Data from the
NATIONAL HEALTH SURVEY

Series 13
Number 32

# 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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## SYMBOLS

| | |
|---|---|
| Data not available | - - - |
| Category not applicable | . . . |
| Quantity zero | - |
| Quantity more than 0 but less than 0.05 | 0.0 |
| Figure does not meet standards of reliability or precision | * |

# 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 |
| **Ownership** | Average total monthly charge[3] | | | | | Percent distribution of residents[4] | | | | |
| 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

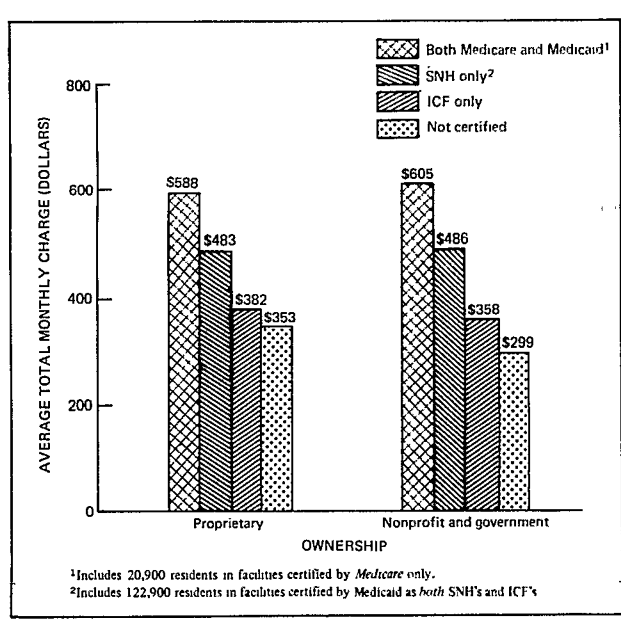
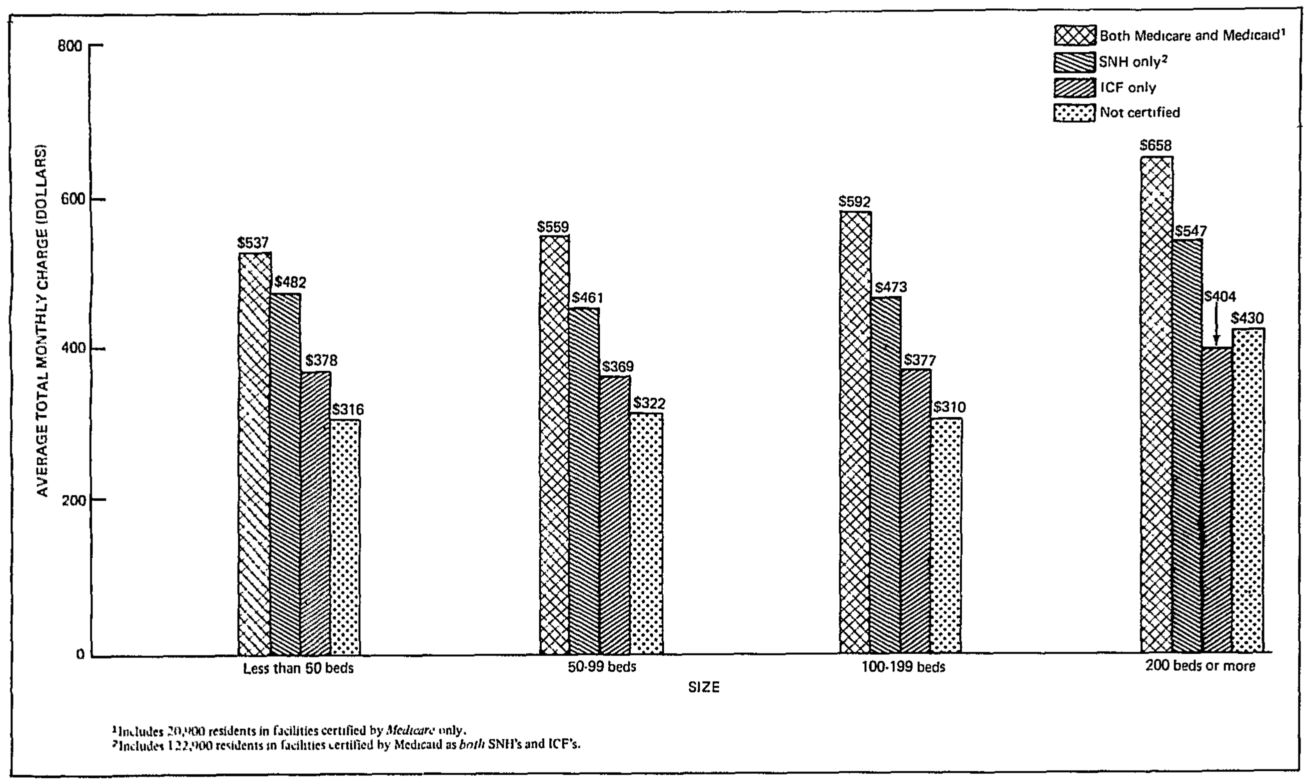
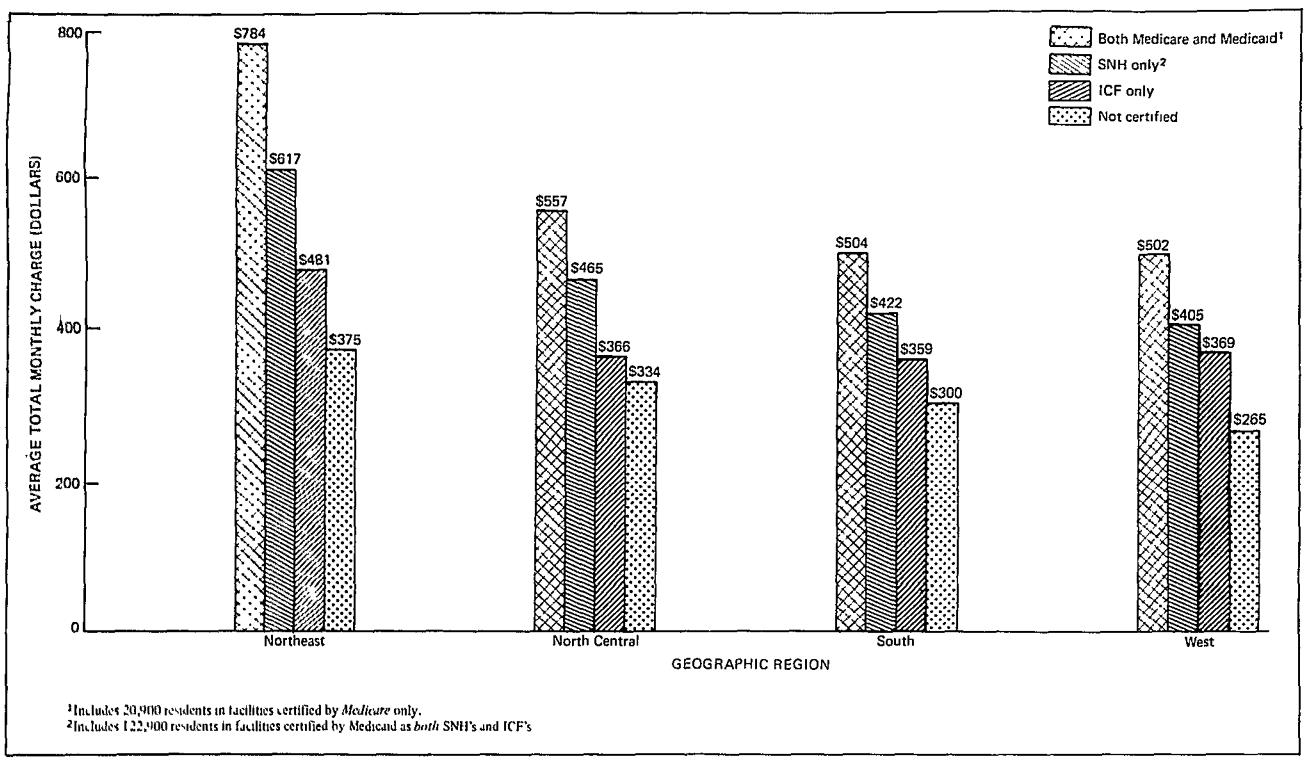



Figure 1. Average total monthly charge for care, by certification and ownership: United States, August 1973-April 1974




[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.

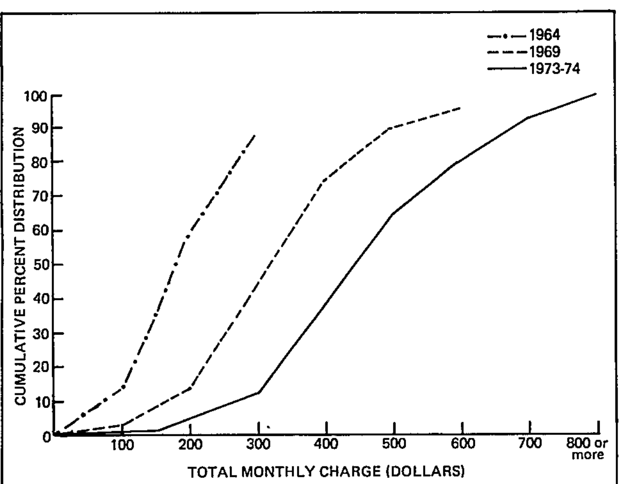



Figure 4. Cumulative percent distribution of nursing home residents, by total monthly charge for care: United States, 1964, 1969, and 1973-74

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.

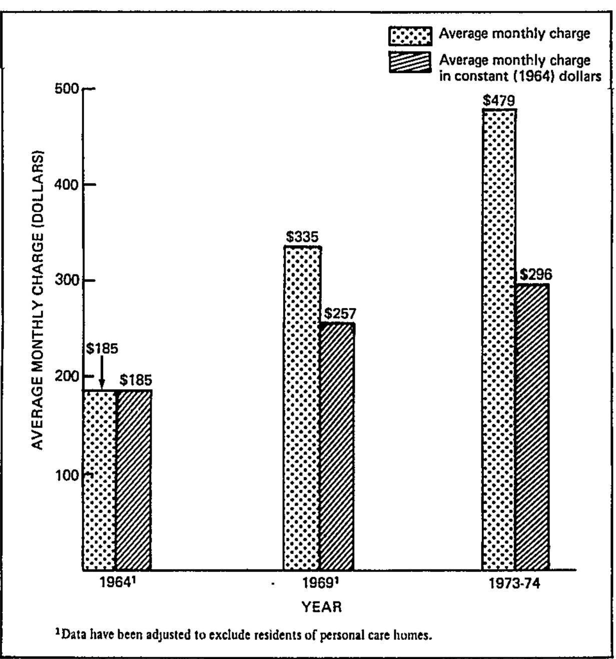



Figure 5. Average total monthly charge for care and average total monthly charge in constant (1964) dollars: United States, 1964, 1969, and 1973-74

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).

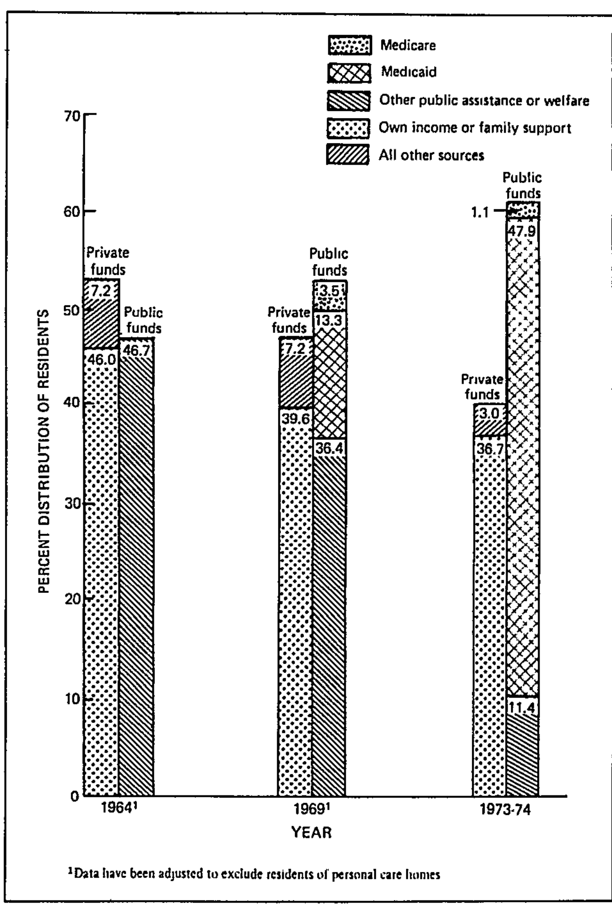



Figure 6. Percent distribution of residents by primary source of payment: United States, 1964, 1969, and 1973-74

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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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 |
| | | | Percent distribution | | | | | | | | |
| Medicaid only: ICF | | | | | | | | | | | |
| 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 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 |
| 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 | $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 |

| Estimated number of residents | $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

RELATIVE STANDARD ERROR IN PERCENT

SIZE OF ESTIMATE

100 1,000 10,000 100,000 1,000,000

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.**

[Base of percentage shown on curves]

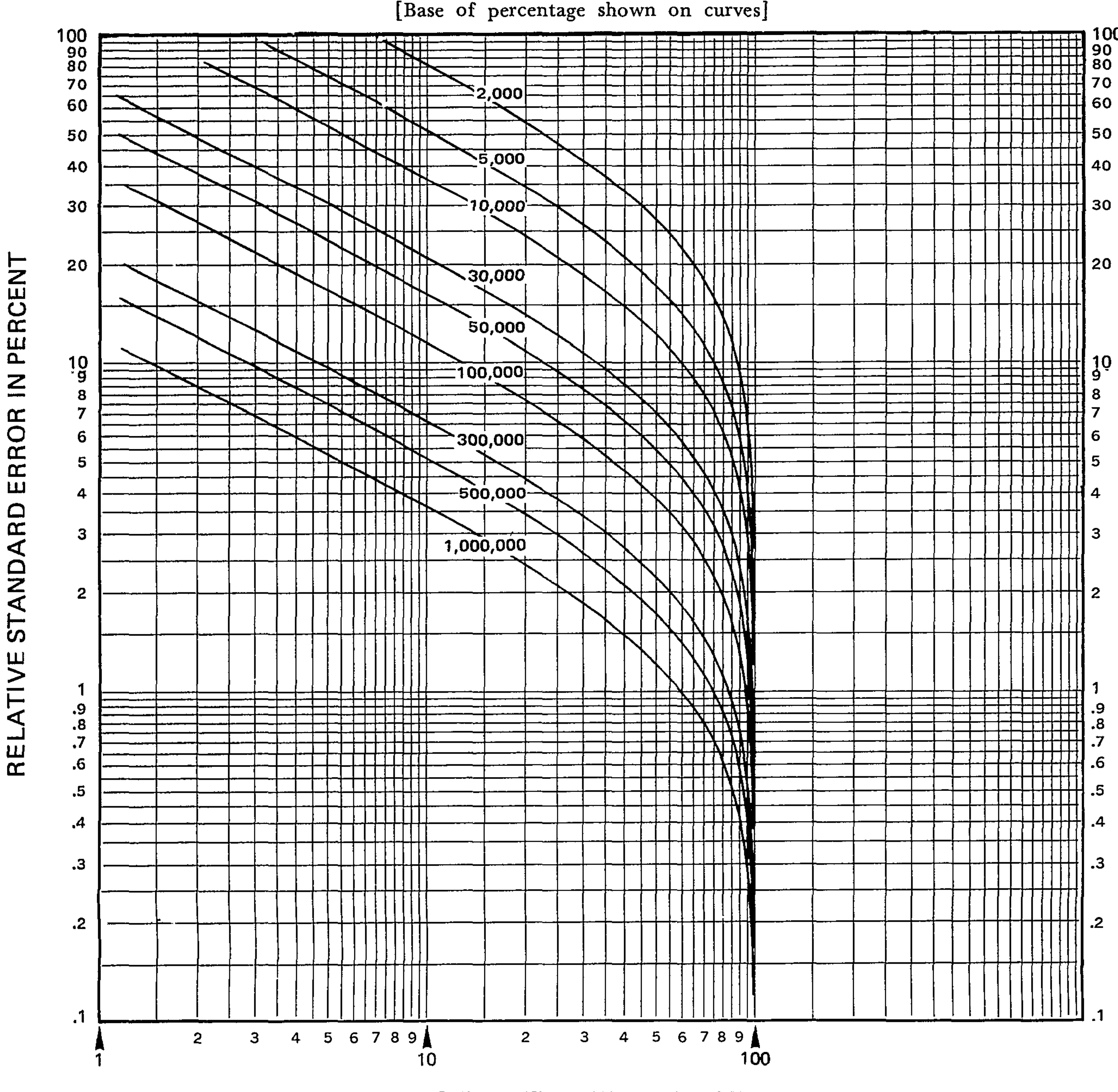


*Illustration of use of figure II:* Table 13 shows that 17.3 percent of the 484,300 Medicaid recipients had a length of stay of less than 6 months. From figure 2, the relative standard error for 17.3 percent (on scale at bottom of chart) is between 4.8 percent for a base of 300,000 (read from the scale 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 $Y$ = average total monthly charge, $X$ = length of stay, $\alpha$ = "Y-intercept," i.e., value of average total monthly charge if length of stay equaled zero, $\beta$ = 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, $\epsilon$ = 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 $S_{\bar{y}_i}$ be its estimated standard error for the $i$th 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 $\beta$.

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:

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

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 |

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## 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 ☐ → 6b
(6) Other place, (Specify) ______ 36- -6 ☐ → 6b
(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)

Form 73NHS-7

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?

| a. At admission | b. At 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, arerioles, 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; feableness.)

-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

Form 73NHS-7

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. | Professional 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

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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

---

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?

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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 ☐ |

(-4 to -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 ☐ |

(-3 to -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?

☐ Yes 56-1 ☐ No -2 ☐ Doubtful -3

---

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 ☐ |

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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)

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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?

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

b. DOES – USE THE DENTURES?

☐ Yes (40-1) ☐ No (-2)

---

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

☐ Yes (41-1) ☐ No (-2)

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?

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

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

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CARD 5
14-5

23a. DOES – HAVE ANY VISITORS?

☐ 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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