of a telephone. Medicare, for example, is a health *insurance* program for the aged. Of the maximum of 100 days of extended care that Medicare provides for, the first 20 days are paid in full. For the remaining 80 days, however, the patient was responsible for co-insurance payments each day equal to one-eighth of the current inpatient hospital deductible. The Medicare daily co-insurance rate was $9.00 in 1973 and $10.50 in 1974.[9] Medicare recipients were also responsible for the costs of noncovered services which included: personal convenience items, private-duty nursing, private room charges, eye or ear examinations, routine physical examinations, or immunizations (unless required because of an injury or immediate risk of infection).[10]

Services covered by Medicaid varied from State to State since, in this State-Federal program, States determined which services would be reimbursed. In general, Medicaid did not cover personal convenience items.

CHARGES IN 1964, 1969, AND 1973-74

CHARGES FOR CARE

In the last 10 years, the increased utilization of nursing homes has made them one of the most rapidly expanding sectors of the Nation's health care delivery system. In 1973-74, 5 percent of the U.S. population aged 65 years and over resided in nursing homes; in contrast, the proportion in 1964 was only 3 percent.[2,11] In actual numbers, the population in nursing homes nearly doubled between 1964 and 1973-74.[2,11]

Comparisons of the average monthly charge in 1973-74 with the average charges from similar surveys of nursing homes conducted by the National Center for Health Statistics in 1964[6] and 1969[7] show that between 1964 and 1973-74, the average total monthly charge increased 159 percent—from $185 in 1964 to $479 in 1973-74 (table M). The largest percent increase in average charge occurred between 1964 and 1969 when charges increased 81 percent or about 16 percent per year. In contrast, the average charge increased by only 43 percent from 1969 to 1973-74, or about 11 percent per year. An examination of the cumulative percent distribution of monthly charges for 1964, 1969, and 1973-74 further illustrates this increase in charges (figure 4). Whereas 87 percent of the residents were charged $300 or less in 1964, the proportion of residents in this range was less than 50 percent in 1969 and only 12 percent in 1973-74.

When charges were compared for the three survey periods, increases occurred for each type of service category, for each type of ownership, for each age group, and for males as well as females. The average charge was found to increase in the Northeast, North Central, and South Regions for all 3 survey years. The difference was not statistically significant, however, for the West between 1969 and 1973-74. When levels of care received[c] were compared for the 3 survey years, the average charge consistently increased for all levels of care with the exception of residents receiving neither nursing nor personal care. For such residents, charges did not differ significantly between 1969 and 1973-74 due to the large sampling variability for this small group. Although charge data by size of facility were not available for 1964, a comparison of charges by size for 1969 and 1973-74 found that charges were higher in 1973-74 than in 1969 for each size category.

[c]Data in 1964 and 1969 for other nursing care correspond to combined data for the limited and routine nursing care categories of 1973-74.

Table M. Average total monthly charge for care and percent distribution of residents, by selected facility and resident characteristics: United States, 1964, 1969, and 1973-74

Selected facility and resident characteristics	1964[1]		1969[1]		1973-74	
	Average total monthly charge[2]	Percent distribution of residents	Average total monthly charge[2]	Percent distribution of residents	Average total monthly charge[2]	Percent distribution of residents
FACILITY CHARACTERISTICS						
All facilities	$185	100.0	$335	100.0	$479	100.0
Type of service provided						
Nursing care	211	72.0	356	81.4	495	64.8
Personal care with nursing	118	28.0	242	18.6	448	35.2
Ownership						
Proprietary	208	60.2	352	68.0	489	69.8
Nonprofit and government	150	39.8	300	32.0	456	30.2
Size						
Less than 50 beds	---	---	288	27.3	397	15.2
50-99 beds	---	---	345	36.0	448	34.1
100-199 beds	---	---	363	26.2	502	35.6
200 beds or more	---	---	352	10.6	576	15.1
Geographic region						
Northeast	209	28.4	395	22.5	651	22.0
North Central	172	36.5	302	36.0	433	34.6
South	162	18.7	311	27.3	410	26.0
West	198	16.5	370	14.2	454	17.4
RESIDENT CHARACTERISTICS						
All residents	185	100.0	335	100.0	479	100.0
Age						
Under 65 years	162	11.4	288	10.8	434	10.6
65-74 years	186	18.9	332	16.5	473	15.0
75-84 years	188	41.8	343	39.5	488	35.5
85 years and over	190	28.0	343	33.2	485	38.8
Sex						
Male	175	34.6	323	30.4	466	29.1
Female	191	65.4	340	69.6	484	70.9
Level of care received						
Intensive nursing care	221	33.0	374	33.7	510	40.6
Other nursing care[3]	197	30.3	335	43.0	469	42.1
Personal care	162	25.6	293	18.0	435	16.4
No nursing or personal care	97	11.1	230	5.3	315	0.9

[1]Data have been adjusted to exclude residents of personal care homes. For sources of data, see references 6 and 7, respectively.
[2]Includes life-care residents and no-charge residents.
[3]Data in 1964 and 1969 for other nursing care correspond to combined data for the limited and routine nursing care categories of 1973-74.

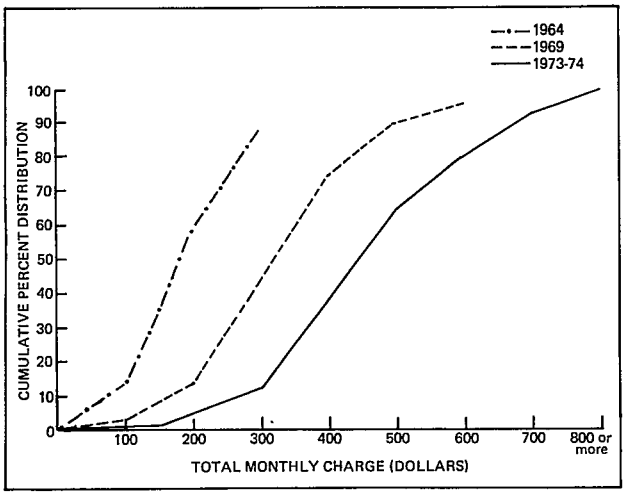


Figure 4. Cumulative percent distribution of nursing home residents, by total monthly charge for care: United States, 1964, 1969, and 1973-74

The increase in the average total monthly resident charges between 1964 and 1973-74 may have been the result of several factors including: the price of services and supplies, increased utilization, supply of facilities and health manpower, and the quality and quantity of care received. Of these factors, rising medical care prices (or inflation) played a dominant role. The Consumer Price Index (CPI) prepared by the Bureau of Labor Statistics measures the change in average prices of goods and services purchased by urban wage earners and clerical workers and their families. One measure of overall medical care prices is the medical care component of the CPI. Using 1964 as the base year, the medical care component indicates that medical care prices increased 62 percent between 1964 and 1973-74 (column 3 of table N).[d] That is, the same medical services that cost $100 in 1964 would have cost $162 in 1973-74. Thus, charges for nursing home residents increased because the prices of medical services and supplies rose.

The increase in charges not attributable to inflation may be roughly estimated by converting the average charges to constant dollars so that they do not reflect the effect of rising medical care prices. Column 4 of table N shows the average total monthly charges for 1969 and 1973-74 expressed in terms of 1964 dollars (average total monthly charge divided by the consumer price index for medical care services). In constant dollars, the average monthly resident charge increased 60 percent between 1964 and 1973-74: from $185 to $296. The largest constant dollar increase (39 percent) was between 1964 and 1969; between 1969 and 1973-74 the constant dollar increase in average charges was only 15 percent (table O). Figure 5 further illustrates this increase in constant dollar charges.

Table O shows the constant dollar average charge by selected facility and resident characteristics. Examination of this table shows that constant dollar charges increased for each survey year for each type of service provided by the home, for each type of ownership, for the Northeast, North Central, and South Regions, for each age and sex group, and for each level of care received.

At least part of the increase in the constant dollar average charges for 1964, 1969, and 1973-74 was due to an excess demand for

[d]The medical care component of the CPI was used as an overall measure of nursing home prices because the CPI does not have a nursing home component.

Table N. Average total monthly charge for care, number of residents, medical care price index, and average total monthly charge in constant (1964) dollars: United States, 1964, 1969, and 1973-74

	Average total monthly charge[1]	Number of residents	Medical care price index[2]	Average total monthly charge in constant (1964) dollars[3]
1964[4]	$185	518,700	100.0	$185
1969[4]	335	728,600	130.6	257
1973-74	479	1,012,000	162.0	296

[1]Includes life-care and no-charge residents.

[2]The medical care price index was adjusted to make 1964 equal to 100 by dividing the medical care component of the CPI for each year by that for 1964. Data used in this adjustment are presented below. Source: Bureau of Labor Statistics.

Medical care component of the CPI (1967=100)	*Date*
87.3	June 1964
114.0	July 1969
141.4	December 1973

[3]To convert average charges to constant (1964) dollars, charges were divided by the medical care price index and multiplied by 100.

[4]Data have been adjusted to exclude residents of personal care homes. For sources of data, see references 6 and 7, respectively.

Table O. Average total monthly charge for care in constant (1964) dollars and percent change, by selected facility and resident characteristics: United States, 1964, 1969, and 1973-74

Selected facility and resident characteristics	1964[1]	1969[1]		1973-74	
	Average total monthly charge in constant (1964) dollars	Average total monthly charge in constant (1964) dollars[2]	Percent change 1964-69	Average total monthly charge in constant (1964) dollars[2]	Percent change 1969-74
FACILITY CHARACTERISTICS					
All facilities	$185	$257	38.7	$296	15.3
Type of service provided					
Nursing care	211	273	29.2	306	12.1
Personal care with nursing	118	185	57.0	277	49.2
Ownership					
Proprietary	208	270	29.6	302	12.0
Nonprofit and government	150	230	53.1	281	22.5
Size					
Less than 50 beds	---	221	---	245	11.1
50-99 beds	---	264	---	277	4.7
100-199 beds	---	278	---	310	11.5
200 beds or more	---	270	---	356	31.9
Geographic region					
Northeast	209	302	44.7	402	32.9
North Central	172	231	34.4	267	15.6
South	162	238	47.0	253	6.3
West	198	283	43.1	280	-1.1
RESIDENT CHARACTERISTICS					
All residents	185	257	38.7	296	15.3
Age					
Under 65 years	162	221	36.1	268	21.5
65-74 years	186	254	36.7	292	14.9
75-84 years	188	263	39.7	301	14.7
85 years and over	190	263	38.2	299	14.0
Sex					
Male	175	247	41.3	288	16.3
Female	191	260	36.3	299	14.8
Level of care received					
Intensive nursing care	221	286	29.6	315	9.9
Other nursing care[3]	197	257	30.2	290	12.9
Personal care	162	224	38.5	269	19.7
No nursing or personal care	97	176	81.6	194	10.4

[1]For sources of data, see table M and references 6 and 7. Includes life-care and no-charge residents.

[2]To convert average charges to constant (1964) dollars, charges were divided by the medical care price index and multiplied by 100.

[3]Data in 1964 and 1969 for other nursing care correspond to combined data for the limited and routine nursing care categories of 1973-74.

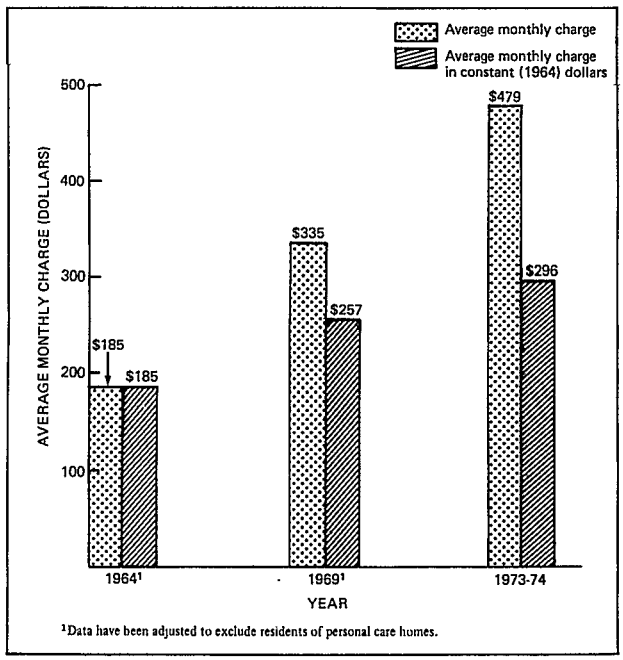


Figure 5. Average total monthly charge for care and average total monthly charge in constant (1964) dollars: United States, 1964, 1969, and 1973-74

nursing home beds. A previous report on the utilization of nursing homes found that in 1973-74, 72 percent of all nursing homes maintained waiting lists.[3] The increased demand for nursing home beds was probably due to the increase in number of elderly persons and the lack of available caregivers for many of them. This demand was greatly stimulated in the late 1960's when Medicare and Medicaid funds became available for nursing home care.

The overall quality of care received also influenced the increase in charges, since more residents received intensive or other nursing care services (the highest two levels) in 1973-74 than in either of the preceding survey periods. In 1973-74, 83 percent of the residents received intensive or other nursing care compared with 77 percent in 1969 and 63 percent in 1964. Furthermore, the percent of residents receiving no nursing or personal care (the lowest level) decreased both in 1969 and in 1973-74. Less than 1 percent of the residents received no nursing or personal care in 1973-74 compared with 5 percent in 1969 and 11 percent in 1964 (table M).

PRIMARY SOURCE OF PAYMENT

The implementation of the Medicare and Medicaid programs in 1966 had the major effect of shifting a large proportion of the aged's nursing home bill from the private to the public sector. In 1964, 47 percent of the residents used public funds (chiefly other public assistance or welfare) for primary payment, and 53 percent of the residents used private sources (own income and all other sources—figure 6). After the introduction of Medicare and Medicaid, however, the proportion of residents using public funds increased to 53 percent in 1969 and was up to 60 percent in 1973-74. Thus there were more than 2½ times as many residents using public funds for primary payment in 1973-74 as there were in 1964 (table P).

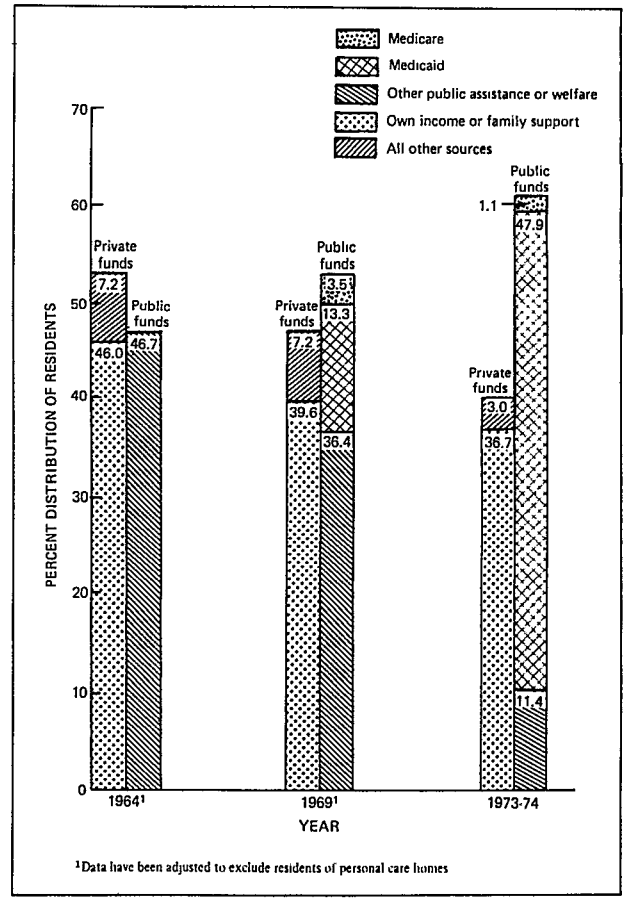


Figure 6. Percent distribution of residents by primary source of payment: United States, 1964, 1969, and 1973-74

Table P. Average total monthly charge for care and number and percent distribution of residents, by primary source of payment: United States, 1964, 1969, and 1973-74

Primary source of payment	1964[1]			1969[1]			1973-74		
	Average total monthly charge	Number of residents	Percent distribution of residents	Average total monthly charge	Number of residents	Percent distribution of residents	Average total monthly charge	Number of residents	Percent distribution of residents
All sources	$185	518,700	100.0	$335	728,600	100.0	$479	1,012,000	100.0
Own income or family support	206	238,500	46.0	350	288,500	39.6	491	371,700	36.7
Public assistance:									
Medicare	...	...	...	533	25,200	3.5	754	108,000	1.1
Medicaid	...	...	...	395	97,000	13.3	503	484,300	47.9
Other public assistance or welfare	184	243,000	46.9	288	265,600	36.4	381	114,900	11.4
All other sources[2]	58	37,100	7.2	287	52,200	7.2	225	30,200	3.0

[1]Data have been adjusted to exclude residents of personal care homes. For sources of data, see references 6 and 7, respectively.
[2]Includes church support, VA contract, initial payment/life care, no charge for care, and miscellaneous sources.

Medicaid funding, in particular, played an increasingly important role after 1966. In 1969, 13 percent of the residents used Medicaid funds for primary payment; by 1973-74, 48 percent of all residents were using this source. The actual number of residents using Medicaid increased almost fivefold, from 97,000 residents in 1969 to 484,300 residents in 1973-74 (table P). Use of Medicare funds for extended-care services, in contrast, was less prevalent. In 1969, 4 percent of the residents used Medicare as the primary source for payment but by 1973-74, only 1 percent of the residents used this source. Medicare program statistics indicate that the number and rate of extended-care admissions reached a peak in 1969 and then declined,[9] due to strict enforcement of the level of care requirements for coverage.[8] Declines in the proportion of residents using Medicare for primary payment, as well as declines from 1964 to 1973-74 in the proportions using their own income (from 46 to 37 percent), other public assistance or welfare (from 47 to 11 percent), and all other sources (from 7 percent to 3 percent) were chiefly due to the increasing reliance on Medicaid funds as the primary source of payment for nursing home care.

For most primary payment sources, the average total monthly charge increased in each survey year. The increase in charge for most payment sources was more pronounced between 1964 and 1969 than between 1969 and 1973-74. The average charge for residents using their own income, for example, increased 70 percent between 1964 and 1969 (from $206 to $350), while the increase between 1969 and 1973-74 was only 40 percent (table P). The average charge for residents receiving other public assistance or welfare increased 57 percent between 1964 and 1969 but only 32 percent between 1969 and 1973-74. An exception to this pattern was the average charge for residents using all other sources. Between 1964 and 1969, charges for these residents increased 395 percent (from $58 to $287); between 1969 and 1973-74, however, the difference in charge was not statistically significant.

Since Medicare and Medicaid did not come into existence until after 1964, data on charges for these sources are available for 1969 and 1973-74 only. Between 1969 and 1973-74, however, the average charge for Medicaid residents increased significantly (from $395 to $503). Although the average charge for Medicare residents in 1973-74 ($754) was higher than that in 1969 ($533), the difference was not statistically significant due to the large sampling variability of these estimates.

The increase in charge for Medicaid residents was related to rising medical care prices and to the increased demand for nursing home services under this program (the 97,000 residents served in 1969 rose to 484,300 in 1973-74). Of these two factors, rising medical care prices played the dominant role. When the average charge for these residents was converted to constant dollars (to control for the effects of inflation), the average charge in 1969 ($302) was similar to that in 1973-74 ($310) (table Q). The low percent increase (3 percent) in constant dollar charges for Medicaid residents during that time was probably the result of close monitoring of nursing home reimbursement levels which were set by the States. Because of the unanticipated high cost of the Medicaid program, many States, within a few years of its implementation, sought to cut Medicaid costs by tightening eligibility requirements, reducing the scope of benefits, and cutting back reimbursement levels to providers of medical care services.[1,2]

The care received by Medicaid residents, however, was generally the same in 1973-74 as in 1969. The proportion of Medicaid residents receiving intensive or other nursing care was similar in 1973-74 (86 percent) to the 1969 proportion (85 percent) (table R). This pattern was also true for Medicare residents. In 1973-74, the proportion of Medicare residents receiving intensive or other nursing care (92 percent) was similar to that in 1969 (91 percent).

Table R. Percent of residents receiving intensive or other nursing care, by primary source of payment: United States, 1964, 1969, and 1973-74

Primary source of payment	1964[1]	1969[1]	1973-74
	Percent of residents		
Own income or family support	64.5	74.4	81.2
Medicare	...	90.8	91.6
Medicaid	...	85.1	86.0
Other public assistance or welfare	66.6	77.7	76.0
All other sources[2]	33.3	61.5	70.0

[1]Data in 1964 and 1969 for other nursing care correspond to combined data for the limited and routine nursing care categories of 1973-74. Data have also been adjusted to exclude residents of personal care homes. For sources of data, see references 6 and 7, respectively.

[2]Includes church support, VA contract, initial payment/life care, no charge for care, and miscellaneous sources.

In contrast to Medicare and Medicaid, the level of care received by the residents using the remaining payment sources increased each survey year. In 1964, almost 65 percent of the residents using their own income received intensive or other nursing care compared with 74 percent in 1969 and 81 percent in 1973-74. The dramatic increase in charges for residents using all other sources (from $58 to $287) between 1964 and 1969 was largely a reflection of the increased proportion of residents receiving intensive or other nursing care during that time (from 33 to 62 percent).

Table Q. Average total monthly charge for care in constant (1964) dollars and percent change, by primary source of payment: United States, 1964, 1969, and 1973-74

Primary source of payment	1964[1]	1969[1]		1973-74	
	Average total monthly charge in constant (1964) dollars	Average total monthly charge in constant (1964) dollars[2]	Percent change 1964-69	Average total monthly charge in constant (1964) dollars[2]	Percent change 1969-74
Own income or family support	$206	$268	30.1	$303	13.1
Medicare	...	408	...	465	14.0
Medicaid	...	302	...	310	2.7
Other public assistance or welfare	184	221	19.8	235	6.7
All other sources[3]	58	220	278.9	139	-36.8

[1]For sources of data, see table P and references 6 and 7.

[2]To convert average charges to constant (1964) dollars, charges were divided by the medical care price index and multiplied by 100.

[3]Includes church support, VA contract, initial payment/life care, no charge for care, and miscellaneous sources.

CONCLUSIONS

Since 1964, the average total monthly charge for residents in nursing homes has increased 159 percent—from $185 in 1964 to $479 in 1973-74. Much of the increase was due to inflation or rising medical care prices, but at least part of the increase was due to the increased demand for nursing home services. The higher level of services received by residents also contributed to the increase.

In 1973-74, the average charge was highest in the Northeast Region and in proprietary facilities. Charges increased with the size of the facility and with increasing levels of certification. Charges did not differ for males and females but tended to be lower for those residents under 65 years of age. Residents admitted to the home for physical reasons tended to pay more than those admitted for behavioral, social, or economic reasons; and residents receiving intensive nursing care paid more than residents receiving routine nursing care, personal care, or neither nursing nor personal care. A lower average charge was associated with residents who had longer lengths of stay.

In 1973-74, nearly half of all nursing home residents used Medicare or Medicaid for primary payment. The average charge for Medicare residents tended to be more expensive than for other payment sources due to the higher intensity of services received by these residents. The average charge for Medicaid residents was similar to that for residents using their own income.

Between 1969 and 1973-74, the strict requirements for skilled nursing care under the Medicare program resulted in a decline in use of this program, and the increased demand for nursing home services was accommodated by the Medicaid program.[8] Between 1969 and 1973-74, the average charge for Medicaid residents increased from $395 to $503. When the average charge for these residents was expressed in terms of constant (1964) dollars, however, the charge in 1973-74 was only 3 percent higher than in 1969. Thus, most of the increase in charge for these residents could be traced to inflation or rising medical care prices.

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LIST OF DETAILED TABLES

Table 1. Average total monthly charge for care and number and percent distribution of residents by monthly charge intervals, according to certification, ownership, and size: United States, August 1973-April 1974

Certification, ownership, and size	Average total monthly charge[1]	Number of residents[2]	Total	Monthly charge for care							
				Initial payment/ life care, no charge	$1-$149	$150-$299	$300-$399	$400-$499	$500-$599	$600-$799	$800 or more
				Percent distribution							
All types of certification											
All types of ownership	$479	1,012,000	100.0	1.6	0.9	10.3	26.1	27.1	13.2	13.4	7.4
Less than 50 beds	397	153,500	100.0	2.2	*	23.9	29.4	23.0	9.6	7.0	3.6
50-99 beds	448	345,500	100.0	1.4	0.8	9.0	31.9	29.0	12.5	11.4	4.0
100-199 beds	502	360,500	100.0	1.3	0.8	6.8	24.3	27.5	13.9	17.5	7.8
200 beds or more	576	152,400	100.0	1.7	*	7.7	14.2	25.8	16.7	14.9	17.9
Proprietary	489	706,500	100.0	*	0.4	8.2	26.4	30.3	13.9	13.9	6.8
Less than 50 beds	410	119,000	100.0	*	*	23.3	28.4	25.9	10.3	7.7	3.2
50-99 beds	463	259,200	100.0	*	*	7.3	32.1	30.9	13.4	12.6	3.4
100-199 beds	521	266,600	100.0	*	*	3.4	22.8	31.9	14.9	18.0	8.4
200 beds or more	609	61,700	100.0	*	-	*	14.1	28.8	19.0	13.5	20.9
Nonprofit and government	456	305,400	100.0	4.7	2.2	15.2	25.6	19.7	11.5	12.4	8.8
Less than 50 beds	354	34,500	100.0	9.3	*	26.2	32.8	13.0	7.1	*	*
50-99 beds	406	86,300	100.0	5.6	*	14.1	31.2	23.3	9.9	7.8	5.6
100-199 beds	447	93,900	100.0	4.1	*	16.5	28.7	15.1	11.0	16.2	6.2
200 beds or more	553	90,700	100.0	2.8	*	10.5	14.3	23.7	15.1	15.8	15.8
Both Medicare and Medicaid[3]											
All types of ownership	592	372,300	100.0	1.0	*	2.5	9.8	31.5	17.7	21.9	15.5
Less than 50 beds	537	17,000	100.0	*	-	*	*	21.6	33.7	24.1	*
50-99 beds	559	112,600	100.0	*	*	*	9.4	38.1	18.0	22.4	9.7
100-199 beds	592	170,800	100.0	*	*	2.1	10.4	31.0	16.6	23.9	14.9
200 beds or more	658	72,000	100.0	*	*	4.5	9.9	24.6	15.9	15.9	27.8
Proprietary	588	285,600	100.0	*	*	1.3	9.5	34.9	18.3	21.8	13.9
Less than 50 beds	559	10,800	100.0	-	-	*	*	24.7	37.5	27.8	*
50-99 beds	558	92,900	100.0	-	*	*	8.5	40.8	18.1	23.2	7.9
100-199 beds	588	143,600	100.0	*	*	*	10.0	33.7	17.5	22.9	14.3
200 beds or more	673	38,300	100.0	*	-	*	10.8	27.7	16.8	12.8	30.0
Nonprofit and government	605	86,800	100.0	3.8	*	6.4	11.0	20.5	15.4	22.2	20.6
Less than 50 beds	500	6,100	100.0	*	-	*	*	*	*	*	*
50-99 beds	565	19,700	100.0	*	-	*	13.6	25.4	17.6	18.7	18.4
100-199 beds	611	27,200	100.0	*	-	*	12.6	17.2	12.2	29.0	18.5
200 beds or more	641	33,700	100.0	*	*	7.7	8.9	21.1	14.7	19.5	25.2
Medicaid only: SNH[4]											
All types of ownership	484	278,100	100.0	*	*	5.0	25.0	33.7	15.6	14.8	4.8
Less than 50 beds	482	28,700	100.0	-	*	9.9	20.9	36.7	13.6	8.8	9.6
50-99 beds	461	91,200	100.0	*	*	3.8	27.5	37.6	16.1	11.6	*
100-199 beds	473	105,300	100.0	*	*	5.1	27.8	31.9	14.1	17.8	2.4
200 beds or more	547	53,000	100.0	*	*	4.5	17.4	28.7	18.8	17.4	11.1
Proprietary	483	183,100	100.0	*	*	2.7	25.3	36.5	17.1	14.8	3.5
Less than 50 beds	490	22,300	100.0	-	*	*	20.2	38.1	14.5	11.3	*
50-99 beds	470	65,600	100.0	-	-	*	28.1	37.5	18.6	12.6	*
100-199 beds	478	77,000	100.0	*	*	*	27.3	35.9	14.8	16.9	*
200 beds or more	544	18,100	100.0	-	-	*	12.8	33.4	24.7	18.7	*
Nonprofit and government	486	95,100	100.0	*	*	9.6	24.5	28.2	12.8	14.7	7.4
Less than 50 beds	454	6,300	100.0	-	-	*	*	*	*	-	*
50-99 beds	437	25,600	100.0	*	*	9.5	25.8	37.9	9.8	9.1	*
100-199 beds	460	28,300	100.0	*	*	11.7	29.3	21.0	12.4	20.4	*
200 beds or more	548	34,900	100.0	*	*	*	19.8	26.3	15.8	16.7	12.8

See footnotes at end of table.

Table 1. Average total monthly charge for care and number and percent distribution of residents by monthly charge intervals, according to certification, ownership, and size: United States, August 1973-April 1974—Con.

Certification, ownership, and size	Average total monthly charge[1]	Number of residents[2]	Total	Monthly charge for care							
				Initial payment/ life care, no charge	$1-$149	$150-$299	$300-$399	$400-$499	$500-$599	$600-$799	$800 or more
Medicaid only: ICF			Percent distribution								
All types of ownership	$376	226,900	100.0	*	*	15.4	55.1	19.3	6.6	2.5	*
Less than 50 beds	378	64,100	100.0	*	*	19.6	46.9	24.1	3.6	*	*
50-99 beds	369	92,800	100.0	*	*	12.3	62.7	17.2	6.0	*	*
100-199 beds	377	56,900	100.0	*	*	14.8	58.4	15.2	7.7	*	-
200 beds or more	404	13,100	100.0	*	*	19.5	26.1	28.4	20.5	*	-
Proprietary	382	163,000	100.0	*	*	12.5	55.9	22.2	5.7	2.4	*
Less than 50 beds	388	52,600	100.0	*	*	18.4	42.3	29.0	4.4	*	*
50-99 beds	373	70,200	100.0	-	*	10.7	63.8	18.1	5.7	*	*
100-199 beds	390	36,000	100.0	*	*	8.0	61.5	20.0	*	*	-
200 or more beds	*	4,200	100.0	*	-	*	*	*	*	*	-
Nonprofit and government	358	63,900	100.0	*	*	22.8	52.9	11.9	8.7	*	*
Less than 50 beds	334	11,400	100.0	-	*	25.1	67.8	*	-	*	*
50-99 beds	356	22,600	100.0	*	*	17.5	59.4	14.6	*	*	*
100-199 beds	355	21,000	100.0	-	*	26.6	52.9	*	*	*	-
200 beds or more	404	8,900	100.0	-	*	*	*	30.1	*	*	-
Not certified											
All types of ownership	329	134,500	100.0	7.6	4.5	34.0	24.9	14.4	6.9	5.8	2.0
Less than 50 beds	316	43,800	100.0	6.2	*	47.0	18.4	13.0	6.5	5.3	*
50-99 beds	322	48,800	100.0	6.9	4.8	29.6	33.2	14.5	5.5	4.8	*
100-199 beds	310	27,500	100.0	11.4	*	25.9	26.6	14.1	8.8	*	*
200 beds or more	430	14,400	100.0	*	*	25.1	*	18.4	*	*	*
Proprietary	353	74,900	100.0	*	*	38.5	29.3	15.0	7.2	6.2	*
Less than 50 beds	343	33,200	100.0	*	*	50.0	19.2	13.2	8.1	*	*
50-99 beds	364	30,500	100.0	*	*	30.3	39.6	16.3	*	*	*
100-199 beds	360	10,100	100.0	*	*	*	31.7	*	*	*	*
200 beds or more	*	*	100.0	-	-	*	*	*	-	-	-
Nonprofit and government	299	59,600	100.0	15.9	8.4	28.5	19.3	13.6	6.5	5.3	*
Less than 50 beds	231	10,600	100.0	25.1	*	37.8	*	*	*	*	*
50-99 beds	251	18,300	100.0	17.6	*	28.4	22.6	*	*	*	*
100-199 beds	282	17,400	100.0	14.4	*	28.2	23.6	*	*	*	*
200 beds or more	444	13,200	100.0	*	*	21.5	*	19.5	*	*	*

[1]Includes live-care residents and no-charge residents.
[2]Includes only those residents who have lived in the nursing home for at least a month.
[3]Includes 20,900 residents in facilities certified by *Medicare* only.
[4]Includes 122,900 residents in facilities certified by Medicaid as *both* SNH's and ICF's.

Table 2. Average total monthly charge for care and number and percent distribution of residents by monthly charge intervals, according to ownership and type of service provided: United States, August 1973-April 1974

Ownership and type of service provided	Average total monthly charge[1]	Number of residents[2]	Total	Monthly charge for care							
				Initial payment/ life care, no charge	$1-$149	$150-$299	$300-$399	$400-$499	$500-$599	$600-$799	$800 or more
			Percent distribution								
All types of ownership	$479	1,012,000	100.0	1.6	0.9	10.3	26.1	27.1	13.2	13.4	7.4
Nursing care	495	655,600	100.0	0.9	0.7	6.2	26.8	29.4	14.2	14.3	7.6
Personal care with nursing	448	356,400	100.0	2.8	1.4	17.8	25.0	22.9	11.3	11.9	7.0
Proprietary	489	706,500	100.0	*	0.4	8.2	26.4	30.3	13.9	13.9	6.8
Nursing care	499	487,900	100.0	*	*	5.0	26.8	31.6	14.7	14.3	7.1
Personal care with nursing	465	218,700	100.0	*	*	15.4	25.5	27.3	12.2	12.8	6.1
Nonprofit and government	456	305,400	100.0	4.7	2.2	15.2	25.6	19.7	11.5	12.4	8.8
Nursing care	485	167,700	100.0	2.8	1.6	9.9	26.7	23.0	12.9	14.1	9.1
Personal care with nursing	421	137,700	100.0	7.0	2.9	21.5	24.3	15.8	9.8	10.5	8.3

[1]Includes life-care residents and no-charge residents.
[2]Includes only those residents who have lived in the nursing home for at least a month.

Table 3. Average total monthly charge for care and number and percent distribution of residents by monthly charge intervals, according to certification, ownership, and geographic region of home: United States, August 1973-April 1974

Certification, ownership, and region	Average total monthly charge[1]	Number of residents[2]	Total	Monthly charge for care							
				Initial payment/ life care, no charge	$1-$149	$150-$299	$300-$399	$400-$499	$500-$599	$600-$799	$800 or more
All types of certification			Percent distribution								
All types of ownership	$479	1,012,000	100.0	1.6	0.9	10.3	26.1	27.1	13.2	13.4	7.4
Northeast	651	223,000	100.0	3.4	*	4.9	5.7	17.0	11.7	30.9	25.6
North Central	433	350,100	100.0	1.4	0.8	15.7	28.1	24.6	15.9	10.8	2.7
South	410	262,700	100.0	0.9	1.2	8.9	44.4	26.8	10.1	6.0	1.8
West	454	176,200	100.0	*	*	8.6	20.8	45.2	14.4	7.6	2.1
Proprietary	489	706,500	100.0	*	0.4	8.2	26.4	30.3	13.9	13.9	6.8
Northeast	683	139,800	100.0	*	*	2.5	3.8	18.5	11.9	36.6	26.2
North Central	453	211,400	100.0	*	*	12.9	25.5	28.5	19.0	11.3	2.5
South	411	210,100	100.0	*	*	9.1	45.2	27.4	10.0	5.7	1.4
West	465	145,300	100.0	*	*	5.5	22.3	48.2	14.2	7.6	2.1
Nonprofit and government	456	305,400	100.0	4.7	2.2	15.2	25.6	19.7	11.5	12.4	8.8
Northeast	599	83,200	100.0	8.7	*	8.9	9.0	14.4	11.5	21.2	24.5
North Central	402	138,700	100.0	3.3	1.7	19.9	32.2	18.7	11.0	10.2	3.0
South	407	52,600	100.0	*	*	7.7	41.3	24.3	10.1	7.4	*
West	401	30,900	100.0	*	*	23.3	13.8	30.8	15.6	*	*
Both Medicare and Medicaid[3]											
All types of ownership	592	372,300	100.0	1.0	*	2.5	9.8	31.5	17.7	21.9	15.5
Northeast	784	100,900	100.0	*	*	2.8	2.3	7.3	8.4	34.9	42.6
North Central	557	89,700	100.0	*	*	3.4	8.6	25.9	25.3	27.0	8.0
South	504	72,800	100.0	*	*	*	20.0	38.7	21.0	13.0	5.6
West	502	109,000	100.0	*	*	2.3	11.0	53.8	17.7	11.6	3.1
Proprietary	588	285,600	100.0	*	*	1.3	9.5	34.9	18.3	21.8	13.9
Northeast	790	73,400	100.0	*	*	*	*	6.7	8.5	40.2	41.4
North Central	556	60,600	100.0	*	-	*	6.9	30.1	30.0	24.1	6.3
South	502	56,600	100.0	*	*	*	19.0	39.9	21.6	13.7	4.4
West	505	94,900	100.0	*	*	*	11.5	56.7	16.6	11.0	3.2
Nonprofit and government	605	86,800	100.0	3.8	*	6.4	11.0	20.5	15.4	22.2	20.6
Northeast	768	27,500	100.0	*	-	*	*	8.9	*	20.9	45.8
North Central	561	29,100	100.0	*	*	*	12.1	17.0	15.8	33.0	11.6
South	512	16,200	100.0	-	-	*	23.4	34.5	18.9	*	*
West	482	14,000	100.0	*	-	*	*	34.4	25.3	*	*
Medicaid only: SNH[4]											
All types of ownership	484	278,100	100.0	*	*	5.0	25.0	33.7	15.6	14.8	4.8
Northeast	617	73,700	100.0	*	*	3.5	8.5	19.1	11.6	39.0	16.4
North Central	465	86,200	100.0	*	*	7.7	19.9	32.4	26.8	10.9	*
South	422	75,300	100.0	*	*	*	39.6	45.7	9.6	3.2	-
West	405	42,900	100.0	-	*	8.3	38.1	40.4	10.7	*	*
Proprietary	483	183,100	100.0	*	*	2.7	25.3	36.5	17.1	14.8	3.5
Northeast	637	38,700	100.0	-	*	-	*	19.7	15.6	48.3	14.6
North Central	486	51,400	100.0	-	-	4.8	15.2	34.7	31.6	12.6	*
South	420	60,100	100.0	*	*	*	40.0	47.1	8.7	*	-
West	416	32,900	100.0	-	-	*	42.1	39.8	11.6	*	*
Nonprofit and government	486	95,100	100.0	*	*	9.6	24.5	28.2	12.8	14.7	7.4
Northeast	594	35,000	100.0	*	*	7.4	16.2	18.4	7.2	28.7	18.3
North Central	434	34,900	100.0	*	*	12.0	26.8	28.9	19.7	8.3	*
South	430	15,200	100.0	*	-	*	37.9	40.0	*	*	-
West	371	10,000	100.0	-	*	*	24.9	42.2	*	*	-

See footnotes at end of table.

Table 3. Average total monthly charge for care and number and percent distribution of residents by monthly charge intervals, according to certification, ownership, and geographic region of home: United States, August 1973-April 1974—Con.

Certification, ownership, and region	Average total monthly charge[1]	Number of residents[2]	Total	Monthly charge for care							
				Initial payment/ life care, no charge	$1-$149	$150-$299	$300-$399	$400-$499	$500-$599	$600-$799	$800 or more
Medicaid only: ICF			Percent distribution								
All types of ownership	$376	226,900	100.0	*	*	15.4	55.1	19.3	6.6	2.5	*
Northeast	481	23,600	100.0	*	-	*	10.0	49.5	27.9	*	*
North Central	366	104,000	100.0	*	*	21.9	47.9	23.1	4.7	*	*
South	359	84,600	100.0	*	*	9.6	77.4	6.1	3.1	*	-
West	369	14,700	100.0	-	-	22.9	49.0	20.1	*	*	*
Proprietary	382	163,000	100.0	*	*	12.5	55.9	22.2	5.7	2.4	*
Northeast	475	17,600	100.0	-	-	*	*	57.2	17.9	*	*
North Central	383	62,700	100.0	*	-	18.3	44.6	29.8	4.7	*	*
South	361	69,700	100.0	*	*	8.7	77.8	6.5	3.5	*	-
West	368	13,000	100.0	-	-	18.8	51.1	22.7	*	*	*
Nonprofit and government	358	639,000	100.0	*	*	22.8	52.9	11.9	8.7	*	*
Northeast	502	6,100	100.0	*	-	*	*	*	56.7	*	-
North Central	340	41,300	100.0	-	*	27.4	53.0	12.8	*	*	*
South	349	14,900	100.0	-	*	*	75.9	*	*	*	-
West	*	*	100.0	-	-	*	*	-	-	-	*
Not certified											
All types of ownership	329	134,500	100.0	7.6	4.5	34.0	24.9	14.4	6.9	5.8	2.0
Northeast	375	24,700	100.0	21.3	*	19.2	*	19.3	10.4	12.0	*
North Central	334	70,100	100.0	3.5	3.6	32.0	33.9	15.9	6.8	3.9	*
South	300	30,000	100.0	*	*	43.0	22.8	8.9	*	*	*
West	265	9,600	100.0	*	*	59.4	*	*	*	*	*
Proprietary	353	74,900	100.0	*	*	38.5	29.3	15.0	7.2	6.2	*
Northeast	432	10,100	100.0	*	*	*	*	32.4	*	*	*
North Central	360	36,700	100.0	*	*	32.4	37.7	15.0	7.8	*	*
South	322	23,600	100.0	*	*	49.3	25.2	*	*	*	*
West	*	4,500	100.0	*	-	68.8	*	*	*	-	-
Nonprofit and government	299	59,600	100.0	15.9	8.4	28.5	19.3	13.6	6.5	5.3	*
Northeast	335	14,600	100.0	35.0	*	17.5	*	*	*	*	*
North Central	307	33,500	100.0	7.0	*	31.5	29.6	16.8	*	*	*
South	220	6,400	100.0	*	*	*	*	*	*	*	-
West	249	5,200	100.0	*	*	51.2	*	*	*	*	*

[1]Includes life-care residents and no-charge residents.
[2]Includes only those residents who have lived in the nursing home for at least a month.
[3]Includes 20,900 residents in facilities certified by *Medicare* only.
[4]Includes 122,900 residents in facilities certified by Medicaid as *both* SNH's and ICF's.

Table 4. Average total monthly charge for care and number and percent distribution of residents by monthly charge intervals, according to sex, age, primary reason for admission, and length of stay since current admission: United States, August 1973-April 1974

Sex, age, primary reason for admission, and length of stay since current admission	Average total monthly charge[1]	Number of residents[2]	Total	Monthly charge for care							
				Initial payment/ life care, no charge	$1-$149	$150-$299	$300-$399	$400-$499	$500-$599	$600-$799	$800 or more
Sex and age			Percent distribution								
Both sexes, all ages	$479	1,012,000	100.0	1.6	0.9	10.3	26.1	27.1	13.2	13.4	7.4
Under 65 years	434	107,500	100.0	*	*	16.9	29.9	28.2	9.5	7.4	5.4
65-74 years	473	152,000	100.0	*	*	12.8	25.4	27.8	12.1	12.5	7.2
75-84 years	488	359,500	100.0	1.6	0.8	9.2	25.6	26.6	13.9	14.1	8.1
85 years and over	485	393,000	100.0	1.7	0.9	8.5	25.9	26.9	14.0	14.8	7.3
Male, all ages	466	294,800	100.0	1.2	1.1	12.3	27.9	26.1	12.8	12.0	6.6
Under 65 years	426	49,400	100.0	*	*	18.8	28.8	26.7	10.4	6.8	5.2
65-74 years	464	60,400	100.0	*	*	14.6	25.4	27.1	12.8	11.0	6.7
75-84 years	475	94,500	100.0	*	*	10.1	27.2	26.4	14.0	12.8	7.1
85 years and over	478	90,500	100.0	*	*	9.5	29.7	24.7	12.9	14.6	6.7
Female, all ages	484	717,200	100.0	1.7	0.9	9.5	25.4	27.5	13.3	14.0	7.7
Under 65 years	441	58,100	100.0	*	*	15.2	30.8	29.4	8.8	8.0	5.5
65-74 years	479	91,500	100.0	*	*	11.5	25.4	28.2	11.7	13.5	7.6
75-84 years	493	265,000	100.0	1.7	*	8.9	25.1	26.7	13.8	14.6	8.5
85 years and over	487	302,500	100.0	1.9	0.9	8.2	24.7	27.6	14.3	14.9	7.5
Primary reason for admission											
Physical	499	815,200	100.0	1.0	0.5	7.7	25.7	28.0	14.1	14.6	8.4
Social	369	66,400	100.0	6.5	4.4	24.2	26.7	18.1	8.3	8.6	*
Behavioral	419	119,800	100.0	*	*	19.3	30.2	26.5	9.9	9.1	3.0
Economic	294	10,500	100.0	29.2	*	*	*	*	*	*	*
Length of stay since current admission											
1 to less than 6 months	530	192,700	100.0	*	*	6.4	22.7	26.3	15.7	16.7	11.0
1 to less than 3 months	541	89,800	100.0	*	*	5.7	21.2	27.3	15.5	16.8	12.4
3 to less than 6 months	520	102,900	100.0	*	*	7.1	24.0	25.5	15.8	16.6	9.9
6 to less than 12 months	501	158,300	100.0	*	*	7.9	24.1	28.6	14.9	14.9	8.4
1 to less than 3 years	479	357,700	100.0	1.0	*	9.8	26.3	29.1	13.0	13.4	6.8
3 to less than 5 years	459	149,700	100.0	1.7	*	12.0	29.8	26.3	11.4	11.9	5.9
5 years or more	411	153,500	100.0	4.6	2.9	17.1	28.4	22.7	10.5	9.3	4.5

[1]Includes life-care residents and no-charge residents.
[2]Includes only those residents who have lived in the nursing home for at least a month.

Table 5. Average total monthly charge for care and number and percent distribution of residents by monthly charge intervals, according to level of care received and age. United States, August 1973-April 1974

Level of care received and age	Average total monthly charge[1]	Number of residents[2]	Total	Monthly charge for care							
				Initial payment/ life care, no charge	$1-$149	$150-$299	$300-$399	$400-$499	$500-$599	$600-$799	$800 or more
			Percent distribution								
All levels of care	$479	1,012,000	100.0	1.6	0.9	10.3	26.1	27.1	13.2	13.4	7.4
Under 65 years	434	107,500	100.0	*	*	16.9	29.9	28.2	9.5	7.4	5.4
65-74 years	473	152,000	100.0	*	*	12.8	25.4	27.8	12.1	12.5	7.2
75-84 years	488	359,500	100.0	1.6	0.8	9.2	25.6	26.6	13.9	14.1	8.1
85 years and over	485	393,000	100.0	1.7	0.9	8.5	25.9	26.9	14.0	14.8	7.3
Intensive nursing care	510	411,100	100.0	1.0	*	5.0	24.3	29.2	15.1	16.4	8.4
Under 65 years	491	37,400	100.0	*	*	*	26.8	35.8	10.2	10.6	8.4
65-74 years	508	55,100	100.0	*	*	6.6	21.9	31.5	13.6	16.4	8.2
75-84 years	517	145,800	100.0	*	*	4.7	23.9	28.3	15.7	17.2	8.8
85 years and over	509	172,800	100.0	*	*	4.7	24.8	27.9	16.1	17.0	8.0
Limited nursing care	480	98,700	100.0	*	*	9.2	27.1	27.2	13.8	13.3	7.0
Under 65 years	421	9,900	100.0	*	*	*	31.4	27.1	*	*	*
65-74 years	492	16,900	100.0	*	*	*	22.9	31.4	*	*	*
75-84 years	486	36,700	100.0	*	*	7.8	28.1	25.8	15.2	14.0	7.1
85 years and over	485	35,200	100.0	*	*	8.0	27.0	26.7	13.5	14.4	7.5
Routine nursing care	466	327,200	100.0	1.3	1.0	10.8	29.8	27.3	12.1	10.8	6.9
Under 65 years	421	32,400	100.0	*	*	15.9	37.4	24.5	9.6	*	*
65-74 years	454	51,700	100.0	*	*	12.8	30.6	27.2	11.6	9.4	6.3
75-84 years	476	119,600	100.0	*	*	9.9	28.7	27.6	12.4	11.5	7.8
85 years and over	473	123,600	100.0	*	*	9.6	28.5	27.8	12.6	12.1	7.0
Personal care	435	165,900	100.0	2.9	1.7	21.2	23.3	22.0	10.8	11.7	6.4
Under 65 years	381	26,800	100.0	*	*	32.7	25.3	23.4	*	*	*
65-74 years	432	26,600	100.0	*	*	24.4	24.2	19.7	10.2	10.5	*
75-84 years	447	53,700	100.0	*	*	18.9	22.2	21.3	11.8	12.2	8.1
85 years and over	451	58,800	100.0	*	*	16.8	22.8	23.0	11.5	14.8	6.2
No nursing or personal care	315	9,000	100.0	*	*	41.6	*	*	*	*	*
Under 65 years	*	*	100.0	*	*	*	*	-	*	*	-
65-74 years	*	*	100.0	-	*	*	*	*	*	*	-
75-84 years	*	3,700	100.0	*	*	*	*	*	*	*	*
85 years and over	*	2,600	100.0	*	*	*	*	*	*	*	-

[1]Includes life-care residents and no-charge residents.
[2]Includes only those residents who have lived in the nursing home for at least a month.

Table 6. Average total monthly charge for care and number and percent distribution of residents by monthly charge intervals, according to primary diagnosis at last examination: United States, August 1973-April 1974

Primary diagnosis at last examination	Average total monthly charge[1]	Number of residents[2]	Total	Monthly charge for care							
				Initial payment/ life care, no charge	$1-$149	$150-$299	$300-$399	$400-$499	$500-$599	$600-$799	$800 or more
				Percent distribution							
All primary diagnoses	$479	1,012,000	100.0	1.6	0.9	10.3	26.1	27.1	13.2	13.4	7.4
Accidents, poisonings, and violence	545	42,500	100.0	*	*	5.9	20.7	26.6	14.2	17.0	13.9
Diseases of the skin and subcutaneous tissue	504	5,600	100.0	-	*	*	*	41.4	*	*	*
Neoplasms	498	21,800	100.0	*	*	*	18.3	26.9	17.1	17.8	*
Diseases of the circulatory system	495	424,800	100.0	1.2	0.7	7.4	25.9	28.3	13.9	14.8	7.8
Stroke	508	105,200	100.0	*	*	5.1	24.9	29.7	14.2	16.5	8.0
Hardening of the arteries	502	230,100	100.0	1.0	*	7.7	25.0	28.5	13.8	14.3	9.0
Heart attack	466	52,300	100.0	*	*	8.6	30.2	26.7	14.6	13.6	4.8
Diseases of the circulatory system other than hardening of the arteries, stroke, and heart attack	457	37,200	100.0	*	*	10.8	28.1	25.8	13.5	14.1	*
Senility, old age, other symptoms and ill-defined conditions	495	140,300	100.0	*	*	12.1	26.0	23.9	12.4	12.5	10.9
Diseases of the genitourinary system	493	13,700	100.0	*	*	*	23.1	24.8	19.5	17.9	*
Diseases of the respiratory system	484	19,900	100.0	*	*	13.2	22.7	27.9	12.4	14.0	*
Diseases of the nervous system and sense organs	483	61,500	100.0	*	*	8.5	24.2	28.5	13.2	14.1	8.0
Endocrine, nutritional, and metabolic diseases	474	46,100	100.0	*	*	8.8	26.6	28.5	15.9	13.0	5.4
Diseases of the digestive system	467	18,900	100.0	*	*	*	21.6	27.9	14.2	14.9	*
Diseases of the blood and blood-forming organs	464	7,100	100.0	*	*	*	*	*	*	*	*
Congenital anomalies	*	3,100	100.0	*	-	*	*	*	*	*	*
Diseases of the musculoskeletal system and connective tissue	443	70,000	100.0	*	*	12.0	31.3	26.1	10.7	11.2	5.2
Infective and parasitic diseases	*	*	100.0	-	*	*	*	*	*	*	-
Mental disorders[3]	406	111,600	100.0	*	*	20.0	31.1	25.8	10.1	8.1	2.2
Certain causes of perinatal morbidity and mortality	*	*	100.0	-	-	*	*	*	-	*	*
Unknown diagnoses[4]	400	22,600	100.0	*	*	19.5	27.9	20.2	*	13.0	*

[1]Includes life-care residents and no-charge residents.
[2]Includes only those residents who have lived in the nursing home for at least a month.
[3]Includes mental retardation and mental illness.
[4]Includes complications of pregnancy and childbirth, and other diagnoses not listed above.

Table 7. Average total monthly charge for care and number and percent distribution of residents by monthly charge intervals, according to reported chronic conditions and impairments and number of chronic conditions: United States, August 1973-April 1974

Reported chronic conditions and impairments and number of chronic conditions	Average total monthly charge[1]	Number of residents	Total	Monthly charge for care							
				Initial payment/ life care, no charge	$1-$149	$150-$299	$300-$399	$400-$499	$500-$599	$600-$799	$800 or more
				Percent distribution							
All reported chronic conditions and impairments[2]	$479	1,012,000	100.0	1.6	0.9	10.3	26.1	27.1	13.2	13.4	7.4
Senility	483	590,800	100.0	0.9	0.7	7.6	27.9	28.9	14.0	13.5	6.5
Mental illness	444	191,400	100.0	*	*	13.7	31.0	26.8	12.4	10.1	4.3
Mental retardation	404	70,900	100.0	*	*	20.5	33.0	23.8	9.3	7.4	*
Arthritis or rheumatism	466	352,900	100.0	1.7	1.0	9.2	29.8	27.3	12.4	12.9	5.8
Paralysis or palsy other than arthritis	508	177,100	100.0	*	*	6.4	24.6	29.6	13.6	15.7	8.7
Glaucoma or cataracts	490	106,300	100.0	*	*	8.5	27.0	26.7	12.4	13.7	8.9
Diabetes	502	134,400	100.0	*	*	7.6	23.7	29.1	15.6	14.5	8.2
Chronic trouble with back or spine	467	102,100	100.0	*	*	8.4	29.0	29.4	11.3	13.9	5.4
Amputation of extremities or limbs or permanent stiffness or any deformity of foot, leg, fingers, arm, or back	476	143,800	100.0	1.6	*	6.1	27.8	30.9	13.7	13.1	5.7
Heart trouble	499	337,800	100.0	1.2	0.8	7.9	24.9	28.3	13.7	14.9	8.4
None of the above	473	51,200	100.0	5.4	*	14.3	18.8	21.1	13.0	15.8	9.9
Number of chronic conditions	479	1,012,000	100.0	1.6	0.9	10.3	26.1	27.1	13.2	13.4	7.4
0 conditions	473	51,200	100.0	5.4	*	14.3	18.8	21.1	13.0	15.8	9.9
1 condition	474	277,000	100.0	1.8	1.1	13.4	25.0	25.2	12.5	12.8	8.2
2 conditions	483	330,600	100.0	1.4	0.8	10.4	25.2	27.4	13.4	13.7	7.7
3 conditions	486	212,100	100.0	1.2	*	7.7	27.6	28.1	14.1	13.7	6.8
4 conditions	471	91,300	100.0	*	*	7.9	28.7	30.3	13.6	12.8	5.2
5 conditions or more	470	49,700	100.0	*	*	*	35.1	31.6	11.1	13.1	*

[1]Includes life-care residents and no-charge residents.

[2]Includes only those residents who have lived in the nursing home for at least a month. Number of residents exceeds total since resident could have more than one chronic condition.

Table 8. Average total monthly charge for care and number and percent distribution of residents by monthly charge intervals, according to primary source of payment: United States, August 1973-April 1974

Primary source of payment	Average total monthly charge	Number of residents[1]	Total	Monthly charge for care							
				Initial payment/ life care, no charge	$1-$149	$150-$299	$300-$399	$400-$499	$500-$599	$600-$799	$800 or more
				Percent distribution							
All sources	$479	1,012,000	100.0	1.6	0.9	10.3	26.1	27.1	13.2	13.4	7.4
Own income or family support	491	371,700	100.0	-	1.5	12.7	21.8	21.7	16.9	17.9	7.5
Medicare	754	10,800	100.0	-	-	*	*	*	*	28.2	34.6
Medicaid	503	484,300	100.0	-	*	4.3	29.4	34.3	12.2	11.5	8.2
Other public assistance or welfare	381	114,900	100.0	-	2.3	29.3	32.3	20.3	6.5	6.8	2.5
Church support	*	*	100.0	-	-	*	*	*	*	*	*
VA contract	446	8,200	100.0	-	*	*	*	*	*	*	*
Initial payment/life care	-	6,200	100.0	100.0	-	-	-	-	-	-	-
No charge	*	9,600	100.0	100.0	-	-	-	-	-	-	-
Miscellaneous sources	467	4,400	100.0	-	*	*	*	*	*	*	*

[1]Includes only those residents who have lived in the nursing home for at least a month.

Table 9. Average total monthly charge for care and number of residents, by primary source of payment, certification, ownership, and size: United States, August 1973-April 1974

Certification, ownership, and size	Primary source of payment											
	All sources		Own income or family support		Medicare		Medicaid		Other public assistance or welfare		All other sources[1]	
	Average total monthly charge	Number of residents	Average total monthly charge	Number of residents	Average total monthly charge	Number of residents	Average total monthly charge	Number of residents	Average total monthly charge	Number of residents	Average total monthly charge	Number of residents
All types of certification[2]												
All types of ownership[2]	$479	1,012,000	$491	371,700	$754	10,800	$503	484,300	$381	114,900	$225	30,200
Less than 50 beds	397	153,500	429	63,700	*	*	431	56,900	296	26,800	*	5,200
50-99 beds	448	345,500	484	130,500	*	3,100	449	165,500	356	37,600	186	8,700
100-199 beds	502	360,500	523	130,800	787	4,700	508	183,300	414	31,800	256	10,000
200 beds or more	576	152,400	506	46,700	*	*	656	78,600	496	18,700	307	6,300
Proprietary	489	706,500	525	243,800	754	8,100	486	367,000	373	77,700	406	9,900
Less than 50 beds	410	119,000	449	47,600	*	*	426	47,000	294	22,100	*	*
50-99 beds	463	259,200	514	91,700	*	2,500	444	133,300	360	29,000	*	2,700
100-199 beds	521	266,600	569	89,100	783	4,200	499	147,600	445	20,900	409	4,900
200 beds or more	609	61,700	564	15,500	*	*	647	39,000	477	5,600	*	*
Nonprofit and government	456	305,400	427	127,900	*	2,600	556	117,300	397	37,300	136	20,300
Less than 50 beds	354	34,500	367	16,100	*	*	451	9,900	*	4,700	*	3,300
50-99 beds	406	86,300	413	38,900	*	*	469	32,200	341	8,600	*	6,000
100-199 beds	447	93,900	425	41,700	*	*	545	35,700	353	10,900	*	5,100
200 beds or more	553	90,700	477	31,300	*	*	664	39,600	504	13,100	298	5,800
Both Medicare and Medicaid[3]												
All types of ownership	592	372,300	613	134,100	754	10,800	591	200,900	480	18,300	334	8,300
Less than 50 beds	537	17,000	577	7,800	*	*	532	6,900	*	*	*	*
50-99 beds	559	112,600	619	43,300	*	3,100	521	59,100	437	5,500	*	*
100-199 beds	592	170,800	621	63,800	787	4,700	579	90,500	505	8,600	*	3,200
200 beds or more	658	72,000	587	19,200	*	*	716	44,500	*	3,600	*	2,700
Proprietary	588	285,600	625	103,800	754	8,100	566	157,700	481	13,000	*	2,900
Less than 50 beds	559	10,800	596	5,600	*	*	516	4,600	*	*	*	*
50-99 beds	558	92,900	626	35,600	*	2,500	508	50,100	*	3,900	*	*
100-199 beds	588	143,600	627	53,200	783	4,200	562	76,900	495	7,500	*	*
200 beds or more	673	38,300	628	9,400	*	*	698	26,100	*	*	*	*
Nonprofit and government	605	86,800	571	30,200	*	2,600	682	43,200	479	5,400	*	5,300
Less than 50 beds	500	6,100	*	*	*	*	*	*	*	*	*	*
50-99 beds	565	19,700	585	7,600	*	*	597	9,000	*	*	*	*
100-199 beds	611	27,200	589	10,600	*	*	676	13,600	*	*	*	*
200 beds or more	641	33,700	548	9,800	*	*	741	18,300	*	*	*	2,500
Medicaid only: SNH[4]												
All types of ownership	484	278,100	489	88,400	...	...	489	162,900	469	21,700	308	5,100
Less than 50 beds	482	28,700	478	12,000	...	...	512	13,000	*	3,200	*	*
50-99 beds	461	91,200	489	30,900	...	...	453	53,900	448	4,900	*	*
100-199 beds	473	105,300	489	31,600	...	...	465	65,600	506	5,900	*	*
200 beds or more	547	53,000	500	13,900	...	...	595	30,300	488	7,700	*	*
Proprietary	483	183,100	520	52,300	...	...	466	114,900	498	13,400	*	2,400
Less than 50 beds	490	22,300	529	7,900	...	...	491	11,100	*	2,900	*	*
50-99 beds	470	65,600	508	20,300	...	...	451	41,500	*	3,200	*	*
100-199 beds	478	77,000	525	20,500	...	...	451	51,100	590	4,100	*	*
200 beds or more	544	18,100	*	3,600	...	...	559	11,300	*	3,200	*	*
Nonprofit and government	$486	95,100	$445	36,100	...	...	$544	48,000	$422	8,400	*	2,700
Less than 50 beds	454	6,300	*	4,100	...	...	*	*	*	*	*	*
50-99 beds	437	25,600	451	10,500	...	...	460	12,400	*	*	*	*
100-199 beds	460	28,300	423	11,100	...	...	511	14,600	*	*	*	*
200 beds or more	548	34,900	487	10,300	...	...	616	19,000	478	4,600	*	*

See footnotes at end of table.

Table 9. Average total monthly charge for care and number of residents, by primary source of payment, certification, ownership, and size: United States, August 1973-April 1974—Con.

Certification, ownership, and size	Primary source of payment											
	All sources		Own income or family support		Medicare		Medicaid		Other public assistance or welfare		All other sources[1]	
	Average total monthly charge	Number of residents	Average total monthly charge	Number of residents	Average total monthly charge	Number of residents	Average total monthly charge	Number of residents	Average total monthly charge	Number of residents	Average total monthly charge	Number of residents
Medicaid only: ICF												
All types of ownership	376	226,900	388	81,200	...	...	375	120,600	333	22,000	*	3,200
Less than 50 beds	378	64,100	393	20,500	...	...	383	37,000	301	5,800	*	*
50-99 beds	369	92,800	384	32,400	...	...	363	52,500	330	6,800	*	*
100-199 beds	377	56,900	382	20,900	...	...	378	27,200	360	7,900	*	*
200 beds or more	404	13,100	402	7,400	...	...	*	3,900	*	*	*	*
Proprietary	382	163,000	410	49,700	...	...	376	94,400	334	16,500	*	2,400
Less than 50 beds	388	52,600	415	15,400	...	...	390	31,300	299	5,100	*	*
50-99 beds	373	70,200	403	21,900	...	...	360	41,800	333	5,900	*	*
100-199 beds	390	36,000	422	10,600	...	..	380	19,700	367	4,900	*	*
200 beds or more	*	4,200	*	*	...	...	*	*	*	*	*	*
Nonprofit and government	358	63,900	352	31,500	...	...	372	26,200	332	5,500	*	*
Less than 50 beds	334	11,400	325	5,100	...	...	344	5,700	*	*	-	-
50-99 beds	356	22,600	346	10,500	...	...	372	10,800	*	*	*	*
100-199 beds	355	21,000	341	10,300	...	...	371	7,500	*	3,000	*	*
200 beds or more	404	8,900	405	5,600	...	...	*	*	*	*	*	*
Not certified												
All types of ownership	329	134,500	377	68,000	...	...	...	...	330	52,800	*	13,700
Less than 50 beds	316	43,800	386	23,400	...	...	...	...	273	17,200	*	3,100
50-99 beds	322	48,800	370	24,000	...	...	...	...	321	20,400	*	4,500
100-199 beds	310	27,500	369	14,400	...	...	...	...	316	9,400	*	3,700
200 beds or more	430	14,400	392	6,200	...	...	...	...	548	5,800	*	2,400
Proprietary	353	74,900	407	37,900	...	...	...	...	303	34,800	*	*
Less than 50 beds	343	33,200	400	18,600	...	...	...	...	273	141,000	*	*
50-99 beds	364	30,500	413	13,800	...	...	...	...	327	16,000	*	*
100-199 beds	360	10,100	439	4,700	...	..	...	...	*	4,400	*	*
200 beds or more	*	*	*	*	...	...	...	...	*	*	*	*
Nonprofit and government	299	59,600	339	30,200	...	...	...	...	381	18,000	*	11,500
Less than 50 beds	231	10,600	330	4,800	...	...	...	...	*	3,100	*	2,700
50-99 beds	251	18,300	312	10,200	...	...	...	...	*	4,500	*	3,700
100-199 beds	282	17,400	334	9,700	...	...	...	...	320	5,000	*	2,800
200 beds or more	444	13,200	406	5,500	...	...	...	...	566	5,500	*	*

[1]Includes church support, VA contract, initial payment/life care, no charge for care, and miscellaneous sources.
[2]Includes only those residents who have lived in the nursing home for at least a month.
[3]Includes 20,900 residents in facilities certified by *Medicare* only.
[4]Includes 122,900 residents in facilities certified by Medicaid as *both* SNH's and ICF's.

Table 10. Average total monthly charge for care and number of residents, by primary source of payment, certification, ownership, and geographic region of home: United States, August 1973-April 1974

Certification, ownership, and region	Primary source of payment											
	All sources		Own income or family support		Medicare		Medicaid		Other public assistance or welfare		All other sources[1]	
	Average total monthly charge	Number of residents	Average total monthly charge	Number of residents	Average total monthly charge	Number of residents	Average total monthly charge	Number of residents	Average total monthly charge	Number of residents	Average total monthly charge	Number of residents
All types of certification[2]												
All types of ownership	$479	1,012,000	$491	371,700	$754	10,800	$503	484,300	$381	114,900	$225	30,200
Northeast	651	223,000	637	68,100	*	3,000	718	118,500	538	23,400	131	9,900
North Central	433	350,100	449	155,500	*	2,800	454	124,700	360	56,500	252	10,600
South	410	262,700	452	81,400	*	2,900	408	145,000	306	27,000	278	6,400
West	454	176,200	487	66,700	*	*	442	96,100	323	8,000	*	3,300
Proprietary	489	706,500	525	243,800	754	8,100	486	367,000	373	77,700	406	9,900
Northeast	683	139,800	685	45,000	*	2,700	705	76,400	529	14,300	*	*
North Central	453	211,400	490	86,600	*	*	449	85,600	362	34,300	*	3,200
South	411	210,100	460	60,700	*	*	405	120,400	308	23,500	*	3,600
West	465	145,300	519	51,500	*	*	439	84,700	313	5,600	*	*
Nonprofit and government	456	305,400	427	127,900	*	2,600	556	117,300	397	37,300	136	20,300
Northeast	599	83,200	543	23,100	*	*	742	42,100	552	9,100	*	8,400
North Central	402	138,700	398	68,900	*	*	466	39,100	357	22,200	175	7,400
South	407	52,600	427	20,700	*	*	424	24,600	*	3,500	*	2,800
West	401	30,900	381	15,200	*	*	464	11,500	*	2,400	*	*
Both Medicare and Medicaid[3]												
All types of ownership	592	372,300	613	134,100	754	10,800	591	200,900	480	18,300	334	8,300
Northeast	784	100,900	741	32,900	*	3,000	844	57,100	585	5,300	*	2,600
North Central	557	89,700	589	36,600	*	2,800	545	39,800	486	7,300	*	3,200
South	504	72,800	556	26,500	*	2,900	471	39,000	*	3,400	*	*
West	502	109,000	564	38,200	*	*	468	65,000	*	*	*	*
Proprietary	588	285,600	625	103,800	754	8,100	566	157,700	481	13,000	*	2,900
Northeast	790	73,400	761	24,900	*	2,700	824	41,100	576	4,000	*	*
North Central	556	60,600	604	25,900	*	*	513	27,500	478	4,700	*	*
South	502	56,600	572	19,500	*	*	462	31,600	*	2,900	*	*
West	505	94,900	571	33,400	*	*	463	57,500	*	*	*	*
Nonprofit and government	605	86,800	571	30,200	*	2,600	682	43,200	479	5,400	*	5,300
Northeast	768	27,500	679	7,900	*	*	894	16,000	*	*	*	*
North Central	561	29,100	553	10,600	*	*	617	12,300	*	2,600	*	2,500
South	512	16,200	508	6,900	*	*	510	7,300	*	*	*	*
West	482	14,000	519	4,800	*	*	504	7,500	*	*	*	*
Medicaid only: SNH[4]												
All types of ownership	484	278,100	489	88,400	...	...	489	162,900	469	21,700	308	5,100
Northeast	617	73,700	583	20,000	...	...	646	45,200	583	7,500	*	*
North Central	465	86,200	483	34,200	...	...	471	39,600	423	10,600	*	*
South	422	75,300	459	18,800	...	...	411	53,200	*	*	*	*
West	405	42,900	417	15,400	...	...	399	24,900	*	*	*	*
Proprietary	483	183,100	520	52,300	...	...	466	114,900	498	13,400	*	2,400
Northeast	637	38,700	668	10,300	...	...	622	23,200	647	4,900	*	*
North Central	486	51,400	521	17,900	...	...	475	26,600	437	6,200	*	*
South	420	60,100	458	13,700	...	...	410	43,700	*	*	*	*
West	416	32,900	453	10,400	...	...	400	21,400	*	*	*	*
Nonprofit and government	486	95,100	445	36,100	...	...	544	48,000	422	8,400	*	2,700
Northeast	594	35,000	494	9,700	...	...	672	22,000	*	2,700	*	*
North Central	434	34,900	442	16,300	...	...	462	13,000	405	4,400	*	*
South	430	15,200	461	5,100	...	...	416	9,400	*	*	*	*
West	371	10,000	341	4,900	...	...	*	3,500	*	*	*	*

See footnotes at end of table.

Table 10. Average total monthly charge for care and number of residents, by primary source of payment, certification, ownership, and geographic region of home: United States, August 1973-April 1974—Con.

Certification, ownership, and region	Primary source of payment											
	All sources		Own income or family support		Medicare		Medicaid		Other public assistance or welfare		All other sources[1]	
	Average total monthly charge	Number of residents	Average total monthly charge	Number of residents	Average total monthly charge	Number of residents	Average total monthly charge	Number of residents	Average total monthly charge	Number of residents	Average total monthly charge	Number of residents
Medicaid only: ICF												
All types of ownership	$376	226,900	$388	81,200	. . .	. . .	$375	120,600	$333	22,000	*	3,200
Northeast	481	23,600	515	4,800	. . .	. . .	475	16,200	*	*	*	*
North Central	366	104,000	378	47,400	. . .	. . .	360	45,200	331	10,000	*	*
South	359	84,600	375	22,300	. . .	. . .	359	52,900	316	8,700	*	*
West	369	14,700	402	6,700	. . .	. . .	352	6,300	*	*	*	*
Proprietary	382	163,000	410	49,700	. . .	. . .	376	94,400	334	16,500	*	2,400
Northeast	475	17,600	542	3,800	. . .	. . .	457	12,000	*	*	*	*
North Central	383	62,700	410	23,200	. . .	. . .	371	31,500	342	6,900	*	*
South	361	69,700	385	16,900	. . .	. . .	360	45,100	313	7,200	*	*
West	368	13,000	398	5,800	. . .	. . .	353	5,800	*	*	*	*
Nonprofit and government	358	63,900	352	31,500	. . .	. . .	372	26,200	332	5,500	*	*
Northeast	502	6,100	*	*	. . .	. . .	528	4,200	*	*	*	*
North Central	340	41,300	348	24,200	. . .	. . .	335	13,700	*	3,200	*	*
South	349	14,900	346	5,400	. . .	. . .	354	7,800	*	*	*	*
West	*	*	*	*	. . .	. . .	*	*	*	*	*	*
Not certified												
All types of ownership	329	134,500	377	68,000	. . .	. . .	. . .	. . .	330	52,800	*	13,700
Northeast	375	24,700	467	10,500	. . .	. . .	. . .	. . .	487	8,400	*	5,800
North Central	334	70,100	371	37,400	. . .	. . .	. . .	. . .	314	28,500	*	4,200
South	300	30,000	367	13,800	. . .	. . .	. . .	. . .	275	13,100	*	3,000
West	265	9,600	284	6,300	. . .	. . .	. . .	. . .	*	2,800	-	*
Proprietary	353	74,900	407	37,900	. . .	. . .	. . .	. . .	303	34,800	*	*
Northeast	432	10,100	490	6,000	. . .	. . .	. . .	. . .	*	3,900	*	*
North Central	360	36,700	407	19,600	. . .	. . .	. . .	. . .	308	16,400	*	*
South	322	23,600	376	10,600	. . .	. . .	. . .	. . .	283	11,900	*	*
West	*	4,500	*	*	. . .	. . .	. . .	. . .	*	2,600	-	*
Nonprofit and government	299	59,600	339	30,200	. . .	. . .	. . .	. . .	381	18,000	*	11,500
Northeast	335	14,600	438	4,600	. . .	. . .	. . .	. . .	591	4,500	*	5,500
North Central	307	33,500	333	17,800	.	. . .	..	. . .	321	12,100	*	3,500
South	220	6,400	*	3,200	. . .	. . .	. . .	. . .	*	*	*	*
West	*	5,200	*	4,600	. . .	. . .	..	. . .	*	*	-	*

[1]Includes church support, VA contract, initial payment/life care, no charge for care, and miscellaneous sources.
[2]Includes only those residents who lived in the nursing home for at least a month.
[3]Includes 20,900 residents in facilities certified by *Medicare* only.
[4]Includes 122,900 residents in facilities certified by Medicaid as *both* SNH's and ICF's.

Table 11. Average total monthly charge for care and number of residents, by primary source of payment, ownership, and type of service provided: United States, August 1973-April 1974

Ownership and type of service provided	Primary source of payment											
	All sources		Own income or family support		Medicare		Medicaid		Other public assistance or welfare		All other sources[1]	
	Average total monthly charge	Number of residents	Average total monthly charge	Number of residents	Average total monthly charge	Number of residents	Average total monthly charge	Number of residents	Average total monthly charge	Number of residents	Average total monthly charge	Number of residents
All types of ownership[2]	$479	1,012,000	$491	371,700	$754	10,800	$503	484,300	$381	114,900	$225	30,200
Nursing care	495	655,600	516	235,500	803	7,800	501	334,900	398	62,500	296	14,800
Personal care with nursing	448	356,400	447	136,200	*	2,900	507	149,500	361	52,400	156	15,400
Proprietary	489	706,500	525	243,800	754	8,100	486	367,000	373	77,700	406	9,900
Nursing care	499	487,900	542	167,400	806	6,000	486	263,300	388	44,400	427	6,900
Personal care with nursing	465	218,700	487	76,400	*	*	485	103,700	353	33,300	*	3,100
Nonprofit and government	456	305,400	427	127,900	*	2,600	556	117,300	397	37,300	136	20,300
Nursing care	485	167,700	453	68,100	*	*	557	71,600	422	18,200	184	8,000
Personal care with nursing	421	137,700	396	59,800	*	*	556	45,700	374	19,100	*	12,300

[1]Includes church support, VA contract, initial payment/life care, no charge for care, and miscellaneous sources.
[2]Includes only those residents who have lived in the nursing home for at least a month.

Table 12. Average total monthly charge for care and number of residents, by primary source of payment, sex, age, primary reason for admission, and length of stay since current admission: United States, August 1973-April 1974

Sex, age, primary reason for admission, and length of stay since current admission	Primary source of payment											
	All sources		Own income or family support		Medicare		Medicaid		Other public assistance or welfare		All other sources[1]	
	Average total monthly charge	Number of residents	Average total monthly charge	Number of residents	Average total monthly charge	Number of residents	Average total monthly charge	Number of residents	Average total monthly charge	Number of residents	Average total monthly charge	Number of residents
Sex and age												
Both sexes, all ages[2]	$479	1,012,000	$491	371,700	$754	10,800	$503	484,300	$381	114,900	$225	30,200
Under 65 years	434	107,500	497	19,500	*	*	457	57,900	351	24,000	325	6,000
65-74 years	473	152,000	470	46,800	*	*	503	78,900	367	20,200	*	3,700
75-84 years	488	359,500	490	149,500	725	5,000	517	163,300	385	30,900	219	10,900
85 years and over	485	393,000	498	155,900	*	3,400	505	184,300	402	39,800	152	9,600
Male, all ages	466	294,800	471	105,700	*	2,600	495	137,200	360	36,200	341	13,100
Under 65 years	426	49,400	470	9,100	*	*	459	24,600	337	11,500	*	4,100
65-74 years	464	60,400	449	16,500	*	*	505	32,500	348	8,300	*	2,400
75-84 years	475	94,500	472	41,700	*	*	504	39,800	382	7,500	*	4,400
85 years and over	478	90,500	479	38,400	*	*	500	40,200	381	8,900	*	*
Female, all ages	484	717,200	499	266,000	735	8,200	506	347,200	390	78,700	136	17,100
Under 65 years	441	58,100	520	10,400	*	*	455	33,400	364	12,400	*	*
65-74 years	479	91,500	482	30,400	*	*	501	46,400	381	11,900	*	*
75-84 years	493	265,000	497	107,800	726	4,000	521	123,400	386	23,400	*	6,500
85 years and over	487	302,500	504	117,500	*	2,600	506	144,000	408	30,900	*	7,400
Primary reason for admission												
Total	479	1,012,000	491	371,700	754	10,800	503	484,300	381	114,900	225	30,200
Physical	499	815,200	506	301,700	764	10,400	514	407,700	408	77,600	281	17,900
Social	369	66,400	384	31,900	*	*	452	19,200	305	9,100	*	6,200
Behavioral	419	119,800	468	35,700	*	*	436	54,600	331	26,300	*	2,900
Economic	294	10,500	*	2,400	*	*	*	2,900	*	*	*	3,200
Length of stay since current admission												
Total	479	1,012,000	491	371,700	754	10,800	503	484,300	381	114,900	225	30,200
1 to less than 6 months	530	192,700	549	80,600	795	8,900	517	82,600	412	15,200	331	5,400
1 to less than 3 months	541	89,800	555	35,800	781	7,200	518	36,600	428	7,500	*	2,600
3 to less than 6 months	520	102,900	544	44,800	*	*	516	46,100	397	7,700	*	2,700
6 to less than 12 months	501	158,300	512	68,000	*	*	516	73,200	400	13,900	*	2,600
1 to less than 3 years	479	357,700	485	128,200	*	*	503	182,300	392	38,600	261	7,800
3 to less than 5 years	459	149,700	456	48,200	*	*	500	76,800	367	19,900	*	4,700
5 years or more	411	153,500	412	46,700	*	*	474	69,400	348	27,400	136	9,700

[1]Includes church support, VA contract, initial payment/life care, no charge for care, and miscellaneous sources.
[2]Includes only those residents who have lived in the nursing home for at least a month.

Table 13. Average total monthly charge for care and number and percent distribution of residents by length of stay since current admission, according to level of care received and primary source of payment: United States, August 1973-April 1974

Level of care received and primary source of payment	Average total monthly charge	Number of residents	Total	Length of stay since current admission				
				1 to less than 6 months	6 to less than 12 months	1 to less than 3 years	3 to less than 5 years	5 years or more
			Percent distribution of residents					
All levels of care[1]	$479	1,012,000	100.0	19.3	15.4	35.4	14.8	15.2
Own income or family support	491	371,700	100.0	22.1	17.9	34.5	13.0	12.6
Medicare	754	10,800	100.0	82.5	*	*	*	*
Medicaid	503	484,300	100.0	17.3	14.9	37.6	15.9	14.3
Other public assistance or welfare	581	114,900	100.0	13.2	12.1	33.6	17.3	23.9
All other sources[2]	225	30,200	100.0	17.9	8.5	25.9	15.5	32.2
Intensive nursing care	510	411,100	100.0	21.5	15.0	34.3	14.9	14.3
Own income or family support	541	151,700	100.0	23.0	17.7	34.5	12.8	12.1
Medicare	773	6,800	100.0	85.1	*	*	*	*
Medicaid	504	205,900	100.0	18.8	14.1	35.9	16.7	14.5
Other public assistance or welfare	427	37,800	100.0	18.1	11.3	32.9	16.6	21.2
All other sources[2]	267	8,900	100.0	26.7	*	*	*	27.5
Limited nursing care	480	98,700	100.0	20.0	15.3	34.5	15.7	14.4
Own income or family support	492	34,100	100.0	26.0	15.9	32.1	15.7	10.3
Medicare	*	*	100.0	*	*	*	-	-
Medicaid	506	47,800	100.0	16.7	15.4	38.7	15.3	13.8
Other public assistance or welfare	392	12,500	100.0	*	*	32.1	20.8	20.2
All other sources[2]	*	3,200	100.0	*	*	*	*	*
Routine nursing care	466	327,200	100.0	18.4	16.7	37.3	14.0	13.7
Own income or family support	467	116,100	100.0	22.6	19.1	35.6	12.1	10.7
Medicare	*	*	100.0	*	*	*	-	*
Medicaid	498	162,900	100.0	16.5	16.2	39.8	14.8	12.7
Other public assistance or welfare	364	37,100	100.0	10.5	13.9	35.1	16.6	23.9
All other sources[2]	231	9,100	100.0	*	*	29.3	*	28.1
Personal care	435	165,900	100.0	15.6	14.0	34.8	15.6	19.9
Own income or family support	430	64,300	100.0	18.1	16.8	34.3	13.6	17.2
Medicare	*	*	100.0	*	*	*	*	-
Medicaid	508	66,300	100.0	14.8	14.0	37.2	16.4	17.7
Other public assistance or welfare	339	26,100	100.0	10.9	9.9	33.7	17.8	27.7
All other sources[2]	178	8,200	100.0	*	*	*	*	36.9
No nursing or personal care	315	9,000	100.0	*	*	29.8	*	31.4
Own income or family support	327	5,500	100.0	*	*	*	*	*
Medicare	-	-	-	-	-	-	-	-
Medicaid	*	*	100.0	*	*	*	*	*
Other public assistance or welfare	*	*	100.0	*	*	*	*	*
All other sources[2]	*	*	100.0	*	-	*	*	*

[1]Includes only those residents in the home for at least a month.
[2]Includes church support, VA contract, initial payment/life care, no charge for care, and miscellaneous sources.

Table 14. Number of residents by sources of payment, sex, and age: United States, August 1973-April 1974

Sex and age	All residents[2]	Sources of payment[1]									Number of sources of payment		
		Own income or family support	Medicare	Medicaid	Other public assistance or welfare	Church support	VA contract	Initial payment/ life care	No charge	Miscellaneous sources	One source	Two sources	Three sources or more
Both sexes	Number of residents												
All ages	1,012,000	787,700	18,200	505,300	138,500	4,200	10,000	10,100	8,900	7,500	533,400	461,600	17,000
Under 65 years	107,500	56,700	*	60,300	27,900	*	3,500	*	*	*	62,300	43,600	*
65-74 years	152,000	107,700	3,500	82,800	24,900	*	*	*	*	*	79,700	69,300	2,900
75-84 years	359,500	297,700	7,900	173,000	39,000	*	3,300	3,900	3,000	*	187,200	165,800	6,600
85 years and over	393,000	325,600	6,300	189,100	46,800	*	*	5,600	3,200	*	204,300	182,900	5,800
Male													
All ages	294,800	221,200	4,500	146,800	43,700	*	7,600	*	2,800	4,100	157,300	131,800	5,700
Under 65 years	49,400	26,400	*	25,900	13,300	-	2,900	-	*	*	27,900	20,600	*
65-74 years	60,400	41,500	*	34,400	10,500	*	*	-	*	*	30,200	28,800	*
75-84 years	94,500	77,600	*	44,300	9,600	*	2,400	*	*	*	51,000	41,600	*
85 years and over	90,500	75,800	*	42,200	10,200	*	*	*	*	*	48,200	40,900	*
Female													
All ages	717,200	566,500	13,700	358,500	94,800	3,700	2,400	9,200	6,100	3,400	376,200	329,800	11,300
Under 65 years	58,100	30,400	*	34,400	14,600	*	*	*	*	*	34,400	23,000	*
65-74 years	91,500	66,200	*	48,400	14,300	*	*	*	*	*	49,500	40,500	*
75-84 years	265,000	220,100	6,300	128,800	29,400	*	*	3,500	*	*	136,200	124,200	4,700
85 years and over	302,500	249,800	5,000	146,800	36,500	*	*	5,000	2,400	*	156,100	142,000	4,400

[1]Includes only those residents who have lived in the nursing home for at least a month.
[2]Number of residents exceeds total since residents may have more than one source of payment.

Table 15. Number and percent distribution of residents by number of sources of payment, according to primary source of payment: United States, August 1973-April 1974

Primary source of payment	All residents[1]	Number of sources of payment							
		One source	Two sources	Secondary source					Three sources or more
				Own income or family support	Medicare	Medicaid	Other public assistance or welfare	All other sources[2]	
	Number of residents								
All sources	1,012,000	533,400	461,600	401,700	4,800	21,000	20,900	13,100	17,000
Own income or family support	371,700	330,200	39,700	-	3,200	19,000	9,100	8,400	*
Medicare	10,800	3,000	6,800	5,700	-	*	*	*	*
Medicaid	484,300	132,600	343,300	330,100	*	-	10,300	*	8,500
Other public assistance or welfare	114,900	53,000	60,300	58,400	*	*	-	*	*
All other sources[2]	30,200	14,700	11,500	7,500	-	*	*	*	4,100
	Percent distribution of residents								
All sources	100.0	52.7	45.6	39.7	0.5	2.1	2.1	1.3	1.7
Own income or family support	100.0	88.8	10.7	-	0.9	5.1	2.5	2.3	*
Medicare	100.0	27.4	63.2	53.0	-	*	*	*	*
Medicaid	100.0	27.4	70.9	68.1	*	-	2.1	*	1.8
Other public assistance or welfare	100.0	46.2	52.5	50.9	*	*	-	*	*
All other sources[2]	100.0	48.6	38.0	24.9	-	*	*	*	13.5

[1]Includes only those residents who have lived in the nursing home for at least a month.
[2]Includes church support, VA contract, initial payment/life care, no charge for care, and miscellaneous sources.

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APPENDIX I

TECHNICAL NOTES ON METHODS

SURVEY DESIGN

From August 1973 to April 1974, the Division of Health Resources Utilization Statistics (DHRUS) conducted the National Nursing Home Survey (NNHS)—a sample survey of nursing homes, their residents and staff in the conterminous United States. The survey was designed and developed by DHRUS in conjunction with a group of experts in various fields encompassing the broad area of long-term care.[13] It was specifically designed as the first of a series of surveys to satisfy the diverse data needs of those who establish standards for, plan, provide, and assess long-term care services.

Sampling Frame

The 1973-74 NNHS focused on nursing homes which *provided some level of nursing care.* Only facilities providing nursing care were included because detailed questions on facility services and resident health status were relevant only to these facilities. They included both nursing care homes and personal care with nursing homes, while personal care homes and domiciliary care homes were excluded. Facilities were either freestanding establishments, or nursing care units of hospitals, retirement centers, and similar institutions. A definition of nursing care and detailed criteria for classifying facilities providing such care are presented in appendix II.

The survey universe consisted of two groups of facilities: those providing some level of nursing care as classified in the 1971 Master Facility Inventory (MFI) *and* those opening for business in 1972. The major group (93 percent) was composed of all nursing homes providing some level of nursing care as classified by the 1971 MFI. The MFI is a census of all inpatient health facilities conducted every 2 years by mail by the National Center for Health Statistics. A detailed description of how the MFI was developed, its content, and procedures for updating and assessing its coverage has been published.[14-16]

In order for data collection to begin in August, the sampling frame was "frozen" in the spring of 1973 so that the sample could be selected in ample time to permit the scheduling of nationwide data collection. To obtain as current a sample frame as possible, all nursing homes which opened for business during 1972 were also included in the universe. (Facilities opening in early 1973 could not be included since data about them were not yet available.) The facilities which opened in 1972 comprised the second, and smaller (7 percent), group of facilities in the universe. Although the universe included only facilities providing nursing care, all facilities opened in 1972 were included because the level of nursing care they provided was unknown prior to the survey. Once the NNHS was conducted, facilities not meeting the criteria were classified as out of scope (see table I for details).

Although the NNHS was conducted in 1973-74, it should be noted that estimates will not correspond precisely to figures from the 1973 MFI census for several reasons. In comparison to the MFI, the NNHS universe excluded the following: (1) personal care homes and domiciliary care homes; (2) facilities which opened in 1973; and (3) facilities which, between 1971 and 1973, upgraded the level of care they pro-

NOTE: The list of references follows the text.

vided, thereby meeting the "nursing care" criteria when surveyed in the 1973 MFI. Data from the NNHS are also subject to sampling variability, while data from the MFI are not, since the MFI is a census.

Sampling Design

The sampling was a stratified two-stage probability design: The first stage was a selection of establishments and the second stage was a selection of residents and employees of the sample establishments. In preparation for the first-stage sample selection, establishments listed in the MFI were sorted into three types of strata based on Medicare and Medicaid certification: (1) both Medicare and Medicaid *and* Medicare only; (2) Medicaid only; and (3) not certified. Facilities in each of these three strata were sorted into bed-size groups, producing 26 primary strata as shown in table I. The nursing homes in the universe were ordered by type of ownership, geographic region, State, and county. The sample

Table I. Distribution of facilities in the 1973-74 National Nursing Home Survey universe and disposition of sample facilities according to primary sampling strata: conterminous United States

Certification status and size of facility	Universe (sampling frame)[1]	Number of facilities in sample			
		Total facilities	Out of scope or out of business	In scope and in business	
				Nonresponding	Responding
All types	17,685	2,118	147	63	1,908
Both Medicare and Medicaid and Medicare only	4,099	803	20	26	757
Unknown number of beds	2	0	0	0	0
Less than 25 beds	149	4	0	1	3
25-49 beds	538	35	0	1	34
50-99 beds	1,713	228	7	7	214
100-199 beds	1,385	370	8	11	351
200-299 beds	224	100	4	3	93
300-499 beds	68	46	1	2	43
500 beds or more	20	20	0	1	19
Medicaid only	7,473	790	34	24	732
Unknown number of beds	3	0	0	0	0
Less than 15 beds	250	5	1	2	2
15-24 beds	967	36	5	1	30
25-49 beds	2,253	123	11	3	109
50-99 beds	2,688	293	4	8	281
100-199 beds	1,108	241	3	6	232
200-299 beds	145	52	5	3	44
300-499 beds	43	24	3	1	20
500 beds or more	16	16	2	0	14
Not certified	6,113	525	93	13	419
Unknown number of beds	19	0	0	0	0
Less than 15 beds	1,279	23	10	0	13
15-24 beds	1,062	38	9	0	29
25-49 beds	1,575	87	13	3	71
50-99 beds	1,334	145	19	5	121
100-199 beds	652	141	21	4	116
200-299 beds	120	43	12	0	31
300-499 beds	52	28	4	1	23
500 beds or more	20	20	5	0	15

[1]The universe consisted of nursing homes providing some level of nursing care as classified in the 1971 MFI and those opened for business in 1972.

was then selected systematically after a random start within each primary stratum. Table I shows the distribution of establishments in the sampling frame and the final disposition of the sample with regard to response and in-scope status. The number of facilities estimated by the survey (15,749) is less than the universe figure (17,685) because some facilities went out of business or out of scope between the time the universe was "frozen" and the survey was conducted. Differences ranging from 2,100-2,900 between survey estimates and universe figures occurred in the 1963,[17] 1964,[18] and 1969[19] nursing home surveys for the same reason.

The second-stage selection of residents and employees was carried out by the interviewers at the time of their visits to the establishments in accordance with specific instructions given for each sample establishment. The sample frame for residents was the total number of residents on the register of the establishment on the evening prior to the day of the survey. Residents who were physically absent from the facility due to overnight leave or a hospital visit but had a bed maintained for them at the establishment were included in the sample frame. An average of 10 residents was in the sample per facility.

The sampling frame for employees was the Staff Control Record on which the interviewer listed the names of all staff (including those employed by contract) and sampled professional, semiprofessional, and nursing staff. Those generally *not* involved in direct patient care, such as office staff, food service, housekeeping, and maintenance personnel were excluded from the sample. The interviewer used predesignated sampling instructions that appeared at the head of each column of this form. An average of 14 staff was in the sample per facility.

Data Collection Procedures for 1973-74 National Nursing Home Survey

The 1973-74 NNHS utilized eight questionnaires. (See appendix III for questionnaire relevant to this report. For all other data collection instruments, see reference 1.)

Administrator Letter and Worksheet
Facility Questionnaire
Expense Questionnaire
Resident Control Record
Resident Questionnaire
Staff Questionnaire—Parts I and II
Staff Control Record

Data were collected according to the following procedure:

1. A letter was sent to the administrators of sample facilities informing them of the survey and the fact that an interviewer would contact them for an appointment. On the back of the letter was a worksheet which the administrator was requested to fill out prior to the interviewer's visit. This worksheet asked for those data that required access to records and some time in compiling (such as total admissions and discharges, inpatient days of care, etc.). Included with this introductory letter were letters of endorsement from the American Nursing Home Association and the American Association of Homes for the Aging urging the administrators to participate in the survey.

2. Several days to 1 week after the mailing of the letters, the interviewer telephoned the sample facility and made an appointment with the administrator.

3. At the time of the appointment, the following procedures were followed: The Facility Questionnaire was completed by the interviewer who interviewed the administrator or owner of the facility. After completing this form, the interviewer secured the administrator's permission to send the Expense Questionnaire to the facility's accountant. (If financial records were not kept by an outside firm, the Expense Questionnaire was filled out by the administrator, with the interviewer present.) The interviewer completed the Staff Control Record (a list of all currently employed staff both full and part time), selected the sample of staff from it, and prepared Staff Questionnaires, Parts I and II, which were left

for each sample staff person to complete, seal in addressed and franked envelopes (one for each part of the questionnaire), and return either to the interviewer or by mail. The interviewer then completed the Resident Control Record (a list of all residents currently in the facility), selected the sample of residents from it, and filled a Resident Questionnaire for each sample person by interviewing the member of the nursing staff familiar with care provided to the resident. The nurse referred to the resident's medical records. No resident was interviewed directly.

If the Expense Questionnaire was not returned within 2 weeks, the interviewer telephoned the accountant requesting its prompt return. If the Staff Questionnaires were not returned in one week, the interviewer contacted the staff member and requested the return of the form.

Table II presents a summary of the data collection procedures.

Table II. Summary of data collection procedures

Questionnaire	Respondent	Interview situation
Facility	Administration	Personal interview
Expense	Facility's accountant	Self-enumerated questionnaire
Resident	Member of nursing staff familiar with care provided to the resident or resident's medical records (10 sampled residents per facility)	Personal interview
Staff	Sampled staff member (14 per facility)	Self-enumerated questionnaire

GENERAL QUALIFICATIONS

Nonresponse and Imputation of Missing Data

Response rates differed for each type of questionnaire as indicated by the following:

Questionnaire	*Response rate*
Facility	97 percent
Expense	88 percent
Resident	98 percent
Staff	82 percent

Generally, response rates were higher for questionnaires administered in a personal interview situation (Facility and Resident) as compared to those which were self-enumerated (Expense and Staff). Statistics presented in this report were adjusted for failure of a facility to respond. Data were also adjusted for nonresponse which resulted from failure to complete one of the questionnaires (Expense, Resident, Staff) or from failure to complete an item on a questionnaire. Those items left unanswered on a partially completed questionnaire (Facility, Expense, Resident, Staff) were generally imputed by assigning a value from a responding unit with major characteristics identical to those of the nonresponding unit.

Rounding of Numbers

Estimates of residents have been rounded to the nearest hundred. For this reason detailed figures within tables do not always add to totals. Percents were calculated on the basis of original, unrounded figures and will not necessarily agree precisely with percents which might be calculated from rounded data.

Data Processing

A series of checks were performed during the course of the survey. This included field followups for missing and inconsistent data, some manual editing of the questionnaires, extensive editing conducted by computer to assure that all responses were accurate, consistent, logical, and complete. Once the data base was edited, the computer was used to calculate and assign weights, ratio adjustments, recodes, and other related procedures necessary to produce national estimates from the sample data.

Estimation Procedures

Statistics reported in this publication are derived by a ratio estimating procedure. The purpose of ratio estimation is to take into account all relevant information in the estimation process, thereby reducing the variability of the estimate. The estimation of number of establishments and establishment data not related to size are inflated by the reciprocal of the probability of selecting the sample establishment and adjusted for the nonresponding establishments within primary certification-size strata. Two ratio adjustments, one at each stage of selection, were also used in the estimation process. The first-stage ratio adjustment (along with the above inflation factors) was included in the estimation of establishment data related to size, resident data, and staff data for all primary certification-size strata from which a sample of facilities was drawn. The numerator was the total beds according to the Master Facility Inventory data for all facilities in the stratum. The denominator was the estimate of the total beds obtained through a simple inflation of the Master Facility Inventory data for the sample homes in the stratum. The effect of the first-stage ratio adjustment was to bring the sample in closer agreement with the known universe of beds. The second-stage ratio adjustment was included in the estimation of resident and staff data within establishments. The second-stage ratio adjustment is the product of two fractions: the first is the inverse of the sampling fraction for residents (or staff) upon which the selection is based; the second is the ratio of the number of sample residents (or staff) in the establishment to the number of residents (or staff) for whom questionnaires were completed within the facility.

RELIABILITY OF ESTIMATES

As in any survey, the results are subject to reporting and processing errors and errors due to nonresponse. To the extent possible, these types of errors were kept to a minimum by methods built into survey procedures.

Since statistics presented in this report are based on a sample, they will differ somewhat from figures that would have been obtained if a complete census had been taken using the same schedules, instructions, and procedures.

The standard error is primarily a measure of the variability that occurs by chance because only a sample, rather than the entire universe, is surveyed. The standard error also reflects part of the measurement error, but it does not measure any systematic biases in the data. It is inversely proportional to the square root of the number of observations in the sample. Thus, as the sample size increases, the standard error generally decreases.

The estimated standard errors of the average monthly charge used in this report are presented in table III. The chances are about 68 out of 100 that an estimate from the sample would differ from a complete census by less than the standard error. The chances are about 95 out of 100 that the difference would be less than twice the standard error and about 99 out of 100 that it would be less than 2½ times as large. Thus, for example, the standard error of an average monthly charge of $400 for a base of 100,000 residents is approximately $21 (table III). The chances are 95 out of 100 that the true value of the average monthly charge is contained in the interval $400 ± $42 (i.e., between $358 and $442).

The relative standard error of an estimate is obtained by dividing the standard error of the estimate by the estimate itself and is expressed as a percentage of the estimate. The relative standard errors for the estimated number of residents and for percentages in percent distribution of residents are presented in figures I and II, respectively. Because of the relationship between the relative standard error and the estimate, the standard error of an estimate can be found by multiplying the estimate by its relative standard error. Illustrations of use of these relative standard error charts have been provided.

According to NCHS standards, reliable estimates are those which have a relative standard error of 25 percent or less. Thus in figure I, an estimate of 2,300 residents has a relative standard error of 25 percent. In this report, asterisks are shown for any cell with a resident estimate of less than 2,300 or a percentage which represents a number of less than 2,300, i.e., with more than a 25-percent relative standard error.

Table III. Standard errors of average total monthly resident charge

Estimated number of residents	Average total monthly resident charge												
	$150	$200	$250	$300	$325	$350	$375	$400	$425	$450	$475	$500	$525
	Standard error in dollars												
3,500	*	*	*	*	*	*	*	*	*	*	*	*	*
4,000	*	*	*	*	*	*	*	*	*	*	118	123	128
5,000	*	*	*	74	79	84	88	93	97	101	106	110	115
6,000	*	*	60	68	72	76	80	84	89	93	97	101	105
7,000	*	47	55	63	67	71	74	78	82	86	89	93	97
8,000	36	44	52	59	62	66	70	73	77	80	84	87	91
9,000	34	42	49	55	59	62	66	69	72	76	79	82	85
10,000	32	39	46	53	56	59	62	65	69	72	75	78	81
20,000	23	28	33	37	39	42	44	46	48	51	53	55	57
30,000	19	23	27	30	32	34	36	38	40	41	43	45	47
40,000	16	20	23	26	28	30	31	33	34	36	37	39	41
50,000	15	18	21	24	25	26	28	29	31	32	33	35	36
60,000	13	16	19	21	23	24	25	27	28	29	31	32	33
70,000	12	15	17	20	21	22	23	25	26	27	28	29	31
80,000	11	14	16	19	20	21	22	23	24	25	26	28	29
90,000	11	13	15	18	19	20	21	22	23	24	25	26	27
100,000	10	12	15	17	18	19	20	21	22	23	24	25	26
200,000	7	9	10	12	12	13	14	15	15	16	17	17	18
300,000	6	7	8	10	10	11	11	12	12	13	14	14	15
400,000	5	6	7	8	9	9	10	10	11	11	12	12	13
500,000	5	6	6	7	8	8	9	9	10	10	10	11	11
600,000	4	5	6	7	7	7	8	8	9	9	9	10	10
700,000	4	5	5	6	7	7	7	8	8	8	9	9	9
800,000	4	4	5	6	6	6	7	7	7	8	8	8	9
900,000	3	4	5	5	6	6	6	7	7	7	8	8	8
1,000,000	3	4	4	5	5	6	6	6	7	7	7	8	8
1,100,000	3	4	4	5	5	5	6	6	6	7	7	7	7
	$550	$575	$600	$625	$650	$675	$700	$750	$800	$850	$900	$950	$1,000
	Standard error in dollars												
3,500	*	*	*	*	*	169	174	184	195	205	215	226	236
4,000	133	138	143	148	153	158	163	172	182	192	201	211	221
5,000	119	124	128	132	137	141	145	154	163	171	180	189	197
6,000	109	113	117	121	125	129	133	141	149	157	164	172	180
7,000	101	104	108	112	115	119	123	130	138	145	152	160	167
8,000	94	98	101	105	108	111	115	122	129	136	142	149	156
9,000	89	92	95	99	102	105	108	115	121	128	134	141	147
10,000	84	87	90	94	97	100	103	109	115	121	127	133	140
20,000	60	62	64	66	68	70	73	77	81	86	90	94	99
30,000	49	50	52	54	56	58	59	63	66	70	73	77	81
40,000	42	44	45	47	48	50	51	54	57	61	64	67	70
50,000	38	39	40	42	43	45	46	49	51	54	57	60	62
60,000	34	36	37	38	39	41	42	44	47	49	52	54	57
70,000	32	33	34	35	36	38	39	41	43	46	48	50	53
80,000	30	31	32	33	34	35	36	38	41	43	45	47	49
90,000	28	29	30	31	32	33	34	36	38	40	42	44	46
100,000	27	28	28	29	30	31	32	34	36	38	40	42	44
200,000	19	19	20	21	21	22	23	24	26	27	28	30	31
300,000	15	16	16	17	17	18	19	20	21	22	23	24	25
400,000	13	14	14	15	15	16	16	17	18	19	20	21	22
500,000	12	12	13	13	13	14	14	15	16	17	18	18	19
600,000	11	11	11	12	12	13	13	14	14	15	16	17	18
700,000	10	10	11	11	11	12	12	13	13	14	15	15	16
800,000	9	9	10	10	10	11	11	12	12	13	14	14	15
900,000	9	9	9	10	10	10	10	11	12	12	13	13	14
1,000,000	8	8	9	9	9	10	10	10	11	12	12	13	13
1,100,000	8	8	8	9	9	9	9	10	10	11	12	12	13

For reporting means (average total monthly charge), two basic criteria were used. The first criteria was that the relative standard error of the base (number of residents) was less than 20 percent.[20] In figure I, this corresponds with a base of at least 3,500. Thus, for example, in table 13 the average charge for residents receiving limited nursing care and using all other

Figure I. Relative standard errors of estimated number of residents

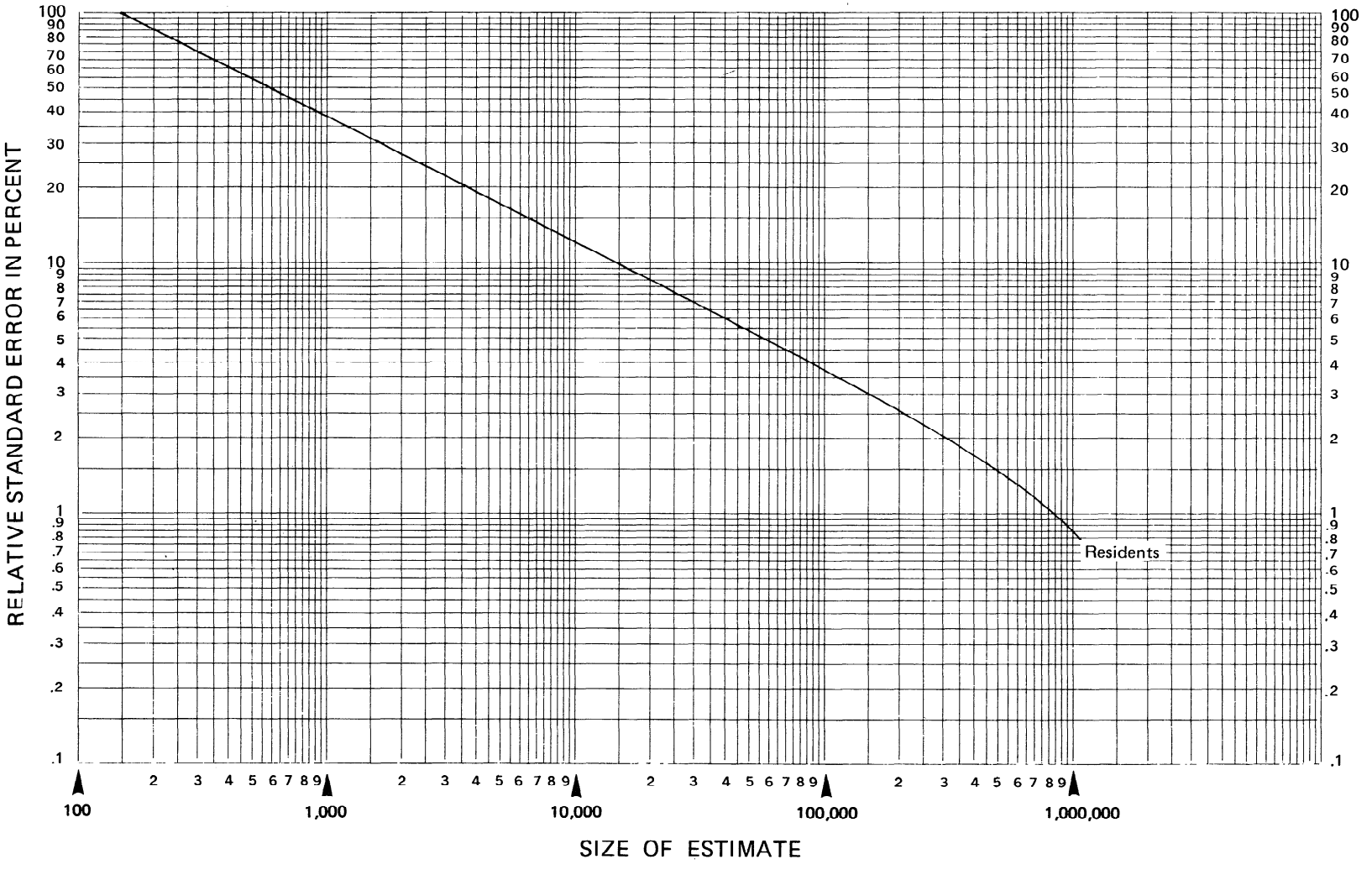

Illustration of use of figure I: An estimate of 2,300 residents (on scale at bottom of chart) has a relative standard error of 25 percent (read from curve on scale at left side of chart) or a standard error of 575 (25 percent of 2,300).

Figure II. Relative standard errors of estimated percentages of residents.

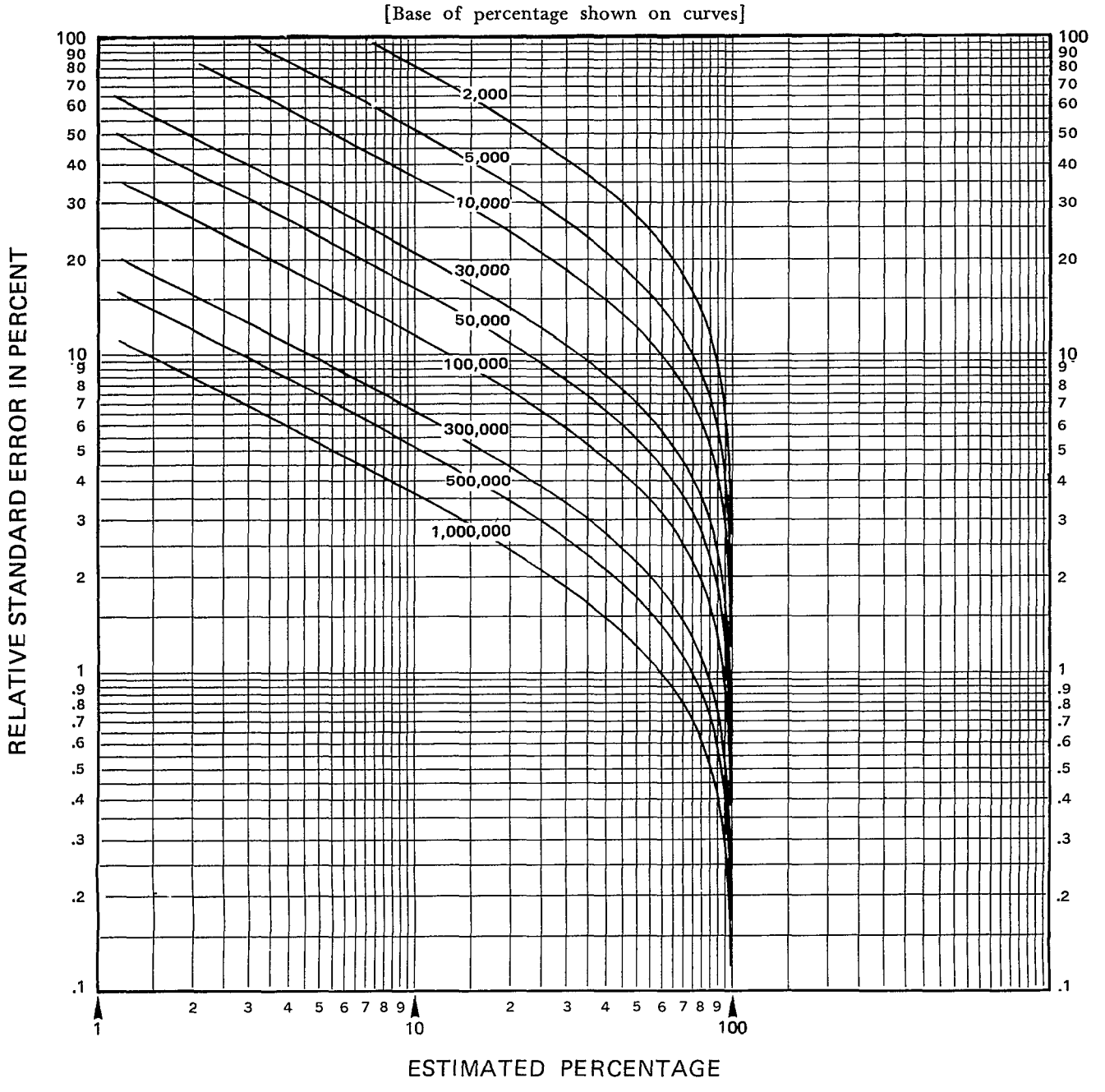

Illustration of use of figure II: Table 13 shows that 17.3 percent of the 484,300 Medicaid recipients had a length of stay of less than 6 months. From figure 2, the relative standard error for 17.3 percent (on scale at bottom of chart) is between 4.8 percent for a base of 300,000 (read from the scale at left side of chart) and 3.7 percent for a base of 500,000. Using interpolation, the relative standard error is 3.8 percent for a base of 484,300. The standard error in percentage points is equal to 17.3 percent X 3.8 percent or 0.66 percentage points.

sources for primary payment was unreliable (since the base was 3,200) and was replaced with an asterisk. If, on the other hand, the first criterion was satisfied, then the second criterion of a relative standard error of 25 percent or less must have been demonstrated as well. In table III, average charges with estimates of standard errors have a relative standard error of 25 percent or less, and asterisks denote failure to meet this criterion.

HYPOTHESIS TESTING

Two methods of hypothesis testing were used in this report:

Z test.—To test the difference between two statistics (mean, percent, etc.) the standard normal test was performed to determine whether or not to reject the null hypothesis (for the two means X_1, X_2, the null hypothesis is $H_0: X_1 = X_2$ with the alternative $H_A : X_1 \neq X_2$). The standard error of the difference of the two estimates is approximately the square root of the sum of the squares of the standard errors of each of the estimates. Thus if $SE(X_1)$ is the standard error of X_1 and $SE(X_2)$ is the standard error of X_2, the standard error of the difference $(X_1 - X_2)$ is $SE(X_1 - X_2) = \sqrt{SE^2(X_1) + SE^2(X_2)}$ (This formula will represent the actual standard error for the difference between separate and uncorrelated characteristics although it is only a rough approximation in most other cases.)

The null hypothesis is rejected (i.e., the two means X_1 and X_2 are different) if the probability of a type I error is less than 5 percent, i.e., if

$$Z = \frac{X_1 - X_2}{\sqrt{SE^2(X_1) + SE^2(X_2)}} > 1.96.$$

For example, from table 1, the average charge for the 706,500 residents in proprietary facilities was $489 while the average charge for the 305,400 residents in nonprofit and government facilities was $456. From table III, linear interpolation yields an approximate standard error of $8.90 for proprietary facilities and $13.10 for nonprofit and government facilities. Since

$$Z = \frac{489 - 456}{\sqrt{(8.9)^2 + (13.1)^2}} = 2.08 > 1.96,$$

the average charge for residents in proprietary facilities was higher than the average charge for residents in nonprofit or government facilities.

Weighted least squares as a test for trend.—If there exists a strong relationship between an independent variable (e.g., length of stay) and average total monthly charge, then a useful test for this relationship would be to fit a regression line to the data to determine the slope and then to determine whether or not this slope is significantly greater than zero. That is, a regression line of the form $Y = \alpha + \beta_i X_i + \epsilon_i$ is to be fit to the data, where in this case $\overline{Y}$ = average total monthly charge, X = length of stay, α = "Y-intercept," i.e., value of average total monthly charge if length of stay equaled zero, β = slope of Y on X, i.e., the rate of change in average total monthly charge per unit change in length of stay, and finally, ϵ = unexplained error.

The data available from the National Nursing Home Survey present certain very basic problems which discourage the use of classical regression procedures. Among these problems are violation of the assumptions of independence of the original observations, violation of homoscedasticity, i.e., equal variances of the dependent variable within each category of the independent variable, perhaps violation of the normality assumption, etc. Dr. Paul Levy, formerly of NCHS, has worked out a "modified regression model which makes no assumptions about the original observations and which makes no stronger assumptions about the sample estimates than are made in testing whether two means are equal when the estimated means and their standard errors are obtained from complex surveys."[e]

The proposed model is as follows:

1. Let $\overline{Y}_i$ be the estimated mean and $S_{\overline{y}_i}$ be its estimated standard error for the ith group.

2. Let X_i be the midpoint of the independent variable for the group.

[e] From an unpublished memorandum by Dr. Levy.

3. Assume $S_{\bar{y}_i}$ is based on a large enough number of observations that it can be assumed it is, in fact, equal to $\sigma_{\bar{y}_i}$ and thus has no sampling error.

4. Further assume that

$$E(\bar{Y}_i) = \alpha + \beta X_i$$

$$V(\bar{Y}_i) = S^2_{\bar{y}_i} \quad \text{for } i = 1, 2, \ldots, K,$$

where K is the number of groups.

5. Finally, it is assumed that the $\bar{Y}_i$'s are normally distributed and they are statistically independent of each other.

The weighting procedure proposed weights all observations by the reciprocal of the variance. That is, $w_i = 1/S^2_{\bar{y}_i}$ and the mean $\bar{X} = \Sigma w_i X_i / \Sigma w_i$ and the mean $\bar{\bar{Y}} = \Sigma w_i \bar{Y}_i / \Sigma w_i$.

The slope is computed in a manner similar to the classical least squares regression, by the following formula:

$$b = \frac{\Sigma w_i (X_i - \bar{X})\bar{Y}_i}{\Sigma w_i (X_i - \bar{X})^2}$$

Computationally, this is easily computed by

$$b = \frac{\Sigma w_i X_i \bar{Y}_i - (\Sigma w_i)(\bar{X})(\bar{\bar{Y}})}{\Sigma w_i X_i^2 - (\Sigma w_i)\bar{X}^2}$$

The variance of the slope is

$$\sigma_b^2 = \frac{\Sigma w_i (X_i - \bar{X})^2 \sigma^2_{\bar{y}}}{[\Sigma w_i (X_i - \bar{X}^2)]^2}$$

Now since $w_i = 1/\sigma^2_{\bar{y}_i}$, this formula can be simplified to

$$\sigma_b^2 = \frac{\Sigma w_i (X_i - \bar{X})^2}{[\Sigma w_i (X_i - \bar{X})^2]^2} = \frac{1}{\Sigma w_i (X_i - \bar{X})^2}$$

and computationally

$$S_b = \sqrt{\frac{1}{\Sigma w_i X_i^2 - (\Sigma w_i)\bar{X}^2}}$$

An approximate normal deviate test can now be performed by $z = b/S_b$. This would test the hypothesis that $\beta = 0$ or, alternatively, compute confidence intervals for β.

As an example, the average total monthly charge by current length of stay is recorded as shown in table IV. Applying this described method to the data shown, we have:

$\Sigma w_i X_i \bar{Y}_i = 221.8860$	$\bar{X} = 28.8583$
$\Sigma w_i = 0.01711$	$\bar{\bar{Y}} = 474.4717$
$\Sigma w_i X_i = 0.4938$	$b = -1.7779$
$\Sigma w_i \bar{Y}_i = 8.1182$	$S_b = 0.3788$
$\Sigma w_i X_i^2 = 21.2192$	$z = b/S_b = -4.6935$

Thus, since the z value is quite large, a negative association is demonstrated between the average total monthly charge and the resident's current length of stay in the facility.

Table IV. Worksheet for weighted least squares regression of average total monthly charges, by length of stay since current admission: United States, 1973-74

Length of stay since current admission	Midpoint of length-of-stay group (months)	Average total monthly charge	Standard error of average total monthly charge	$S^2_{\bar{Y}_i}$	$W_i = \frac{1}{S^2_{\bar{Y}_i}}$
1 month to less than 3 months	2.0	$541	28.3	800.89	.00125
3 months to less than 6 months	4.5	521	25.2	635.04	.00157
6 months to less than 12 months	9.0	499	20.4	416.16	.00240
1 year to less than 3 years	24.0	479	12.8	163.84	.00610
3 years to less than 5 years	48.0	459	19.6	384.16	.00260
5 years and more	60.0	411	17.7	313.29	.00319

APPENDIX II

DEFINITION OF CERTAIN TERMS USED IN THIS REPORT

Terms Relating to Facilities

Facilities included in the survey.—Institutions included in the 1973-74 Nursing Home Survey were those classified as either nursing care homes or personal care homes with nursing according to data collected in the 1971 Master Facility Inventory (MFI) Survey[21] conducted by the National Center for Health Statistics.

Definitions for these two classes of nursing homes were as follows:

Nursing care home

Fifty percent or more of the residents received nursing care during the week prior to the survey. (Nursing care is defined as the provision of one or more of the following services: taking temperature-pulse-respiration or blood pressure; full bed bath; application of dressings or bandages; catheterization; intravenous, intramuscular, or hypodermic injection; nasal feeding; irrigation; bowel and bladder retraining; oxygen therapy; and enema.)

At least one full-time (35 or more hours per week) registered nurse (RN) or licensed practical nurse (LPN) was employed.

Personal care home with nursing

Some, but less than 50 percent of the residents received nursing care during the week prior to the survey.

At least one full-time RN or LPN was employed.

or

Some of the residents received nursing care during the week prior to the survey.

No full-time RN or LPN was employed.

The institution either provided administration of medicines or supervision over self-administered medicines, *or* provided assistance with three or more activities for daily living (such as help with tub bath or shower; help with dressing, correspondence, or shopping; help with walking or getting about; and help with eating).

Certification status.—Certification status refers to the facility certification by the Medicare and/or Medicaid programs.

Medicare refers to the medical assistance provided in Title XVIII of the Social Security Act. Medicare is a health insurance program administered by the Social Security Administration for persons aged 65 years and over who are eligible for benefits.

Extended care facility refers to certification as an extended care facility under Medicare.

Medicaid refers to the medical assistance provided in Title XIX of the Social Security Act. Medicaid is a State-administered program for the medically indigent.

Skilled nursing home refers to certification as a skilled nursing home under Medicaid.

Intermediate care facility refers to certification as an intermediate care facility under Medicaid.

NOTE: The list of references follows the text.

Not certified refers to facilities which are not certified as providers of care either by Medicare or Medicaid.

Type of ownership.—Type of ownership refers to the type of organization that controls and operates the nursing home.

Proprietary facility is a facility operated under private commercial ownership.

Nonprofit facility is a facility operated under voluntary or nonprofit auspices, including both church-related facilities and those not church-related.

Government facility is a facility operated under Federal, State, or local government auspices.

Bed.—One set up and regularly maintained for patients or residents. Beds maintained for staff and beds used exclusively for emergency services are excluded.

Terms Relating to Residents

Charge.—The *total* amount charged to the resident each month by the establishment. Included in the average total monthly charge were all charges for lodging, meals, nursing care, special services, drugs, and special medical supplies. Charges that were not part of the bill rendered by the institution, such as those for services of physicians, were not included.

Resident.—A person who has been formally admitted but not discharged from an establishment. All such persons were included in the survey whether or not they were physically present in the facility at the time of the survey.

Age.—Age of resident at date survey was conducted.

Reported chronic conditions and impairments.—A reported condition was considered to be the affirmative response by the respondent to any and all categories of item 9 of the Resident Questionnaire. The respondent, who was the nurse most familiar with the care provided to the resident, reported the existence of these chronic conditions and impairments based upon knowledge of the resident's health and by checking the resident's medical record.

Primary diagnosis at last examination.—The primary diagnosis was the condition reported by the respondent in response to item 8 of the Resident Questionnaire. The list of conditions corresponds to ICDA Eight Revision.[22] With the assistance of the interviewer, the respondent was instructed to extract from the resident's medical record the primary diagnosis recorded at the last examination.

Level of care received.—These levels are defined in terms of the nursing services actually received by the resident.

Based on the services listed in item 12 of the Resident Questionnaire, the following classifications were made, each succeeding level being exclusive of the previous levels:

Intensive nursing care
Catheterization
Oxygen therapy
Intravenous injections
Tube feeding
Bowel/bladder retraining
Full bed bath

Limited nursing care
Application of sterile dressings
Irrigation
Hypodermic injections

Routine nursing care
Enema
Blood pressure reading
Temperature-pulse-respiration checked

Personal care
Rub or massage
Special diet
Administration of treatment or medication
Assistance in personal hygiene or eating

No nursing or personal care.—None of the preceding services were received.

Length of stay since current admission.—Length of stay refers to the current stay of a resident in the facility. It means the period of stay starting from the date of most recent admission to the institution to the date of the survey.

Primary source of payment.—Primary source of payment refers to private income or medical assistance used in payment for resident's stay in the nursing home.

Own income is any private source or income from investments, Social Security, or pension plans.

Medicare refers to payments from Medicare program described above.

Medicaid refers to payment from Medicaid program described above.

Other public assistance refers to any public assistance other than Medicare and Medicaid.

Other refers to all other methods of payment or support including church support, VA contract, initial payment for life care, cases for which no charge was made, and miscellaneous sources.

Geographic Terms

Classification of homes by geographic area is provided by grouping the States (excluding Alaska and Hawaii) into regions. These regions correspond to those used by the U.S. Bureau of the Census and are as follows:

Region	*States included*
Northeast	Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut, New York, New Jersey, Pennsylvania
North Central	Michigan, Ohio, Illinois, Indiana, Wisconsin, Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, Kansas
South	Delaware, Maryland, District of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida, Kentucky, Tennessee, Alabama, Mississippi, Arkansas, Louisiana, Oklahoma, Texas
West	Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada, Washington, Oregon, California

APPENDIX III

RESIDENT QUESTIONNAIRE USED IN THE 1973-74 NATIONAL NURSING HOME SURVEY

NOTE: See reference 1 for copies of all instruments used in the survey.

RESIDENT QUESTIONNAIRE

OMB #068-S-72172
Expires 7-31-74

1973 Nursing Home Survey
National Center for Health Statistics
Health Resources Administration
Rockville, Maryland

1-7

ASSURANCE OF CONFIDENTIALITY — All information which would permit identification of the individual will be held in strict confidence, will be used only by persons engaged in and for the purposes of the survey, and will not be disclosed or released to others for any purposes.

ESTABLISHMENT NO. ☐☐☐☐☐☐☐☐☐ cc2

LINE NO. ☐☐☐ cc11

cc14-1

1. WHAT IS — DATE OF BIRTH? Month ☐☐ cc15,16 Day ☐☐ 17, 18 Year ☐☐ 19-21 or Age ☐☐ cc22-24

2. WHAT IS — SEX? 25-1 ☐ Male -2 ☐ Female

3. WHAT IS — ETHNIC BACKGROUND? (Mark (X) Only one box)
26-1 ☐ Caucasion -2 ☐ Negro -3 ☐ Oriental
-4 ☐ Spanish American -5 ☐ American Indian -6 ☐ Other

4. WHAT IS — CURRENT MARITAL STATUS? (Mark (X) only one box)
27-1 ☐ Married -2 ☐ Widowed -3 ☐ Divorced
-4 ☐ Separated -5 ☐ Never Married

5. WHAT WAS THE DATE OF — CURRENT ADMISSION TO THIS PLACE? Month ☐☐ cc28, 29 Day ☐☐ 30-31 Year ☐☐ 32-34

6a. WHERE DID — LIVE AT THE TIME OF ADMISSION? (Mark (X) only one box)

(1) In a boarding home 35-1 ☐
(2) In another nursing home or related facility -2 ☐
(3) In a mental hospital or other long-term specialty hospital -3 ☐
(4) In a general or short-stay hospital -4 ☐
(5) In a private apartment or house -5 ☐
(6) Other place, (Specify) _____ 36- -6 ☐
(7) Don't know -7 ☐

6b. AT THE TIME OF ADMISSION DID — LIVE WITH: (Mark (X) all that apply)

			Yes	No
(1)	Spouse?	37-1	☐	-2 ☐
(2)	Children?	38-1	☐	-2 ☐
(3)	Other relatives?	39-1	☐	-2 ☐
(4)	Unrelated persons?	40-1	☐	-2 ☐
(5)	Lived alone?	41-1	☐	-2 ☐
(6)	Don't know?	42-1	☐	

7. WHAT IS THE PRIMARY REASON FOR — ADMISSION TO THE HOME? (Enter "1" in box for primary reason; if secondary reason given, enter "2".)

43- ☐ Physical reasons (e.g., illness or need for treatments)
44- ☐ Social reasons (e.g., no family, or lack of family interest)
45- ☐ Behavioral reasons (e.g., disruptive behavior, mental deterioration)
46- ☐ Economic reasons (e.g., no money and/or resources)

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8. WHAT WAS THIS RESIDENT'S PRIMARY DIAGNOSIS: (Mark (X) only one box in each column)

a. AT ADMISSION?	b. AT THE TIME OF–LAST EXAMINATION?	
49,50 ☐ a01	51,52 ☐ b01	Senility, old age, and other symptoms and ill-defined conditions (e.g., coma, uremia)
☐ a02	☐ b02	Heart attack (e.g., ischemic heart disease)
☐ a03	☐ b03	Stroke (e.g., cerebrovascular diseases)
☐ a04	☐ b04	Hardening of arteries (e.g., arteriosclerosis, diseases of the arteries, arterioles, capillaries)
☐ a05	☐ b05	Other diseases of the circulatory system (e.g., NOT heart attack, stroke, or hardening of the arteries)
☐ a06	☐ b06	Accidents, poisonings, and violence (e.g., fracture of hip, other broken bones, burns, concussion)
☐ a07	☐ b07	Mental disorders (e.g., mental retardation, psychoses, neuroses, mental illness, emotional problems)
☐ a08	☐ b08	Diseases of the musculoskeletal system and connective tissue (e.g., arthritis, rheumatism, back pain)
☐ a09	☐ b09	Endocrine, nutritional, and metabolic diseases (e.g., goiter, diabetes, gout)
☐ a10	☐ b10	Diseases of the respiratory system (e.g., pneumonia, emphysema)
☐ a11	☐ b11	Neoplasms (e.g., cancer, tumors)
☐ a12	☐ b12	Diseases of the nervous system and sense organs (e.g., Parkinson's disease, glaucoma, cataracts, blindness, multiple sclerosis, spastic paralysis, epilepsy)
☐ a13	☐ b13	Diseases of the digestive system (e.g., cirrhosis of liver, ulcer, intestinal obstruction)
☐ a14	☐ b14	Infective and parasitic diseases (e.g., T.B., polio, syphilis)
☐ a15	☐ b15	Diseases of the genitourinary system (e.g., nephrosis, chronic pelvic infection, hyperplasia of prostate)
☐ a16	☐ b16	Diseases of the skin and subcutaneous tissue (e.g., cellulitis, abscess, chronic ulcer)
☐ a17	☐ b17	Diseases of the blood and blood-forming organs (e.g., anemia)
☐ a18	☐ b18	Congenital anomalities (e.g., hydrocephalus)
☐ a19	☐ b19	Complications of pregnancy, childbirth and the puerperium (e.g., infections, hemorrhage, toxemias)
☐ a20	☐ b20	Certain causes of perinatal morbidity and mortality (e.g., birth injury or immaturity of infant)
☐ a21	☐ b21	Don't know
☐ a22	☐ b22	Other (Specify) _____ 54-

Specify: _____ 53-

9. DOES – HAVE ANY OF THE FOLLOWING CONDITIONS OR IMPAIRMENTS? (Mark (X) all that apply)

cc55-65
-1 ☐ a. Senility (includes decline in intellect, memory, and judgement, loss of orientation, difficulty in speaking; feebleness.)
-2 ☐ b. Mental illness (Psychiatric or emotional problems)
-3 ☐ c. Mental retardation
-4 ☐ d. Arthritis or rheumatism
-5 ☐ e. Paralysis or palsy other than arthritis

e. (1) IS THIS THE RESULT OF A STROKE? ☐ Yes 66-1 ☐ No -2

-6 ☐ f. Glaucoma or cataracts
-7 ☐ g. Diabetes
-8 ☐ h. Any CHRONIC trouble with back or spine
-9 ☐ i. Amputation of extremities or limbs; or permanent stiffness or any deformity of the foot, leg, fingers, arm, or back
-0 ☐ j. Heart trouble

OR

-& ☐ k Resident has none of the above conditions or impairments

10. DOES THIS RESIDENT REGULARLY USE ANY OF THE FOLLOWING AIDS?

CARD 2
14-2

		No	Yes
a.	Walker	15-2 ☐	-1 ☐
b.	Crutches	16-2 ☐	-1 ☐
c.	Braces	17-2 ☐	-1 ☐
d.	Wheelchair	18-2 ☐	-1 ☐
e.	Artificial Limb	19-2 ☐	-1 ☐
f.	Self-feeder	20-2 ☐	-1 ☐
g.	Any other aids (do not count glasses or hearing aids)	21-2 ☐	-1 ☐

Specify _____ 22-

11. DURING THE LAST MONTH, HOW MANY TIMES DID–RECEIVE ANY OF THE FOLLOWING THERAPY SERVICES? (INCLUDE ONLY SERVICES PROVIDED BY A LICENSED OR REGISTERED PROFESSIONAL WHETHER INSIDE OR OUTSIDE THE HOME.)

			NUMBER OF TIMES
a.	Physical therapy	☐ None or	☐ cc23
b.	Recreational therapy	☐ None or	☐ cc25
c.	Occupational therapy	☐ None or	☐ cc27
d.	Speech therapy	☐ None or	☐ cc29
e.	Hearing therapy	☐ None or	☐ cc31
f.	Profassional counseling by social worker, psychologist or other mental health worker	☐ None or	☐ cc33

12. DURING THE PAST 7 DAYS, WHICH OF THESE SERVICES DID–RECEIVE? (Mark (X) all that apply)

cc35-62	-01 ☐	a.	Rub or massage
	-02 ☐	b.	Administration of treatment by staff
	-03 ☐	c.	Special diet
	-04 ☐	d.	Application of sterile dressings or bandages
	-05 ☐	e.	Temperature-pulse-respiration
	-06 ☐	f.	Full bed-bath
	-07 ☐	g.	Enema
	-08 ☐	h.	Catheterization
	-09 ☐	i.	Blood pressure reading
	-10 ☐	j.	Irrigation
	-11 ☐	k.	Oxygen therapy
	-12 ☐	l.	Intravenous injection
	-13 ☐	m.	Hypodermic injection
	OR		
	-14 ☐	n.	None of the above services received

13. DURING THE PAST 7 DAYS, DID – RECEIVE ANY MEDICATIONS?

CARD 3 / 14-3 ☐ 15-2 No (Skip to Question 14) ☐ -1 Yes

WHICH TYPES OF MEDICATIONS DID – RECEIVE? (Mark (X) All That Apply)

cc16-45 -01 ☐ a. Tranquilizers (e.g., Thorazine, Mellaril)

-02 ☐ b. Hypnotics – Sedatives (e.g., Nembutal, Seconal, Phenobarbital, Butisol, Placidyl, Chloral Hydrate)

-03 ☐ c. Stool softeners (e.g., Peri-Colace)

-04 ☐ d. Anti-Depressant (e.g., Elavil)

-05 ☐ e. Anti-Hypertensives (e.g,. Ismelin)

-06 ☐ f. Diuretics (e.g., Diuril, Esidrex)

-07 ☐ g. Analgesics (e.g., Aspirin, Darvon, Demerol, Percodan, Empirin with Codeine)

-08 ☐ h. Diabetic agents (e.g., Orinase, Insulin)

-09 ☐ i. Anti-inflammatory agents (e.g., Cortisone, Sodium Salicylate, Butazolidin, Indocin)

-10 ☐ j. Anti-infectives (i.e., antibiotics)

-11 ☐ k. Anti-Anginal drugs (e.g., Nitroglycerin, Peritrate)

-12 ☐ l. Cardiac Glycosides (e.g., Digitalis, Lanoxin)

-13 ☐ m. Anti-Coagulants (e.g., Dicumarol, Warfarin)

-14 ☐ n. Vitamins or iron

-15 ☐ o. Other types of medications not listed above

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14. THE FOLLOWING ACTIVITIES FOR DAILY LIVING LIST VARIOUS LEVELS OF CARE THAT MAY BE NEEDED BY A RESIDENT. PLEASE INDICATE THE ONE THAT BEST DESCRIBES THE LEVEL OF CARE NEEDED BY THIS RESIDENT. FOR EACH ACTIVITY, THE LEVELS ARE GIVEN IN ASCENDING ORDER: IN OTHER WORDS, THE LEVEL DESCRIBING THE MINIMUM CARE IS FIRST AND THE LEVEL DESCRIBING THE MOST CARE IS LAST. IF YOU ARE UNDECIDED WHICH OF TWO LEVELS TO INDICATE, CHOOSE THE ONE DESCRIBING THE LESSER AMOUNT OF CARE.

a. CONSIDERING THE FOLLOWING FOUR HYGIENE ACTIVITIES (WASHING FACE AND HANDS, BRUSHING TEETH OR DENTURES, COMBING HAIR, AND SHAVING OR APPLYING MAKE-UP) DOES THIS RESIDENT:

(Mark (X) Only One Box)

46-1 ☐ Perform all four with no assistance?

-2 ☐ Perform all four with no assistance, but needs help in getting and/or putting away equipment?

-3 ☐ Perform three or four with no assistance, but requires help with a complete bath?

-4 ☐ Require assistance with one or two of these hygiene activities?

-5 ☐ Require assistance with all four of these hygiene activities?

b. CONCERNING DRESSING, DOES THIS RESIDENT:

(Mark (X) Only One Box)

47-1 ☐ Get clothes from closets and drawers and completely dress without assistance?

-2 ☐ Get clothes from closets and drawers and completely dress with some assistance (tying shoes, fastening braces, closing buttons or zippers in back of garments)?

-3 ☐ Receive assistance in getting clothes, or in dressing (do not count tying shoes, fastening braces, closing buttons or zippers in back of garments as assistance)?

-4 ☐ Stay partly or completely undressed?

c. CONCERNING FEEDING, DOES THIS RESIDENT:

(Mark (X) Only One Box)

48-1 ☐ Feed self without assistance?

-2 ☐ Feed self with minor assistance (cutting meat or buttering bread)?

-3 ☐ Receive major assistance in feeding (do not count cutting meat or buttering bread)?

-4 ☐ Require intravenous feeding?

-5 ☐ Require tube feeding?

d. CONCERNING AMBULATION TO REACH THE TOILET ROOM, IS THIS RESIDENT:

(Mark (X) Only One Box)

51-1 ☐ Able to go to the toilet room without nurses' assistance (may use cane, walker, wheelchair, or other object of support), may manage bedpan or commode at night?

-2 ☐ Receiving nurses' assistance in going to the toilet room (do not count use of cane, walker, or other object of support), using bedpan or commode at night, or cleaning self or arranging clothes after elimination?

-3 ☐ Unable to go to the toilet room for the elimination process?

e. CONCERNING MOVING IN AND OUT OF A BED OR CHAIR, IS THIS RESIDENT:

(Mark (X) Only One Box)

Receiving no assistance? 52-1 ☐

Walking with assistance of one person? -2 ☐

Walking with assistance of two persons? -3 ☐

Up in a chair with assistance once in 8 hours? -4 ☐

Up in a chair with assistance twice in 8 hours? -5 ☐

Bedfast with assistance in turning every two hours? -6 ☐

Bedfast with assistance in turning every hour? -7 ☐

→ e.(1) DOES – HAVE BED SORES? 53-1 ☐ Yes -2 ☐ No

(continue with part f.)

f. CONCERNING CONTINENCE, IS THIS RESIDENT:

(Mark (X) Only One Box)

In control of both bowels and bladder? 54-1 ☐

An ostomy patient? -2 ☐

In control of bladder only? -3 ☐

In control of bowels only? -4 ☐

Not in control of bowels or bladder? -5 ☐

→ f.(1) IS – RECEIVING BOWEL AND/OR BLADDER RETRAINING?

55-1 ☐ Yes (Skip to Question 15a.)

-2 ☐ No

→ f.(2) WOULD RETRAINING GIVE THIS RESIDENT CONTROL OVER BOWELS AND/OR BLADDER?

56-1 ☐ Yes -2 ☐ No -3 ☐ Doubtful

15a. DOES THIS RESIDENT EXHIBIT ANY OF THE FOLLOWING BEHAVIOR?

b. DOES THIS RESIDENT EXHIBIT THIS BEHAVIOR MORE OFTEN THAN ONCE A WEEK OR ONCE A WEEK OR LESS?

		No	Yes	More often than once a week	Once a week or less
(1)	Depressed	57-2 ☐	-1 ☐ →	58-1 ☐	-2 ☐
(2)	Agitated, nervous	59-2 ☐	-1 ☐ →	60-1 ☐	-2 ☐
(3)	Abusive, aggressive	61-2 ☐	-1 ☐ →	62-1 ☐	-2 ☐
(4)	Confused, senile	63-2 ☐	-1 ☐ →	64-1 ☐	-2 ☐
(5)	Disturbed sleep	65-2 ☐	-1 ☐ →	66-1 ☐	-2 ☐
(6)	Other problem behavior	67-2 ☐	-1 ☐ → (Specify) _____ 68-	→ 69-1 ☐	-2 ☐

16a. DURING THIS RESIDENT'S STAY HERE, WHEN DID – LAST SEE A PHYSICIAN FOR TREATMENT, MEDICATION, OR FOR AN EXAMINATION?

CARD 4
14-4

Month ☐ cc15,16 | Day ☐ 17,18 | Year ☐ 19,20

OR ☐ 21-1 Has Never Seen A Doctor While Here (Skip to Question 17a.)

b. AT THAT TIME, DID – RECEIVE:

			Yes	No
(1)	An examination?	22-1	☐	-2 ☐
(2)	Treatment?	23-1	☐	-2 ☐
(3)	Prescription?	24-1	☐	-2 ☐
(4)	Other?	25-1	☐	-2 ☐

Specify _____ 26-

c. DID THE PHYSICIAN ATTEND THE RESIDENT: (Mark (X) Only One Box)

27-1 ☐ as a private physician?

-2 ☐ for the home itself which furnishes the medical care?

-3 ☐ temporarily as a replacement for the resident's private physician who was unable to attend the resident?

-4 ☐ under some other arrangement? (Specify) _____ 28-

d. DOES A PHYSICIAN EXAMINE THIS RESIDENT: (Mark (X) Only One Box)

29-1 ☐ only when called?

-2 ☐ irregularly, but without being called?

-3 ☐ on a scheduled basis?

d. (1) HOW OFTEN DOES THE PHYSICIAN EXAMINE THE RESIDENT? (Mark (X) Only One Box.)

30-1 ☐ once a week

-2 ☐ every 2 weeks

-3 ☐ once a month

-4 ☐ every three months

-5 ☐ once a year

-6 ☐ other (Specify) _____ 31-

17a. DOES – WEAR EYE GLASSES?

Yes ☐ 32-1 | No ☐ -2

b. IS – SIGHT WITH GLASSES: (Mark (X) Only One Box)

33-1 ☐ not impaired? (e.g., can read ordinary newspaper print)

-2 ☐ partially impaired? (e.g., can watch television 8 to 12 feet across the room)

-3 ☐ severely impaired? (e.g., can recognize the features of familiar persons if they are within 2 to 3 feet)

-4 ☐ completely lost? (e.g., blind)

c. IS – SIGHT: (Mark (X) Only One Box)

33-1 ☐ not impaired? (e.g., can read ordinary newspaper print without glasses)

-2 ☐ partially impaired? (e.g., can watch television 8 to 12 feet across the room)

-3 ☐ severely impaired? (e.g., can recognize the features of familiar persons if they are within 2 to 3 feet)

-4 ☐ completely lost? (e.g., blind)

18a. DOES – USE A HEARING AID?

Yes ☐ 34-1 | No ☐ -2

b. IS – HEARING WITH A HEARING AID: (Mark (X) Only One Box)

35-1 ☐ not impaired? (e.g., can hear a telephone conversation on an ordinary telephone)

-2 ☐ partially impaired? (e.g., can hear most of the things a person says)

-3 ☐ severely impaired? (e.g., can hear only a few words a person says or loud noises)

-4 ☐ completely lost? (e.g., deaf)

c. IS – HEARING: (Mark (X) Only One Box)

35-1 ☐ not impaired? (e.g., can hear a telephone conversation on an ordinary telephone)

-2 ☐ partially impaired? (e.g., can hear most of the things a person says)

-3 ☐ severely impaired? (e.g., can hear only a few words a person says or loud noises)

-4 ☐ completely lost? (e.g., deaf)

19. IS – ABILITY TO SPEAK: (Mark (X) Only One Box)

38-1 ☐ not impaired? (e.g., is able to be understood; can carry on a normal conversation)

-2 ☐ partially impaired? (e.g., is able to be understood but has difficulty pronouncing some words)

-3 ☐ severely impaired? (e.g., cannot carry on a normal conversation; is understood only with difficulty)

-4 ☐ completely lost? (e.g., is mute)

20a. DOES THIS RESIDENT HAVE DENTURES?

☐ 39-1 Yes → ☐ -2 No (Skip to Question 21a.)

b. DOES – USE THE DENTURES?

☐ 40-1 Yes ☐ -2 No

21a. DURING THE LAST MONTH, DID – LEAVE THE HOME FOR ANY RECREATIONAL OR LEISURE ACTIVITIES?

☐ 41-1 Yes ← ☐ -2 No →

b. FOR WHICH OF THE FOLLOWING ACTIVITIES DID – LEAVE THE HOME? (Mark (X) All That Apply)

cc42-52 -1 ☐ Get books, etc., from the library

-2 ☐ Attend plays, movies, concerts, etc.

-3 ☐ Attend arts and crafts classes outside the home

-4 ☐ Visit museums, parks, fairs, etc.

-5 ☐ Go on shopping trips organized by the home

-6 ☐ Go on independent shopping trips organized by the resident or visitors

-7 ☐ Visit a beauty shop or barber shop

-8 ☐ Visit community clubs (such as community centers, senior citizen clubs, service clubs, bridge clubs, unions, etc.)

-9 ☐ Attend religious services or other religious activities

-0 ☐ Go for a walk

-& ☐ Other, (Specify) _____ 53-

c. WHY DIDN'T – LEAVE THE HOME TO PARTICIPATE IN ANY ACTIVITIES DURING THE LAST MONTH? (Mark (X) All That Apply)

cc42-52 -1 ☐ Resident was too ill or was not able to move well enough to participate

-2 ☐ Resident was not interested

-3 ☐ Staff was unable to determine resident's interests at this point

-4 ☐ Staff feels that the resident's behavior will not be tolerated outside the home

-5 ☐ No one was available to accompany the resident

-6 ☐ Resident cannot afford these activities

-7 ☐ Lack of transportation

-8 ☐ Other, (Specify) _____ 53-

22a. DURING THE PAST YEAR, HAS THIS RESIDENT BEEN ON ANY KIND OF LEAVE OVERNIGHT OR LONGER, EXCLUDING LEAVE FOR MEDICAL REASONS?

☐ 54-1 Yes → ☐ -2 No (Skip to Question 23a.) ☐ -3 Don't know (Skip to Question 23a.)

b. WHERE DID – USUALLY GO WHEN ON LEAVE? (Mark (X) Only One Box)

55-1 ☐ To own home or apartment

-2 ☐ To home of family or relatives

-3 ☐ To home of unrelated friends

-4 ☐ To foster home

-5 ☐ To boardinghouse or room

-6 ☐ To another place, (Specify) _____ 56-

-7 ☐ Don't know

c. ABOUT HOW OFTEN DID THIS RESIDENT GO ON LEAVE? (Mark (X) Only One Box)

57-1 ☐ Nearly every week

-2 ☐ About once a month

-3 ☐ About once every two months

-4 ☐ Several times a year

-5 ☐ About once a year or less

-6 ☐ Other (Specify) _____ 58-

-7 ☐ Don't know

23a. DOES – HAVE ANY VISITORS?

CARD 5 14-5

☐ Yes 15-1 ☐ No -2 ☐ Don't know -3

(Skip to Question 24)

b. HOW FREQUENTLY DO VISITORS SEE THE RESIDENT? (Mark (X) Only One Box)

16-1 ☐ Nearly every week

-2 ☐ About once a month

-3 ☐ About once every two months

-4 ☐ Several times a year

-5 ☐ About once a year or less

-6 ☐ Other (Specify)_____ 17-

-7 ☐ Don't know

---

24. HOW MANY BEDS ARE IN – ROOM? (Mark (X) Only One Box)

18-1 ☐ One bed (i.e., the resident's own bed)

-2 ☐ Two beds

-3 ☐ Three beds

-4 ☐ Four beds

-5 ☐ Five or more beds

25a. HAS THIS RESIDENT LIVED IN THIS FACILITY FOR ONE FULL MONTH OR LONGER?

☐ Yes 19-1 ☐ No -2

Stop, go on to next questionnaire.

b. LAST MONTH, WHAT WAS THE **BASIC** CHARGE FOR THIS RESIDENT'S LODGING, MEALS, AND NURSING CARE NOT INCLUDING PRIVATE DUTY NURSING OR OTHER SPECIAL CHARGES?

☐ No charge is made for care (Skip to Question 26a.)

$_____ • _____ cc20-25

c. LAST MONTH, WHAT WAS THE **TOTAL** CHARGE FOR THIS RESIDENT'S CARE, INCLUDING ALL CHARGES FOR SPECIAL SERVICES, DRUGS, AND SPECIAL MEDICAL SUPPLIES?

☐ No charge is made for care (Skip to Question 26a.)

$_____ • _____ cc26-31

(1) DID THIS AMOUNT INCLUDE SPECIAL CHARGES FOR

		No	Yes
(a)	physician services?	32-2 ☐	-1 ☐
(b)	private duty nursing?	33-2 ☐	-1 ☐
(c)	therapy?	34-2 ☐	-1 ☐
(d)	drugs?	35-2 ☐	-1 ☐
(e)	special medical supplies?	36-2 ☐	-1 ☐
(f)	special diet?	37-2 ☐	-1 ☐
(g)	other?	38-2 ☐	-1 ☐

Specify_____ -39

26a. WHAT WERE **ALL** THE SOURCES OF PAYMENT FOR THIS RESIDENT'S CARE LAST MONTH?
(Mark (X) All That Apply)

cc40-48

☐ (1) Own income or family support (private plans, retirement funds, social security, etc.)

☐ (2) Medicare (Title XVIII)

☐ (3) Medicaid (Title XIX)

☐ (4) Other public assistance or welfare

☐ (5) Church support

☐ (6) VA contract

☐ (7) Initial payment-life care

☐ (8) No charge is made for care

☐ (9) Other (Specify)_____ 49-

b. WHAT WAS THE **PRIMARY** SOURCE OF PAYMENTS FOR – CARE LAST MONTH?
(Mark (X) Only One Box.)

50-1 ☐ Own income or family support (private plans, retirement funds, social security, etc.)

-2 ☐ Medicare (Title XVIII)

-3 ☐ Medicaid (Title XIX)

-4 ☐ Other public assistance or welfare

-5 ☐ Church support

-6 ☐ VA contract

-7 ☐ Initial payment-life care

-8 ☐ No charge is made for care

-9 ☐ Other (Specify)_____ 51-

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